Arizona Health Care Cost Containment System

Contract Year Ending 2017
External Quality Review Annual Report

for

Acute Care and Comprehensive Medical and Dental Program

June 2018

HSAG HEALTH SERVICES ADVISORY GROUP

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Contents

1. Executive Summary

The Code of Federal Regulations (CFR) at 42 CFR §438.364[1-1] 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 §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 and timeliness of, and access to, healthcare services and HSAG's recommendations for improving the quality of services.

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

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

- Section 3—A description of the contract year ending (CYE) 2016 and CYE 2017 EQR activities.
- Section 4—An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care program and those that are specific to the Acute Care program for CYE 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 AHCCCS methodology for the organizational review (OR) and a presentation of CYE 2016 Contractor-specific OR results as well as HSAG's associated findings and recommendations for four Contractors and CAP updates for two Contractors. For this annual report, AHCCCS provided data and information for six Contractors for CYE 2017.
- Section 7 (Performance Measure Performance)—A presentation of rates for AHCCCS-selected performance measures for each Acute Care and Comprehensive Medical and Dental Program (CMDP) Contractor as well as HSAG's associated findings and recommendations for CYE 2016.
- Section 8 (Performance Improvement Project Performance)—A presentation of Contractor-specific PIP qualitative analyses and interventions for the Acute Care Contractors and CMDP for CYE 2016.
- Section 9 (Consumer Assessment of Healthcare Providers and Systems [CAHPS®])[1-2]—A presentation of Contractor-specific CAHPS (adult and child) results for the Acute Care Contractors as well as HSAG's associated findings and recommendations for CYE 2017.

Overview of the CYE 2017 External Review

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

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

[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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 four Contractors—UHCCP-Acute, Health Net, HCA, and Care1st—during CYE 2017. Between CYE 2016 and CYE 2017, AHCCCS monitored the progress of all Contractors in implementing their CAPs for the recommendations from the CYE 2016 OR review cycle. (Included in this report, are the CAP updates for two Contractors that had CYE 2016 activities completed in CYE 2017.)

The CYE 2016 OR (which includes CYE 2016 and CYE 2017 activities) was organized into 11 standard areas. For the Acute Care Contractors, each standard area consisted of several elements designed to measure the Contractor's performance and compliance. The following 11 standard areas and coinciding numbers of elements are used throughout the report:

- Corporate Compliance (CC), five elements
- Claims and Information Systems (CIS), 12 elements
- Delivery Systems (DS), 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), 25 elements
- Member Information (MI), nine elements
- Quality Management (QM), 27 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 acute contract provisions. A Contractor may receive up to a maximum possible score of 100 percent for each standard measured during the CYE 2016 OR. Within each standard are specific scoring detail criteria worth a defined percentage of the total possible score.

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

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

The following table summarizes outcomes of the reviews conducted by AHCCCS related to the four Contractors' scores in the 11 standard areas for the comprehensive OR. Table 1-1 details the numbers of scores at or above 95 percent, numbers of scores below 95 percent, and numbers, if any, of corrective actions for each standard area reviewed. Combined totals for the number of scores above and below the 95 percent compliance threshold are included at the bottom of the table, as well as a combined total number of required corrective actions assigned in all standard areas.

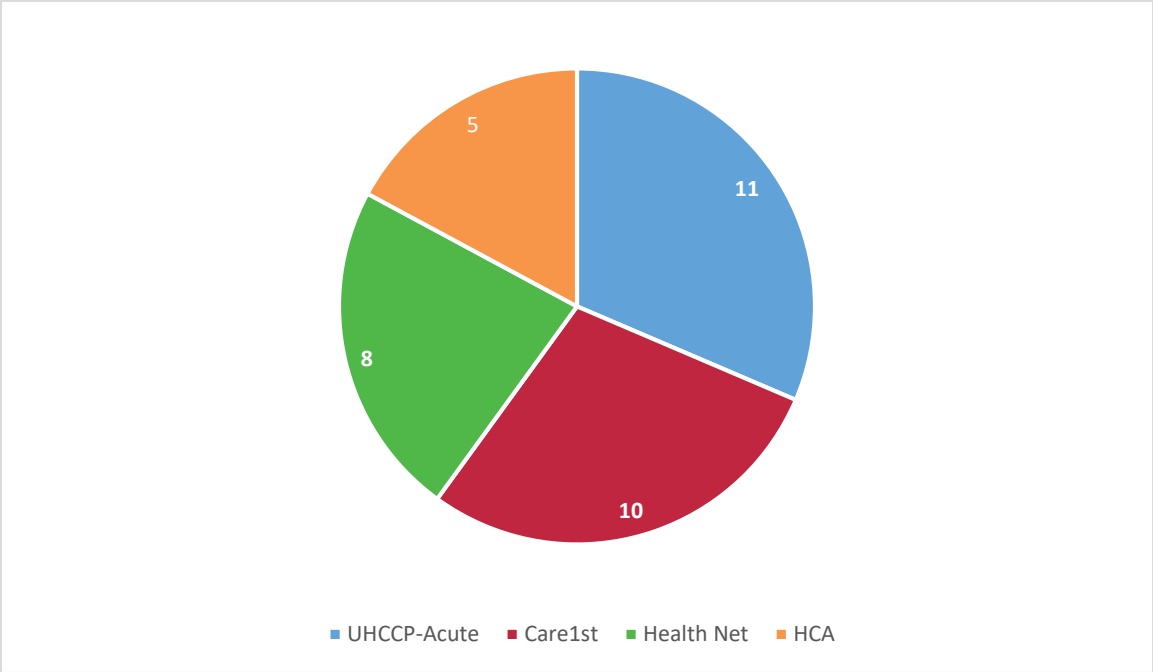
Table 1-1—Score and CAP Summary per Standard Area

Standard Area	Total Scores 95% and Above	Total Scores Below 95%	Required Corrective Actions
Corporate Compliance	2	2	5
Claims and Information Systems	2	2	12
Delivery Systems	3	1	6
General Administration	3	1	1
Grievance Systems	4	0	3
Adult, EPSDT, and Maternal Child Health	3	1	11
Medical Management	3	1	8
Member Information	3	1	1
Quality Management	4	0	6
Reinsurance	4	0	0
Third-Party Liability	3	1	1
Combined Totals	**34**	**10**	**54**

Standards with greatest opportunity for improvement, based on the number of CAPs required, were CIS, MCH, and MM. Standards requiring the fewest CAPs were GA, MI, RI, and TPL. Even though three of four Contractors scored above 95 percent for the MCH standard, AHCCCS required 11 CAPs. The strongest performance was in RI. For each of the CC and CIS standards, two Contractors scored below 95 percent.

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

Figure 1-1—Total Standard Areas With Scores at 95 Percent and Above



UHCCP-Acute, demonstrated scores of 95 percent and above for all eleven standard areas, which was the highest level of compliance, compared to the other three Contractors. Care1st demonstrated the second highest number of standard areas scored at 95 percent and above, with 10 of 11 standards. Health Net had eight of 11 standard areas scored at or above 95 percent. HCA had five of 11 standard areas scored at or above 95 percent, the lowest number of standard areas at 95 percent and above compared to the other three contractors.

Conclusions

For the CYE 2017 AHCCCS OR, two of the four Contractors demonstrated overall positive results. All Contractors scored at or above 95 percent in the GS, QM, and RI standards; and three of four Contractors scored at or above 95 percent in the DS, GA, MCH, MM, MI, and TPL standard areas. The two standard areas for which the highest number of Contractors scored below the 95 percent compliance threshold were the CC and CIS standards.

Recommendations

Based on AHCCCS' review of the Acute Care and CMDP Contractors' performance conducted in CYE 2017 (for the CYE 2016 review period) and the associated opportunities for improvement identified during the OR, HSAG recommends the following:

- Contractors should conduct internal reviews of operational systems to identify barriers that impact 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 their current monitoring processes and activities to identify strengths and opportunities for improvement within their operational processes.
- 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.
- Contractors should implement control systems to address specific findings in the CIS standard that are consistent compliance issues across Contractors related to the requirement that the Contractors must pay applicable interest on all claims (including overturned claim disputes) and that Contractors' remittance advice to providers must contain the minimum required information.
- AHCCCS should concentrate improvement efforts on the CC and CIS standards, as both standards were problematic in CYE 2016 and CYE 2017 ORs.
- AHCCCS could consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. For example, for the CC standard, four out of seven Contractors did not meet the AHCCCS performance threshold. AHCCCS could present identified best practices regarding fraud, waste, and abuse issues and facilitate a group discussion on Contractors' policies and procedures. In addition, AHCCCS could consider conducting a root cause analysis with the Contractors to determine why Contractors continue to have difficulty complying with the CIS standard.
- AHCCCS could consider developing a template or checklist for the Contractors to ensure that Contractors include all minimum required information in remittance advice to providers. The element requiring that Contractors (and their subcontractors) must include the reason and detailed

descriptions of payments less than billed charges, denials, and adjustments on the remits has been out of compliance for both the CYE 2016 and CYE 2017 ORs for all but one of the Contractors. AHCCCS may also consider reviewing the data capture and transfer processes used for the claims processing systems to ensure alignment with the requirements set forth in the CIS standard. Targeting compliance for this standard is of great import as AHCCCS will be working with Contractors (in some cases, new Contractors) who will be providing integrated services, working with new populations, and operating in new geographic service areas, so this is a very important standard to target for compliance.

Performance Measures

Comparative Results for Acute Care Contractors—CYE 2016

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 24 measure rates for the Acute Care Contractors and 14 measure rates for CMDP. 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 measure indicator for the nine Acute Care 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 AHCCCS MPS.

Table 1-2—Acute Care Contractors—Performance Measurement Results

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	39.9%	39.2%	-1.7%	**P<.001**	41.0%
Adults' Access to Preventive /Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	78.3%	76.8%	-1.9%	**P<.001**	75.0%
Annual Dental Visits					
2–20 Years	63.7%	58.6%	-8.0%	**P<.001**	60.0%
Annual Monitoring for Patients on Persistent Medications					
Total	—	86.7%	—	—	75.0%

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value) [1]	Minimum Performance Standard
Breast Cancer Screening					
Breast Cancer Screening	52.2%	53.8%	2.9%	**P<.001**	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	50.9%	50.6%	-0.5%	P=.073	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	95.1%	92.1%	-3.1%	**P<.001**	93.0%
25 Months–6 Years	87.7%	85.4%	-2.6%	**P<.001**	84.0%
7–11 Years	91.5%	90.6%	-1.0%	**P<.001**	83.0%
12–19 Years	89.3%	88.0%	-1.4%	**P<.001**	82.0%
Chlamydia Screening in Women					
Total	46.8%	47.4%	1.3%	P=.072	63.0%
Developmental Screening in the First Three Years of Life					
Developmental Screening in the First Three Years of Life	18.3%	23.7%	29.2%	**P<.001**	55.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	62.1%	57.7%	-7.1%	**P<.001**	65.0%
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	64.6%	61.0%	-5.5%	**P<.001**	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.*

— 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.

As presented in Table 1-2, a statistically significant decrease in performance was demonstrated by the Acute Care Contractors for nine of 14 measure rates (*Adolescent Well-Care Visits*; *Adults' Access to Preventive/Ambulatory Health Services*; *Annual Dental Visits—2–20 Years*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*). Two performance rates (*Breast Cancer Screening* and *Developmental Screening in the First Three Years of Life*) demonstrated a statistically significant increase from CYE 2015 to CYE 2016. Six of the 14 performance measure rates (*Adults' Access to Preventive/Ambulatory Health Services*; *Annual Monitoring for Patients on Persistent Medications—Total*; *Breast Cancer Screening*; *Children and Adolescents' Access to Primary Care*

Practitioners—25 Months–6 Years, *7–11 Years*, and *12–19 Years*) met or exceeded the MPSs for CYE 2016.

Conclusions

The Acute Care Contractors exceeded the MPS for three of the four *Children and Adolescents' Access to Primary Care Practitioners* measure rates; however, the remaining indicator (*12–24 Months*) demonstrated a statistically significant decline, causing the rate to fall below the MPS for CYE 2016. The Acute Care Contractors showed low performance for the *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates, with these rates having statistically significant declines in performance and falling below the MPSs. Further, the performance measure rates for *Cervical Cancer Screening*, *Chlamydia Screening in Women*, and *Developmental Screening in the First Three Years of Life* fell below the MPSs by 13.4 percentage points, 15.6 percentage points, and 31.3 percentage points, respectively. Conversely, the *Annual Monitoring for Patients on Persistent Medications—Total* performance measure rate exceeded the MPS by 11.7 percentage points.

Recommendations

With eight measure rates (*Adolescent Well-Care Visits*; *Annual Dental Visits—2–20 Years*; *Cervical Cancer Screening*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) falling below the established MPSs for CYE 2016, the Acute Care Contractors have opportunities for improvement.

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

Comprehensive Medical and Dental Program (CMDP)

Findings

Table 1-3 presents performance measure rates for CMDP. The table displays the following information for each measure: CYE 2015 performance; CYE 2016 performance; the relative percentage changes between the CYE 2015 and CYE 2016 rates; the statistical significance of the relative percentage changes; and the AHCCCS MPS.

Table 1-3—CMDP—Performance Measurement Results

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	64.3%	68.3%	6.2%	**P=.002**	41.0%
Annual Dental Visits					
2–20 Years	68.3%	68.0%	-0.6%	P=.604	65.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	99.0%	98.3%	-0.6%	P=.233	93.0%
25 Months–6 Years	93.0%	93.2%	0.2%	P=.800	84.0%
7–11 Years	94.3%	96.0%	1.8%	P=.089	83.0%
12–19 Years	96.1%	95.9%	-0.2%	P=.819	82.0%
Chlamydia Screening in Women					
Total	54.4%	52.6%	-3.3%	P=.646	63.0%
Developmental Screening in the First Three Years of Life					
Developmental Screening in the First Three Years of Life	26.7%	30.0%	12.4%	**P=.017**	55.0%
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	69.8%	70.7%	1.3%	P=.520	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.*

As seen in Table 1-3, two measures demonstrated statistically significant increases in performance from CYE 2015 to CYE 2016. No measures demonstrated statistically significant declines in performance from CYE 2015 to CYE 2016. Two measure rates (*Chlamydia Screening in Women—Total* and *Developmental Screening in the First Three Years of Life*) did not meet the MPS for CYE 2016.

Conclusions

CMDP demonstrated a strength in the *Adolescent Well-Care Visits* performance measure rate, with the rate exceeding the MPS by 27.3 percentage points. Further, CMDP also demonstrated strength in the *Children and Adolescents' Access to Primary Care Practitioners* performance measures, as all four measure indicators exceeded the MPSs by at least 5 percentage points for CYE 2016. CMDP demonstrated an opportunity for improvement for the *Chlamydia Screening in Women—Total* and *Developmental Screening in the First Three Years of Life* performance measure rates, which fell below the MPSs by 10.4 percentage points and 25 percentage points, respectively.

Recommendations

Following the CYE 2016 performance measurement period, with the rates for two measures (*Chlamydia Screening in Women—Total* and *Developmental Screening in the First Three Years of Life*) falling below the established MPSs, CMDP has opportunity for improvement. HSAG recommends that CMDP focus efforts on increasing screening for chlamydia in women and ensuring young children receive developmental screenings. Results of these focused efforts should be used to identify strategies that can be translated and applied to drive improvement for other performance measures. HSAG also recommends that AHCCCS re-evaluate the MPSs for the CMDP populations, as the MPSs are similar to those used for the Acute Care Contractors, despite the differences in the CMDP population.

Performance Improvement Projects (PIPs)

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

AHCCCS implemented the *E-Prescribing* PIP to improve preventable errors in communicating a medication between a prescriber and a pharmacy. Research indicated that clinicians make fewer errors when using an electronic system rather than handwritten prescriptions.[1-3] AHCCCS found that sending electronic prescriptions can reduce mistakes related to medication types, dosages, and member information and that electronic prescribing assists pharmacies in identifying potential problems related to medication management and potential reactions members may encounter, especially for those taking multiple medications.

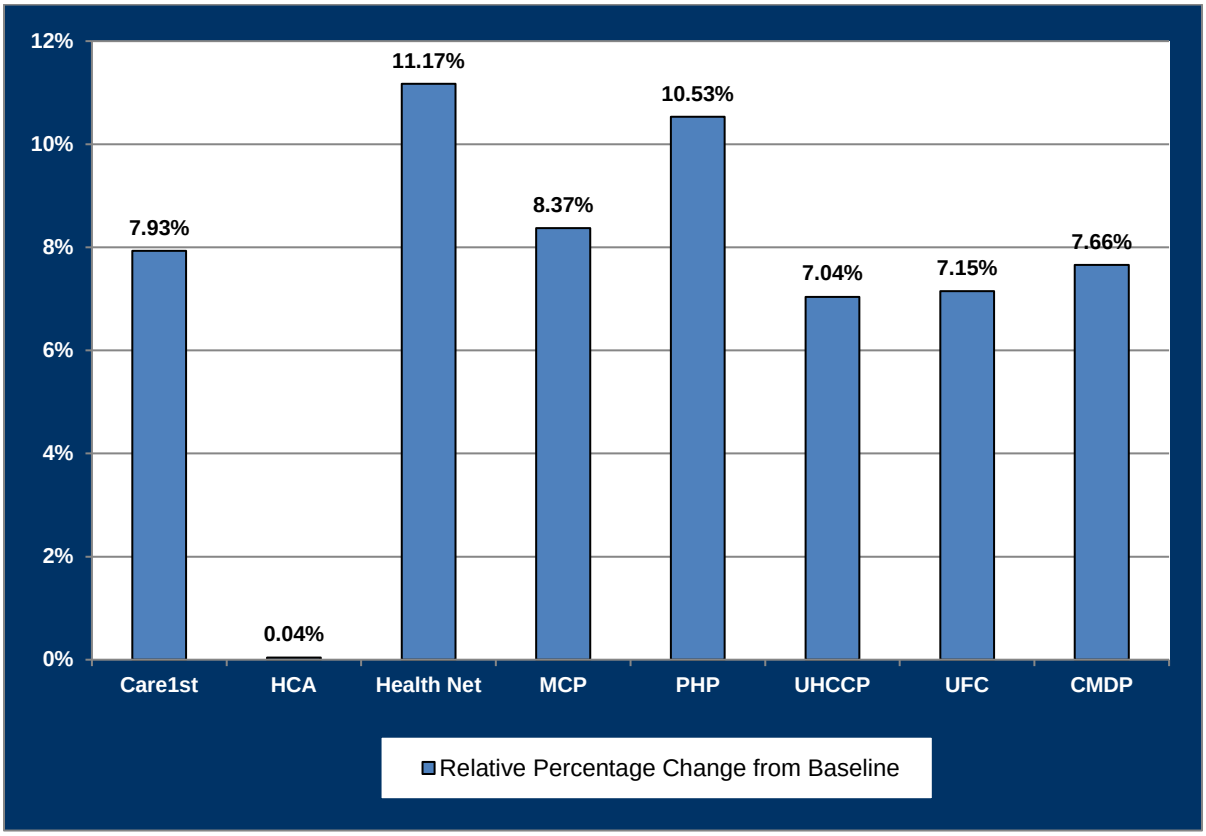
The purpose of the *E-Prescribing* PIP is to increase the number of providers ordering prescriptions electronically (Indicator 1) and to increase the percentage of prescriptions submitted electronically (Indicator 2) in order to improve patient safety. AHCCCS' goal is to demonstrate a statistically significant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

[1-3] Electronic prescribing improves medication safety in community-based office practices. Kaushal R, et al. 6, Alexandria: Springer, 2010, Journal of General Internal Medicine, Vol. 25, pp. 530-536.

Findings

This was the Remeasurement 1 (October 1, 2015, through September 30, 2016) reporting period for the *E-Prescribing* PIP. The Contractors implemented many solid interventions to improve rates for both indicators.

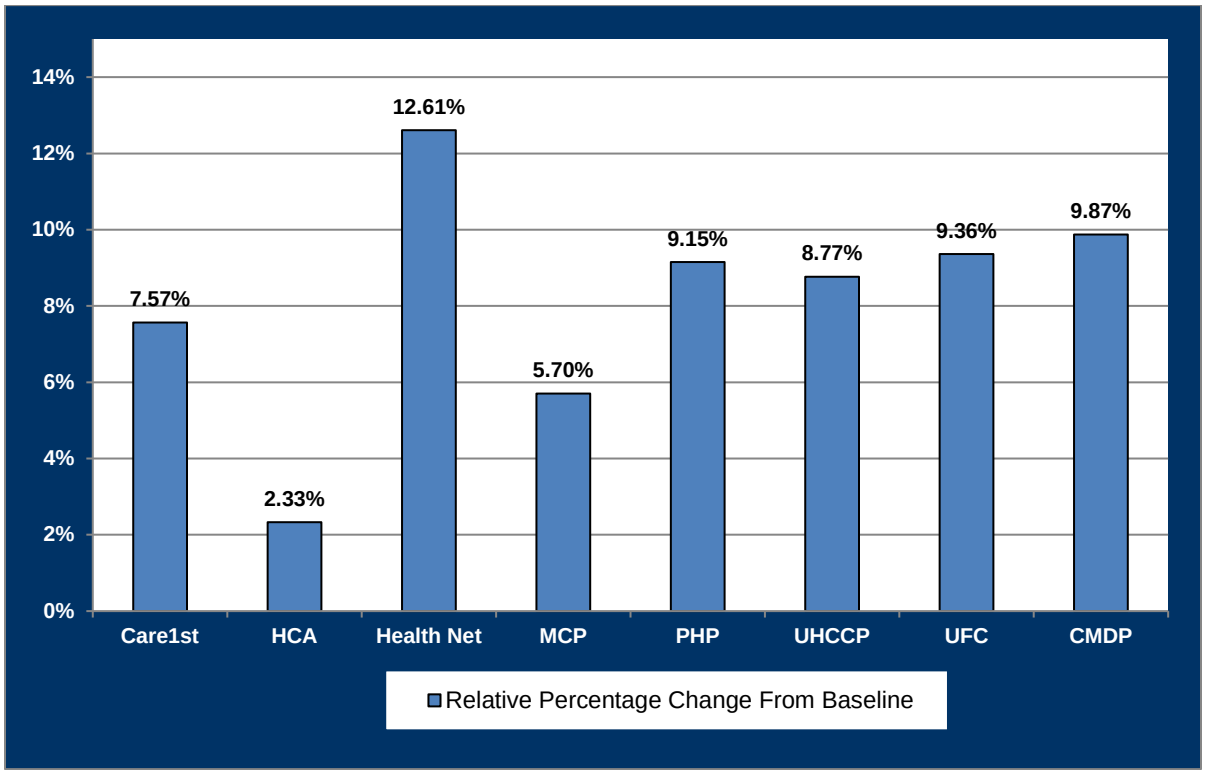
Figure 1-2—Performance Improvement Projects—*E-Prescribing:* Indicator 1: The percentage of providers who prescribed at least one prescription electronically—All Acute and CMDP Contractors*



*Percentage totals have been rounded.

Figure 1-2 shows that the Contractor with the greatest improvement was Health Net, with a relative percentage change from baseline of 11.17 percent. The Contractor with the greatest opportunity for improvement was HCA, with a relative percentage change from baseline of 0.04 percent. Excepting HCA, all Contractors tasked with the PIP exceeded respective baseline rates by statistically significant amounts at the first remeasurement for Indicator 1.

Figure 1-3—Performance Improvement Projects—*E-Prescribing:* Indicator 2: The percentage of prescriptions sent electronically—All Acute and CMDP Contractors *



*Percentage totals have been rounded.

Figure 1-3 shows that the Contractor with the greatest improvement was Health Net, with a relative percentage change from baseline of 12.61 percent. The Contractor with the greatest opportunity for improvement was HCA, with a relative percentage change from baseline of 2.33 percent. All Contractors tasked with the PIP exceeded respective baseline rates by statistically significant amounts at the first remeasurement for Indicator 2. This finding indicates that these Contractors need only sustain their gains for an additional remeasurement cycle.

All Contractors participated in an e-prescribing workgroup (workgroup) formed with other Arizona Contractors. The workgroup developed two surveys. One survey asked providers to identify contributing factors to e-prescribing rates to identify best practices or barriers, and the other addressed Arizona electronic health record (EHR) vendors to determine their system capabilities for e-prescribing controlled substances. Other interventions included education to providers, facility staff, and members; targeting high-volume prescribers; and providing incentives to encourage e-prescribing.

Conclusions

Contractors implemented strong interventions in CYE 2016 for the *E-Prescribing* PIP. HCA was the only Contractor without statistically significant improvement for Indicator 1 in the first remeasurement period. All other Acute and CMDP Contractors performed well on 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

Contractors are 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. In addition, HSAG recommends that AHCCCS continue to encourage 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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Plan-Specific Adult and Child Survey

The CAHPS Health Plan Surveys are standardized survey instruments that measure members' satisfaction with their healthcare. During 2016–2017, HSAG administered the *CAHPS 5.0 Adult Medicaid Health Plan Survey* with the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-4] supplemental set to adult members in the Acute Care program, and the *CAHPS 5.0 Child Medicaid Health Plan Survey* with the HEDIS supplemental item set and the Children with Chronic Conditions (CCC) measurement set to child members (who met age and enrollment criteria) in the Comprehensive Medical and Dental Program (CMDP). The CAHPS surveys were administered using a plan-specific sampling methodology for the adult and child populations. The survey administration protocols used were in accordance with the National Committee for Quality Assurance (NCQA) specifications. These standard protocols promote the comparability of resulting health plan- and/or state-level CAHPS data.

For both the adult and child surveys, the results of 11 measures of satisfaction were reported. These measures included four global ratings (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) and five composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*). In addition, two individual item measures were assessed (*Coordination of Care* and *Health Promotion and Education*).

[1-4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Findings

Table 1-4 presents the 2016 adult and general child Medicaid CAHPS survey results for all Acute Care and CMDP Contractors members enrolled in the Medicaid program (i.e., Acute Care program in aggregate).[1-5] The table displays the following information for each CAHPS survey measure: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings).

Table 1-4—Adult and General Child Medicaid CAHPS Results for Acute Care and CMDP Contractors

	Adult Results		General Child Results	
CAHPS Measure	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	61.2%	★★★ 2.46	73.1%	★★★★ 2.64
Rating of All Health Care	57.3%	★★★★ 2.44	73.4%	★★★★★ 2.65
Rating of Personal Doctor	65.1%	★★★★ 2.53	76.9%	★★★★★ 2.70
Rating of Specialist Seen Most Often	67.0%	★★★ 2.54	65.4%	★★ 2.57
Composite Measures				
Getting Needed Care	83.3%	★★★ 2.36	85.2%	★★ 2.41
Getting Care Quickly	81.5%	★★★ 2.41	87.9%	★★ 2.58
How Well Doctors Communicate	89.8%	★★★★ 2.59	93.5%	★★★ 2.71
Customer Service	88.7%	★★★ 2.55	87.6%	★★★ 2.57
Shared Decision Making	79.5%	NA	77.6%	NA
Individual Item Measures				
Coordination of Care	77.0%	★ 2.27	79.7%	★ 2.33

[1-5] The adult Medicaid CAHPS results are based on the combined results of the eight Acute Care Contractors serving the adult Medicaid population, including Care 1st Health Plan of Arizona, Health Choice Arizona, Health Net Access, Maricopa Health Plan, Mercy Care Plan, Phoenix Health Plan, UnitedHealthcare Community Plan, and University Family Care. The general child Medicaid CAHPS survey results are based on the combined results of the eight Acute Care Contractors and CMDP.

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Health Promotion and Education	72.9%	NA	70.5%	NA

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average.
Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average.
NA indicates that results are not available for the CAHPS measure.
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If fewer than 100 responded for a CAHPS measure, caution should be exercised when interpreting these results.

Conclusions

Based on evaluation of the Acute Care Contractor's overall member satisfaction ratings (i.e., star ratings), priority assignments were determined for each CAHPS measure. The priority assignments are grouped into four main categories for quality improvement (QI): top, high, moderate, and low priority, and are based on results of the NCQA comparisons. Table 1-5 shows how the priority assignments were determined for the Acute Care program for each CAHPS measure.

Table 1-5—Derivation of Priority Assignments

NCQA Comparisons (Star Ratings)	Priority Assignment
★	Top
★★	High
★★★	Moderate
★★★★	Low
★★★★★	Low
NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, priority assignments could not be derived for these measures.	

Based on evaluation of the Acute Care Contractor's overall member satisfaction ratings for the adult and child Medicaid populations, the measures identified as areas of top and high priority are the specific areas that should be targeted for QI initiatives. For the adult and child Medicaid Acute Care and CMDP Contractors, the top priority area identified for QI was *Coordination of Care*. No high priority areas were identified for the adult Medicaid Acute Care Contractors. For child Medicaid Acute Care and CMDP Contractors, high priority areas identified for QI were *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*.

Recommendations

Based on the Acute Care and CMDP Contractors' overall performance on the CAHPS survey measures, recommendations for improvement were identified. These recommendations include best practices and other proven strategies that may be used or adapted by the program to target improvement in the areas of *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, and *Coordination of Care.*

To improve overall performance on the CAHPS measures, the Acute Care and CMDP Contractors should consider the following general recommendations in the context of their own operation and QI activities:

- **Perform Root Cause Analyses**—Contractors should conduct root cause analyses of study indicators that have been identified as areas of low performance. This type of analysis is typically conducted to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies.
- **Conduct Frequent Assessments of Targeted Interventions**—Contractors should support continuous quality improvement and should frequently measure and monitor targeted interventions.
- **Use Health Information Technology**—Contractors should use health information technology to improve patient-tracking capabilities and coordinated care. Health information technology can better facilitate documentation, communication, and decision support.
- **Share Data**—Contractors should design systems to enable effective and efficient coordination of care and reporting on various aspects of quality improvement. Pediatricians and hospitals operating within each organization should have effective communication processes in place to ensure that information is shared timely.
- **Facilitate Coordinated Care**—Contractors should assist in facilitating the process of coordinated care among providers and care coordinators to ensure that patients are receiving the care and services most appropriate for their healthcare needs.

Overall Findings and Conclusions

AHCCCS has completed a strategic plan for SFY 2017–2022 that includes goals related to long-term strategies that bend the cost curve while improving member outcomes, the pursuit of continuous quality improvement, and the reduction of fragmentation through an integrated healthcare system. The results of the three mandatory activities relative to Contractor performance support these goals. AHCCCS has a comprehensive system to monitor and improve the timeliness of, access to, and quality of care that Contractors provide to Medicaid members. All Acute Care and CMDP Contractors are working toward improving the delivery of services and quality of care provided to members. All Contractors demonstrated improvement in nearly all areas in the comprehensive OR. Overall, the Acute Care Contractors' performance measure rates related to access, including *Adults' Access to Preventive/Ambulatory Health Services*, *Children and Adolescents' Access to Primary Care Practitioners*, and *Annual Dental Visit*s, demonstrated statistically significant declines in performance from CYE 2015 to CYE 2016. As a result, these performance measure rates either fell below the MPSs or are at risk for falling below the MPSs in future years. For CMDP, the performance measure rates demonstrate overall positive performance, with almost every performance measure rate performing above the related MPS. AHCCCS has selected for all lines of business a mandatory PIP, *E-Prescribing*, which, to increase patient safety, measures the number of providers that write electronic prescriptions and the number of prescriptions submitted electronically. Most Contractors have employed significant interventions to improve the results of this PIP. AHCCCS could benefit from conducting a root cause analysis of CAHPS measures that have been identified as low-performing to identify potential causes for lower member satisfaction in these areas and to devise possible solutions.

Organizational Assessment and Structure Standards

In CYE 2017, AHCCCS conducted a comprehensive OR for the CYE 2016 review period for four Contractors (UHCCP-Acute, Health Net, HCA, and Care1st), reviewing 11 standards for each Contractor. Additionally, between CYE 2016 and CYE 2017 AHCCCS monitored progress of the remaining Contractors in implementing their CAPs for the recommendations from the 2016 OR.

Overall results for all four Contractors for CYE 2017 were positive. All Contractors scored at or above the 95 percent compliance thresholds for the GS, QM, and RI standards. For the GS standard, UHCCP-Acute, HCA, and Care1st obtained 100 percent and Health Net obtained 96 percent. For the QM standard, Care1st received a 100 percent score, UHCCP-Acute and Health Net received 99 percent, and HCA scored 95 percent. Three of the four Contractors, UHCCP-Acute, HCA, and Care1st, had two standards (GA and TPL) scored at full compliance with 100 percent. One Contractor, Care1st, had eight standards in full compliance, with 100 percent scores. For one Contractor, UHCCP-Acute, all standards were scored at or above the 95 percent compliance threshold.

Standards that required the most corrective actions were CIS (12 CAPs), MCH (11 CAPs), and MM (eight CAPs). Of the standards that incurred CAP(s), the standards with the least number of corrective actions were GA (one CAP), MI (one CAP), and TPL (one CAP).

Performance Measures

Overall, performance for the Acute Care and CMDP Contractors varied across the areas of **quality** and **access**. The Acute Care measure rates for the **quality** area indicated opportunities for improvement, with six of eight measure rates (*Adolescent Well-Care Visits*; *Cervical Cancer Screening*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; *and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) falling below the MPSs. The Acute Care Contractors should focus improvement efforts on well-care visits for children and adolescents and on recommended screenings for women. The Acute Care Contractors demonstrated positive performance in the **access** area, exceeding the CYE 2016 MPSs for four of six measures (*Adults' Access to Preventive/Ambulatory Health Services*; and *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*) within this domain. The Acute Care Contractors should monitor performance within the access domain as all six measures demonstrated statistically significant declines from CYE 2015 to CYE 2016.

Compared to the CYE 2016 MPSs, CMDP's performance in the **quality** and **access** areas indicated strength as seven measure rates (*Adolescent Well-Care Visits*; *Annual Dental Visits—2–20 Years*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) exceeded the MPSs. CMDP should focus improvement efforts on chlamydia screening for women and developmental screenings for young children, as these measures failed to meet the CYE 2016 MPS.

There were no performance measure rates related to **timeliness**; therefore, this area was not discussed. Additionally, the utilization measure rate (*Ambulatory Care*) for the Acute Care and CMDP Contractors 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 that 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 Acute Care and CMDP 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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

HSAG identified the following CAHPS measures that could benefit from quality improvement activities for the Acute Care and CMDP Contractors: *Rating of Specialist Seen Most Often* (child population only), *Getting Needed Care* (child population only), *Getting Care Quickly* (child population only), and *Coordination of Care* (adult and child populations). HSAG recommends that AHCCCS share the survey results with the Contractors and other stakeholders, as appropriate, and use quality improvement tools and processes to improve member satisfaction. The Acute Care and CMDP Contractors should consider the following general recommendations in the context of their own operation and QI activities:

- Perform root cause analyses
- Conduct frequent assessments of targeted interventions
- Use health information technology
- Share data
- Facilitate coordinated care

Conclusions

In general, and as documented in detail in other sections of this report, Acute Care and CMDP Contractors made improvements in the timeliness of, access to, and quality of care 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 Acute Care and CMDP Contractor.

2. Background

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

Most recently, as part of Governor Ducey's administrative simplification initiative, behavioral health services were integrated at AHCCCS, eliminating the Arizona Division of Behavioral Health Services (DBHS) that historically provided behavioral health services through a contract with AHCCCS and subcontracts with the Regional Behavioral Health Authorities (RBHAs). AHCCCS has stated that this merger was a positive step toward increasing integration in the healthcare system and has already

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

AHCCCS' Strategic Plan

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

The plan offers four overarching goals:

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

- Increase use of alternative payment models for all lines of business (LOBs). For example, the VBP initiative is a critical policy strategy allowing AHCCCS to progress toward a financially sustainable healthcare delivery system, which rewards high quality care provided at affordable costs.
- Increase use of value-based access fee schedule differentiation. AHCCCS pursued adjustments in the fee-for-service payment schedule to incentivize certain value measures for providers. Additionally, AHCCCS recently created a program for first responders to provide treatment and referrals instead of requiring transportation to an emergency room to receive payment.

[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.

- 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 toward 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 toward 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.

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®).[2-2] 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"—

[2-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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.

CAHPS Surveys

AHCCCS conducts CAHPS surveys on a regular basis to better understand member satisfaction with the Contractors and/or member satisfaction with the overall AHCCCS healthcare delivery system. The goal of the CAHPS Health Plan Survey for CYE 2016 is to provide performance feedback that is actionable and that will aid in improving overall adult and child member satisfaction.

3. Description of EQR Activities

Mandatory Activities

As permitted by CMS within federal regulation and described in Section 1—Executive Summary, AHCCCS retained the functions associated with the three CMS mandatory activities for its Acute Care and CMDP Contractors:

- Validate Contractor PIP—validation performed by AHCCCS.
- Validate Contractor performance measures—validation performed by AHCCCS.
- Summary and findings of Contractor's performance in complying with the AHCCCS' contract requirements and the federal Medicaid managed care regulations cited at 42 CFR §438.358—Review performed by AHCCCS. (The Operational Review was administered to only four of the Acute Contractors.)

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

Optional Activities

AHCCCS contracted with HSAG to conduct the following optional activity:

- Administer and report the results of the CAHPS Health Plan Survey for adult and child Medicaid members enrolled in the Acute Care program.

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 strategic goals and related strategies and to provide a roadmap for potential changes and new goals and strategies.

AHCCCS Quality Initiatives

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

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

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

Key Accomplishments for AHCCCS

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

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

person health, reduced stigma, enhanced service delivery for all members, and stronger member and family engagement.

- Committed to helping foster families, and in 2016 implemented Jacob's Law. Through this implementation, AHCCCS has simplified access to needed behavioral health services, improved monitoring systems to ensure timely access to services, and engaged with foster families throughout the process.
- Released a report with recommendations to strengthen the healthcare system's ability to respond to the needs of members with or at risk for autism spectrum disorder (ASD), including those with co-occurring diagnoses.
- Released a comprehensive report: *Behavioral Health Needs of Children Involved with the Department of Child Safety: Psychotropic Prescribing Update*. This report analyzed psychotropic prescribing for children in Arizona's foster care system. The report detailed "the percentage of children in foster care receiving psychotropic medications decreased by 26 percent from 2008 to 2014, from 20.3 percent to 14.9 percent respectively. The percentage of children in foster care receiving antipsychotic medication decreased by 43 percent, from 10.9 percent to 6.2 percent."
- Reopened enrollment for the KidsCare program, providing high quality healthcare coverage for children of working families.
- Restored podiatry services provided by a licensed podiatrist and provided a $1,000 dental benefit to all members in the ALTCS program.
- Continues to expand the external contract for determinations for persons with serious mental illness (SMI) to all Arizona counties, including several American Indian tribes, to ensure consistency and equity in the determination process.
- Worked with the Arizona Department of Corrections to establish a Justice System Transition program which allows eligible individuals to be enrolled with AHCCCS immediately upon release.
- Continues to pursue long-term strategies to reduce fragmentation in the healthcare delivery system through service integration.
- Experienced a capitation rate increase of 1.7 percent. This is in-line with the previous four-year average of just 2.1 percent. This is well above the Great Recession period where rates averaged a decrease of 4.6 percent and much more sustainable than the 2005 through 2009 period wherein rates averaged a 6.6 percent increase.
- Continued care delivery and payment reform efforts, with a focus on transitioning from paying for the volume of care to the value of care provided. Contracted managed care organizations were required to have an increased percentage of their provider payments in value-based arrangements, in which payments are related to quality outcomes.
- Met most program integrity goals established in its annual plan. AHCCCS worked successfully with prosecutors on 39 different cases resulting in 62 convictions—a program record. AHCCCS recouped over $1 billion due to coordination of benefits, third party recoveries, and the Office of Inspector General activities, and then began pursuing leveraging private sector expertise on data analyses.
- Registered, validated, and paid 3,600 eligible professionals and 75 acute care and critical access hospitals since the electronic health record program opened in July 2011. These payments total over $666 million. AHCCCS continues to serve on the Health Current 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) transitioned, along with the programs it manages, to AHCCCS, effective July 1, 2016. The behavioral health services were "carved out" benefits administered by DBHS through contracts with the RBHAs. Not only was this transition part of a more efficient government operation, it also coincides with a large integration effort for the seriously mentally ill population in Arizona. Before the integration of services, a member with 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 healthcare has been challenging and further complicated by concerns around poor medication management and stigma, sometimes causing many individuals to forgo physical healthcare. Many persons with SMI also experience co-morbidities; therefore, management of chronic diseases like diabetes or hypertension has also been deficient.

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

AHCCCS CARE: Choice, Accountability, Responsibility, Engagement

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

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

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

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

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

The contributions will range from $4 for opioid prescriptions and between $5 and $10 for copays for specialist services without primary care physician (PCP) referrals. The program introduced other initiatives such as charitable contributions to the member's account, the AHCCCS work program, and health targets for preventive and chronic care. AHCCCS indicated 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. In this order, the

Governor indicated 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 authorized AHCCCS and the Arizona Department of Administration (ADOA) to adopt policies and rules that 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 healthcare 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 healthcare, 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 healthcare 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.
- *Behavioral Health Needs of Children Involved with the Department of Child Safety: Psychotropic Prescribing Update*: AHCCCS is revising the Psychiatric and Psychotherapeutic Best Practices for Children Birth Through Five Years of Age guidance document to ensure that the most recent research on appropriate prescribing is provided to providers, children, and families. AHCCCS is also updating tools that provide best practice strategies related to infants and toddlers—including psychotropic prescribing, early childhood mental health intervention, and trauma-informed care. The document content focuses on the most current prescribing practices and psychotherapeutic approaches for use during early childhood, with the recommendation that psychotherapeutic

approaches be the preferred method of treatment prior to implementation of psychopharmacologic intervention.

- 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 and Child Health Meeting: To further promote the integration of medical and behavioral health services, targeted education is included within the AHCCCS Quarterly Contractor's Quality Management/Maternal Child Health (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/EPSDT 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/EPSDT 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 participate in the Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs (task force). The task force is composed of representatives from various agencies who work to increase awareness and address concerns in the community regarding fetal alcohol spectrum disorders. AHCCCS staff members attend the monthly meetings and regularly participate in discussions related to solutions to reduce prenatal exposure to alcohol and other drugs. A strategic plan has been finalized by the task force, and members 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 and use of all drugs (prescription, opioids, alcohol, etc.) and neonatal abstinence syndrome (NAS). Mercy Care Plan (MCP) and Mercy Maricopa Integrated Care (MMIC) both worked out processes to refer infants with NAS to Southwest Human Development, and MMIC had a perinatal care manager for pregnant members with a designation of SMI. All pregnancies in women with SMI were considered high-risk and were provided integrated care management via MMIC care managers. When additional medical risks to the pregnancy were identified, they were flagged (i.e., substance use or abuse) and a referral was made to Mercy Maricopa Perinatal Care Management for care coordination and support.
- 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 ADHS helps ensure efficient and effective administration and oversight of the federal Vaccines for Children (VFC) program. The VFC program representatives provide education to Contractors; regular notification to AHCCCS regarding vaccine-related trends and issues; and updates regarding the Arizona State Immunization Information System (ASIIS), an immunization registry that can capture immunization data on individuals within the state. 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/EPSDT 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 on-going 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 to help with healthy decisions.

Take Control, the 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 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 care coordination. Launched in early 2017, Southern Colorado, Arizona, Utah, and now Santa Cruz and San Diego HIEs are capable of sharing hospital admission, discharge, or transfer information with a Medicaid member's home HIE if that member seeks care outside his or her Arizona or "home" HIE.
- ADHS Bureau of Tobacco and Chronic Disease: In collaboration with ADHS, AHCCCS monitors the utilization of and access to smoking cessation drugs and nicotine replacement therapy programs. 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.
- Arizona Head Start Association: The Arizona Head Start and Early Head Start programs provide education, development, health, nutrition, and family support services to qualifying families. The Arizona Head Start grantees—including the City of Phoenix, Maricopa County, Chicanos Por La Causa, and Southwest Human Development—continue to host community meetings quarterly. The meetings are attended by families participating in the Head Start program along with AHCCCS staff members and the AHCCCS Contractor MCH/EPSDT coordinators.
- Arizona Medical Association (ArMA) and the Arizona Chapter of the American Academy of Pediatrics (AAP): AHCCCS collaborates with ArMA and the Arizona Chapter of the AAP in numerous ways, from development and review of assessment tools to data sharing and support of system enhancements for providers, including the Electronic Health Records (EHR) Incentive

Program. During this year AHCCCS continued discussions related to increasing use of developmental screening tools, the primary care enhanced payment structure, and care and services delivered to members with a diagnosis of autism. In addition, AHCCCS worked with the organizations related to changes in billing codes for photo-ocular vision screening codes.

- 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.
- Arizona Perinatal Trust (APT): The APT oversees voluntary certification of hospitals for the appropriate level of perinatal care according to established guidelines and conducts site visits for initial certification and recertification. AHCCCS covers over 50 percent of the births in Arizona; therefore, the site reviews provide AHCCCS with a better assessment of the hospitals that provide care to pregnant women and newborns, from normal labor and delivery to neonatal intensive care. Details of the site visit review are kept confidential; however, site visit reviews do allow opportunities for collaboration among healthcare professionals to learn about innovative practices that hospitals have implemented as well as sharing of best practices, policies, and guidelines. AHCCCS continues to support APT and participate in site visits regularly.
- Arizona Newborn Screening Advisory Committee: The Newborn Screening Advisory Committee was established to provide recommendations and advice to ADHS regarding tests that should be included in the newborn screening panel. The committee recommended including the 29 disorders, including hearing loss, of the core panel of the Uniform Screening Panel from the U.S. Department of Health and Human Services (HHS) Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. Any recommendation of a test to be added to the panel must be accompanied by a cost-benefit analysis. The committee is chaired by the ADHS Director (Director) and meets at least annually. The Director appoints the members of the committee, to include seven physicians representing the medical specialties of endocrinology, pediatrics, neonatology, family practice, otology, and obstetrics (OB); a neonatal nurse practitioner; an audiologist; a representative of an agency that provides services under Part C of the Individuals with Disabilities Education Act; at least one parent of a child with a hearing loss or a congenital disorder; a representative from the insurance industry familiar with healthcare reimbursement issues; the AHCCCS Director or director's designee; and a representative of the hospital or healthcare industry.
- Strong Families: Interagency Leadership Team (IALT): IALT was established related to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant, which ensures that high-risk families have access to home visitation services in Arizona. IALT is composed of various stakeholders in the community including DES, the Department of Education, ADHS, and AHCCCS. The purpose of the leadership team is to discuss strategy for building a statewide home-visiting system. Additionally, this team oversees implementation of the MIECHV grant and any decisions required regarding home visitation practices. AHCCCS members benefit from home-visiting programs when identification and referrals are made by AHCCCS Contractors. AHCCCS continues to be a strong referral source to the home-visiting programs, with the anticipated results of improved birth outcomes for mothers and babies.
- Innovations in Childhood Obesity Update: AHCCCS was selected by the Center for Health Care Strategies (CHCS) to participate in this initiative; therefore, AHCCCS formed a collaborative

workgroup to drive these improvements throughout the State. AHCCCS selected a Federally Qualified Health Center (FQHC) with which to work in partnership to collect data and implement interventions relevant to this initiative; AHCCCS Contractors joined the workgroup related to these directives. During Quarter 3, a multi-year childhood obesity initiative was finalized. This longitudinal initiative focused on a cohort of children between 2 to 5 years of age, each with a body mass index (BMI) of 85 percent or more. The study cohort was scattered across multiple contracted health plans, all of which were receiving services in an urban FQHC. The goals are to examine preliminary findings for prevalence of obesity in children of this age and to examine the potential effectiveness of behavioral health intervention strategies.

- 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 of 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.
- Foster Care Initiative: AHCCCS is committed to providing comprehensive, quality healthcare for children in foster, kinship, or adoptive care. Foster children are eligible for medical and dental care,

inpatient, outpatient, behavioral health, and other services through the Comprehensive Medical and Dental Program (CMDP) and the RBHAs or through CRS. Adoptive children are typically AHCCCS eligible and enroll in a health plan/RBHA or CRS like any Medicaid-eligible child. AHCCCS holds a variety of meetings related to improving service delivery for children in foster care. Monthly collaborative meetings with the Department of Children's Services (DCS)/CMDP occur to continue efforts to improve service delivery for children in the foster care system and to ensure that services identified as medically necessary are available. AHCCCS hosts monthly cross-divisional operational team meetings to continue efforts and quarterly meetings with RBHA and CRS leadership to review data and discuss system changes and best practices. System improvements include documenting frequently asked questions, developing behavioral health and crisis services flyers for foster and kinship caregivers, and streamlining health plan deliverables. Additionally, AHCCCS created a dashboard to track and trend utilization for children in foster care. Further, AHCCCS developed a policy (ACOM 449) that outlines specific requirements for behavioral health services for adopted children and for children within custody of the Department of Children's Services (DCS).

- Long-Acting Reversible Contraceptive (LARC) Initiative: AHCCCS instituted the LARC initiative to allow for purchase of LARC devices to be reimbursed outside of the regular hospital payment. Offering members access to LARC devices in the hospital after delivery is expected to increase utilization of such devices as many members do not attend their six-week postpartum office visits.
- Behavioral Health Learning Opportunities: With the advent of administrative simplification, AHCCCS recognized the need to provide learning opportunities for staff lacking behavioral healthcare experience and expertise due to previous historical hiring requirements for medically trained personnel. In July 2016 AHCCCS began to offer formal meetings as well as informal workshops and lunch-hour trainings to ensure that staff had opportunities to increase behavioral health system knowledge. Internal behavioral health subject matter experts, licensed behavioral health practitioners, and community professionals have been procured to offer training on topics such as infant/toddler mental health, trauma-informed care, perinatal mood disorders, and adult system-of- care processes for individuals with general mental health needs and SMI.

  QM is providing additional behavioral health "Lunch and Learn" trainings for QM and quality of care (QOC) staff especially, with attendance open to other departments based on department need. Topics include the following:

  – Regulatory requirements for individuals designated as having an SMI versus having general mental health and/or substance abuse needs (GMHSA)
  – Grant-based housing for individuals with SMI
  – Short-term behavioral health residential services
  – Crisis process and requirements
  – Diagnostic categories and symptoms
  – Best-practice and evidence-based clinical approaches for adults and children
  – Mental health awareness

  To further enhance integration efforts and facilitate quality of care reviews utilizing a behavioral health perspective, AHCCCS is developing a trauma-informed workforce by adding enhanced training on trauma-informed care and court-ordered treatment.

- 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.

5. Contractor Best and Emerging Practices

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

Care1st Health Plan Arizona, Inc. (Care1st)

- Personalized In-Home Care Management with Digital Connectivity: Through the Catalytic Health Partners program, Care1st provides vulnerable members with personalized, in-home, face-to-face care management supported by digital connectivity and advanced analytics. High-risk members with chronic conditions who qualify for the program receive care management and web-enabled telemonitoring via tablet technology. Members can monitor vital signs and symptoms—including glucose, blood pressure, and weight—for conditions such as diabetes, Congestive Heart Failure (CHF), and hypertension. The tablet also enables members to communicate with clinical staff when needed. This approach is based on clinical evidence and draws upon proven care management models such as Coleman's Care Transitions Intervention and Naylor's Transitional Care Model. Best practices in care management for senior populations and those with chronic conditions include face-to-face contact between patients and care managers, close collaboration with PCPs, sharing information across the continuum of care, targeted patient selection, coaching and educating patients in self-management, and using electronic medical records.
- High-Touch Tailored Outreach to Pregnant Members: Immediately after identification of the pregnancy through a variety of means, Care1st employs tailored telephone counseling to educate the member and to ensure that she understands her benefits as well as important information related to accessing services. Tailored telephone counseling has been shown to improve adherence to obtaining services such as those related to colorectal cancer screening and cervical cancer screening. Through a concerted effort, Care1st was able to reach approximately 73 percent of newly identified pregnant members by phone. The maternal child health coordinator also has a protocol for identifying potential triggers for case management on the first call, including asking questions to identify potential depression and then refer the member to behavioral health care management. A pregnant member receives personal calls during the third trimester, at delivery, and during the postpartum period—with staff specializing in helping her navigate the delivery system at those important stages. The member also receives frequent contact from Early and Periodic Screening, Diagnostic and Treatment (EPSDT) specialists during the baby's first two years. In doing so, Care1st addresses external factors that can support an optimal birth outcome, such as encouraging the member to enroll in women, infants, and children (WIC) and linking her to other community resources (teen pregnancy support, parenting classes, housing assistance, general equivalency diploma [GED] or literacy classes, and the like).

Health Choice Arizona (HCA)

- High Touch Transitions of Care: HCA's Medical Management Unit implemented two transition of care program innovations identified as best practice as they provide "high touch" to inpatient members. Objectives with this "high touch" programming include readmission reduction, improvement of customer experience, provision of seamless care transitions, and reduction of medical costs. Care management and assistance are provided to members via more frequent, direct contacts from HCA management staff. The two strategies are similar in process; however, one is hospital-based (face-to-face), and the other is telephonic. Currently, three registered nurses conduct face-to-face visits at Banner Desert, Banner Phoenix, and Banner Tucson. Two care coordinators conduct telephonic "reach in." Members are educated on insurance benefits including transportation and type of follow-up calls that will be made to them post discharge.
- Quality Gap Alert in Electronic Member Platform: The quality gap alert in CareRadius® was implemented in March 2017, with the objective to better close care gaps during point of service calls, thereby reducing number of calls to the member and streamlining this process. This best practice was adopted from the December 2016 Rise Conference. During the conference, a 4.5-star health plan shared this best practice in reducing care gaps. The member service representatives and EPSDT teams have been trained on the care-gap alert, educating members regarding their gaps in care and assisting members in scheduling PCP appointments as needed.
- Medical Management—Medication Adherence Staffing Model Pilot (Pilot): The overarching goal of the pilot, to improve medication adherence, is to provide telephonic outreach to review the importance of filling medications timely, considering options such as auto refills or ninety-day mail orders. A registered nurse and a pharmacy technician were partnered to work collaboratively in assisting members with medication adherence through telephonic outreach conducted monthly. This model was selected as a best practice because, within two months of pilot implementation, HCA was able to document a 65 percent improvement rate.

Health Net Access (Health Net)

- Provider Dashboard: Health Net rolled out a revised dashboard with member-level detail to empower providers to use the dashboard to outreach to members and to close care gaps. This revision came after receiving provider feedback that the data Health Net provided to the providers were not actionable. These dashboards are released to providers monthly. Health Net incorporated into the revised quality metrics dashboard some aspects such as rankings, forecasting, and traffic light graphics. Since implementation, specific provider accolades have been made regarding the level of detail and comprehensiveness of the provided information, the ease of use, the ability to view performance rakings amongst like providers, and detailed member-level information. Key highlights of this dashboard include:
  - The ability to view data in its entirety or by specific health home/PCP.
  - Traffic light graphics, demonstrating progress toward a minimum performance standard (MPS).
  - The ability to view both previous and current quarter data within the same document.

  - Specific numerator and denominator detail.
  - The number of hits needed to meet MPS for a metric.
  - The ability to see health home rakings on various measure sets.
  - A forecast for future performance based on past performance.
  - Control charts comparing specific provider performance to the plan average and to the MPS.
  - A listing of care gaps for specific members related to each measure.
- Intensive Chronic Condition Program: Health Net implemented an intensive chronic condition program aimed at members who present with uncontrolled diabetes (HbA1c > 9.0%). This program was initiated as an intervention due to poor performance on the diabetes performance metrics. The program has been developed to reduce morbidity and mortality related to the condition while assisting members to live happier, healthier lives. Interventions include medication review; development of a medication action plan (MAP); referrals to case management; presentation of the member at rounds with the medical director; and referrals, as needed. Health Net also developed community events targeting diabetes and invited members to join the program.
- Childhood Obesity: Health Net participated in the Read It and Eat early literacy and healthy eating initiative to decrease the number of children with high BMI, as measured through the EPSDT tracking forms. This program is a collaboration with Native Health (clinic that provides integrated primary care services) to provide low-income, government-assisted households with literacy activities; nutrition education; and fun, healthy, cost conscious, and seasonal cooking demonstrations. Health Net sponsors monthly literacy and healthy cooking strategies as well as demonstrations that promote healthier meal preparation for families of children 0 to 5 years of age. The cooking demonstrations occur at the Native Health central clinic. The monthly food preparation and cooking demonstrations are conducted by the Native Health diabetes prevention coordinator and build on an evidence-based curriculum from Washington State Department of Health. The “Let’s Cook!” class curriculum contains healthy, easy recipes that are easily replicated. The proportion of members with elevated BMI decreased from 22 percent in 2016 to 16 percent in 2017.

Mercy Care Plan (MCP)

- Delegation Oversight: MCP regularly monitors the results of corrective actions that identify deficiencies. MCP 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 uses the Exclusive Prescriber program to assist identified members to better utilize available benefits to obtain the best overall health outcomes. MCP 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 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-Acute (UHCCP-Acute)

- Affiliated Practice Dental Hygienist (APDH): Through an agreement with an affiliated practice dentist, APDHs can provide preventive and therapeutic dental hygiene services as he or she determines appropriate, without direct supervision by a dentist. In an affiliated practice model, an unsupervised APDH can provide dental hygiene services in nontraditional, community-based settings and receive direct reimbursement from Medicaid plans. This initiative integrates medical and dental services to concurrently close preventive medical and dental gaps in care and to increase the proportion of UHCCP-Acute enrolled members 2–20 years of age who receive an annual dental visit. The APDH provides dental hygiene services in a medical primary care setting. As the medical provider completes an EPSDT visit, the APDH provides an oral screening, education, fluoride varnish, and referral to a dentist.
- Six Well-Child Visits by 15 Months of Age: UHCCP-Acute implemented a best practice to increase the well-child visits using multiple interventions at the individual member level as well as at the assigned PCP level. Interventions include the identification of members in need of well-child visits,

telephonic and written reminders for members to schedule well-child visits, education to members on developmental milestones, financial incentives to providers, tracking providers' improved performance of well child visits, and provider education.

University Family Care (UFC)

- High Need High Cost: UFC follows the best practice that states that health plans need to address behavioral, social, and functional needs as well as clinical needs to reduce costs and to increase outcomes. UFC has emphasized the use of social interventions for crisis as well as the use of behavioral and medical healthcare. UFC has integrated care that includes cross-disciplinary programs. UFC's behavioral health department is involved in ensuring that patients are treated for their mental health and physical health needs. Case managers interact with patients to offer resources and solutions for both areas of need. The goals of this intervention are to increase proactive identification of member needs and to increase care coordination to improve health outcomes and quality of life. Since January 2016, UFC has seen a reduction of costs for the three RBHAs; CIC (40 percent), MMIC (29 percent), and HCIC (14 percent).
- Diabetes—A1c Control: To improve A1c control in members with diabetes and to improve quality of life and decrease complications associated with uncontrolled diabetes, UFC follows the best practice that states that an A1c level check should be done as often as needed or recommended by a member's provider. UFC's quality department sends out mailings for members and provides articles in the member newsletter. UFC case managers assist members with high A1c levels (>9.0 percent) by following up with providers and caregivers so that interventions are conducted quickly to lower member A1c levels. If a member's A1c level is out of control and the test is only conducted once a year, the case managers will work to have the test done more often to ensure that interventions are working and that the member's A1c level improves. This will continue until the member's A1c levels are in appropriate range.
- High Blood Pressure (Million Hearts): To lower the blood pressure of hypertensive members so as to potentially prevent strokes, cardiovascular disease, or other complications causing decreases in health and quality of life, UFC follows the best practice which states that high-quality blood pressure management requires a high level of medication adherence and adequate follow-up. UFC case managers monitor the blood pressure of members with hypertension; if the levels are high, they follow up with providers and caregivers to assist in any needed medication adjustments or medication adherence assistance. Blood pressure is retaken throughout the year to ensure control or prompt further interventions, if needed.

Comprehensive Medical and Dental Program (CMDP)

- Psychotropic Prescribing Practices: CMDP conducts oversight of prescribing practices when PCPs prescribe psychotropic medications for children. As part of the oversight process, the following indicators are reviewed for appropriate prescribing:
  - Dosing

  - Documentation
  - Involvement in behavioral health services (medical charts are reviewed for evidence of ongoing behavioral health services)
  - Age of child (prior authorization is required for children under 6 years of age)
  - PCPs having been educated on the importance of trauma-informed care (and ability to recognize that CMDP children are more likely to have experienced trauma)
    - PCPs having been educated regarding similarities between trauma symptoms and other medical diagnoses such as ADHD, autism, and diabetes
  - Medical records having been reviewed against guidelines set forth by the American Academy of Pediatrics
  - Quality of care issues, with PCP education addressed as needed
- Onboarding Unit (OBU) Initiative: The OBU initiative, currently a pilot project, aims to provide customer service to the caregiver to assist with timely preventive medical and dental appointments for children. Services provided include support for meeting information and resource needs, so that caregivers can navigate the Arizona Department of Child Safety (DCS) systems for optimal advocacy and engagement. During the caregiver outreach calls, CMDP OBU staff assist with a PCP and primary dental provider (PDP) search. Appointments with those providers may be set up through the OBU staff as well. It is anticipated that as a result of this intervention, the rate of preventative care visits will increase. This is in alignment with the American Academy of Pediatrics healthcare standards for children and teens in foster care.
- Adolescent Health Task Force Initiative: The Adolescent Health Task Force is a collaborative team established to devise and implement plans to engage and educate adolescents about healthy living and healthy decision making, with the goal of empowering adolescents to live their best, healthiest lives. The task force consists of members from the DCS, CMDP, and the ADHS. The task force's project, "The Talk" toolkit, reviews topics such as puberty, sexually transmitted diseases and pregnancy prevention, sexual violence awareness, healthy relationships, human trafficking, and healthy lifestyles. This toolkit will be used by DCS specialists and caregivers as a guide to educate foster care youth.

6. Organizational Assessment and Structure Performance

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

AHCCCS has extensive experience preparing for, conducting, and reporting findings from its reviews of Contractors' compliance with federal and AHCCCS contractual requirements. As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the activities associated with the federal Medicaid managed care mandatory compliance reviews. In accordance with and satisfying the requirements of 42 CFR §438.364, AHCCCS then contracted with HSAG as an EQRO, to use the information 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 comprehensive ORs for three Contractors (Mercy Care Plan, Comprehensive Medical and Dental Program, and Phoenix Health Plan) in CYE 2016 and for four Contractors (United Healthcare Community Plan, Health Net, Health Choice of Arizona and Care1st of Arizona) in CYE 2017. In addition, AHCCCS monitored the progress of Contractors implementing CAPs for the recommendations from the 2015 and 2016 ORs.

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

Conducting the Review

For the CYE 2016 OR (which includes CYE 2016 and 2017 activities), AHCCCS reviewed 11 standards in various categories for each Contractor included in the OR. Details regarding the standards reviewed for each Contractor are included in the findings.

Objectives for Conducting the Review

AHCCCS' objectives for conducting ORs are to:

- Determine if the Contractor satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statutes, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR §438).
- Increase AHCCCS' knowledge of the Contractor's operational encounter processing procedures.

- Provide technical assistance and identify areas in which the Contractor can improve as well as areas of noteworthy performance and 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 reviews all applicable CMS and AHCCCS contract requirements at least once every three years. AHCCCS follows a CMS-approved process to conduct the ORs that is also consistent with CMS' protocol for EQROs that conduct the reviews.[6-1]

AHCCCS' methodology for conducting the OR included the following:

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

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

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

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. . Accessed on: November 14, 2017.

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

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

Standards

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

- Corporate Compliance (CC), five elements
- Claims and Information Systems (CIS), 12 elements
- Delivery Systems (DS), nine elements
- General Administration (GA), three elements
- Grievance Systems (GS), 17 elements
- Adult, EPSDT, and Maternal Child Health (MCH), 15 elements
- Medical Management (MM), 25 elements
- Member Information (MI), nine elements
- Quality Management (QM), 27 elements
- Reinsurance (RI), four elements
- Third-Party Liability (TPL), seven elements

Scoring Methodology

Each standard area contains elements designed to measure the Contractor's performance and compliance with the federal managed care rules and the AHCCCS acute contract provisions. A Contractor may receive up to a maximum possible score of 100 percent for each standard measured in the CYE 2017 OR. Within each standard are specific scoring detail criteria worth defined percentages of the total possible score.

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

Contractors are required to complete a corrective action plan (CAP) for any standard 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 disagreement related to the findings. AHCCCS reviews and responds to any Contractor disagreements based on review of the Contractor information, and then revises the report if necessary. AHCCCS issues the final report to the Contractor, describing the findings, scores, and required CAPs.

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

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

Contractor-Specific Results

For the CYE 2016 review period, AHCCCS conducted the OR with 11 standards for four Contractors during CYE 2017. The updates on CAPs issued during CYE 2016 are included for two Contractors. Contractor-specific results are presented following.

UnitedHealthcare Community Plan-Acute (UHCCP-Acute)

AHCCCS conducted an on-site review of UHCCP-Acute from February 27, 2017, through March 2, 2017. A copy of the draft version of the report was provided to the Contractor on April 13, 2017. UHCCP-Acute was given a period of one week in which to file a challenge to any findings that the Contractor considered inaccurate, based on the evidence available at the time of review.

Findings

For the CYE 2016 review period, AHCCCS conducted in CYE 2017 a comprehensive OR considering 11 standards. Table 6-1 presents the total number of elements; the standard area scores; and the total number, if any, of required corrective actions for each standard area reviewed.

Table 6-1—Standard Areas and Compliance Scores for UHCCP-Acute

Standard Area	Total Number of Elements Scored	Standard Area Score	Required Corrective Actions
Corporate Compliance	5	100%	0
Claims and Information Systems	12	99%	0
Delivery Systems	9	96%	1
General Administration	3	100%	0
Grievance Systems	17	100%	0
Adult, EPSDT, and Maternal Child Health	15	100%	0
Medical Management	25	97%	2
Member Information	9	100%	0
Quality Management	27	99%	1
Reinsurance	4	100%	0
Third Party Liability	7	100%	0

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

- Corporate Compliance (CC): For the five elements within this standard, the Contractor received a score of 100 percent (500 out of 500).
- Claims and Information Systems (CIS): For the 12 elements within this standard, the Contractor received a score of 99 percent (1,197 out of 1,200).
- Delivery Systems (DS): For the nine elements within this standard, the Contractor received a score of 96 percent (867 out of 900).
- General Administration (GA): For the three elements within this standard, the Contractor received a score of 100 percent or the equivalent to (300 out of 300).
- Grievance Systems (GS): For the 17 elements within this standard, the Contractor received a score of 100 percent (1,700 out of 1,700).
- Adult, EPSDT, and Maternal Child Health (MCH): For the 15 elements within this standard, the Contractor received a score of 100 percent (1,500 out of 1,500).
- Medical Management (MM): For the 25 elements within this standard, the Contractor received a score of 97 percent (2,436 out of 2,500).
- Member Information (MI): For the nine elements within this standard, the Contractor received a score of 100 percent (900 out of 900).
- Quality Management (QM): For the 27 elements within this standard, the Contractor received a score of 99 percent (2,678 out of 2,700).

- Reinsurance (RI): For the four elements within this standard, the Contractor received a score of 100 percent (400 out of 400).
- Third-Party Liability (TPL): For the seven elements within this standard, the Contractor received a score of 100 percent (700 out of 700).

Strengths

For this OR, AHCCCS reviewed a total of 11 standards. UHCCP-Acute achieved either full compliance or compliance with all 11 standards. UHCCP-Acute was fully compliant, with 100 percent scores, for seven of the 11 standards reviewed (CC, GA, GS, MCH, MI, RI, and TPL). The Contractor also demonstrated strong performance in the CIS, DS, MM, and QM standards, with compliance scores between 96 percent and 99 percent.

For the CC standard, the Contractor has an operational corporate compliance program, including a work plan that detailed compliance activities. The plan is administered and monitored by a compliance officer who is an on-site official reporting directly to the Contractor's top management. In addition, the Contractor has a compliance committee that monitors, reviews, and assesses the effectiveness of the compliance program and timeliness of reporting.

For the GA standard, the Contractor maintains a policy and procedure for the handling of records which complies with all AHCCCS requirements.

For the GS standard, the Contractor complied with all the timelines required in the standard, transferred denied expedited appeal requests to the standard appeal review process, issued a written notice to the enrollee when an extension was taken, and issued appeal decisions as expeditiously as the member's health condition required.

For the MCH standard, the Contractor has established and operates a maternity care program that meets AHCCCS minimum requirements. The Contractor ensures that postpartum care is provided for a period of up to 60 days after delivery. AHCCCS identified (as a potential best practice) that the CYE 2016 Acute MCH work plan includes goals and objectives to identify substance-dependent pregnancy members and to refer them to appropriate behavioral health and case management services. Additionally, AHCCCS noted positive feedback about the neonatal intensive care unit (NICU) oversight of infants with neonatal abstinence syndrome (NAS).

UHCCP-Acute demonstrated full compliance for the MI standard, which included the requirement to ensure that the Contractor's new member information packets meet AHCCCS standards for content and distribution. For the RI standard (which demonstrated full compliance), the Contractor provided policies, desk-level procedures, and appropriate training of personnel for the processing and submission of transplant reinsurance cases to AHCCCS for reimbursement. Full compliance was demonstrated for the TPL standard, which involved processes to identify claims and services that are potentially subject to third-party payment as well as filing liens on total plan casualty cases that exceed $250.

Although the following standards did not meet full compliance, UHCCP-Acute performed at or above the "95 percent threshold" established by AHCCCS. For the CIS standard (scored at 99 percent), the

Contractor achieved full compliance for almost all elements in the standard, including the requirements that the Contractor's remittance advice to providers contain the minimum required information and that the Contractor pay applicable interest on all claims, including overturned claim disputes. For the DS standard (scored at 96 percent), UHCCP-Acute has a mechanism for tracking and trending provider inquiries, which includes timely acknowledgement and resolution and taking systemic action, as appropriate. UHCCP-Acute also performed well in the MM standard (scored at 97 percent), which included the requirement that the Contractor provide medical home services to members. For the QM standard (scored at 99 percent), it was demonstrated that UHCCP-Acute has a structure and process in place for quality-of-care, abuse and complaint tracking, and trending for member or system resolution.

Opportunities for Improvement and Recommendations

The results of the OR established opportunities for improvement as UHCCP-Acute was less than fully compliant in two standards reviewed, with percentages that varied between 96 percent and 97 percent; however, no standards were below the 95 percent compliance threshold established by AHCCCS.

For the DS standard, the Contractor was found to be not fully compliant with the element that required the Contractor to ensure that its subcontractors are informed of availability of the provider manual.

For the MM standard, regarding the concurrent review process, the Contractor must develop a process to ensure timely initial and subsequent review of admissions. The Contractor must revise the discharge planning policy to ensure that members' needs are met and that a post-discharge telephone call occurs within seven days of discharge.

Corrective Action Plans

UHCCP-Acute submitted the first CAP to AHCCCS on May 25, 2017. AHCCCS reviewed and accepted all CAPs on June 22, 2017. AHCCCS requires that UHCCP-Acute submit to AHCCCS on December 22, 2017, an update for any open CAPs. With few exceptions, AHCCCS' expects all CAP steps to be completed within six months. (The six-month CAP update that UHCCP-Acute was required to provide was not available at the time of this report and is therefore not included.)

For the CIS element that requires payment of applicable interest for hospitals, the Contractor requested reconsideration because, for the case reviewed, the provider was in contract negotiations with the Contractor. AHCCCS accepted this reconsideration and changed the scoring in the final report.

For the DS standard, UHCCP-Acute proposed a CAP for the element requiring that the Contractor ensure that its subcontractors are informed of availability of the provider manual, including contacting subcontractors to inform them of the availability of the provider manual and resources and adding a discussion item to the subcontractor joint operating committee (JOC) meeting agenda to ensure that subcontractors receive information on the provider manual. AHCCCS accepted the CAP in part and has required the Contractor to provide documentation demonstrating that all subcontractors were notified of availability of the provider manual.

For the MM standard, the Contractor was found deficient in areas related to the concurrent review process regarding the medical necessity of inpatient stays as well as concerning proactive discharge planning for members admitted into acute care facilities. The Contractor needed to develop a process to ensure timely initial and subsequent review of admissions as well as to ensure that members' needs are met upon discharge. The Contractor performed a root cause analysis to determine the reason for untimely inpatient and medical necessity reviews and determined that education was needed for staff and hospital personnel. Steps identified in the plan have been completed; however, to close the CAP, the Contractor was required to provide to AHCCCS samples of provider re-education. For the discharge planning element, the Contractor revised policy to reflect all elements of discharge planning. This plan was instituted, and AHCCCS accepted and closed the CAP.

Even though the Contractor scored 99 percent in the QM standard, AHCCCS required a CAP to modify the re-credentialing process to document monitoring and review of adverse events, utilization management, and performance improvement and monitoring data. The Contractor revised the re-credentialing process to meet the requirements; therefore, AHCCCS accepted and closed the CAP.

Summary

UHCCP-Acute was fully compliant in all standards reviewed. For the CC, GA, GS, MCH, MI, RI, and TPL standards, the Contractor scored 100 percent.

The DS standard received the lowest score, 96 percent; and MM scored 97 percent, while the CIS and QM standards each scored 99 percent. CAPs were required for the DS, MM, and QM standards. CAPs were completed, accepted by AHCCCS, and closed for the MM and QM standards; however, for the DS standard, AHCCCS required the Contractor to provide documentation demonstrating that all subcontractors were notified of availability of the provider manual.

Health Net Access (Health Net)

AHCCCS conducted an on-site review of Health Net from June 5, 2017, through June 7, 2017. A copy of the draft version of the report was provided to the Contractor on July 19, 2017. Health Net was given a period of one week in which to file a challenge to any findings that the health plan considered inaccurate, based on the evidence available at the time of review.

Findings

For the CYE 2016 review period, AHCCCS in CYE 2017 conducted a comprehensive OR considering 11 standards. Table 6-2 presents the total number of elements; the standard area scores; and the total number, if any, of required corrective actions for each standard area reviewed.

Table 6-2—Standard Areas and Compliance Scores for Health Net

Standard Area	Total Number of Elements Scored	Standard Area Score	Required Corrective Actions
Corporate Compliance	5	100%	0
Claims and Information Systems	12	90%	4
Delivery Systems	9	96%	1
General Administration	3	89%	1
Grievance Systems	17	96%	3
Adult, EPSDT, and Maternal Child Health	15	96%	1
Medical Management	25	97%	2
Member Information	9	100%	0
Quality Management	27	99%	2
Reinsurance	4	100%	0
Third-Party Liability	7	86%	1

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

- Corporate Compliance (CC): For the five elements within this standard, the Contractor received a score of 100 percent (500 out of 500).
- Claims and Information Systems (CIS): For the 12 elements within this standard, the Contractor received a score of 90 percent (1,080 out of 1,200).
- Delivery Systems (DS): For the nine elements within this standard, the Contractor received a score of 96 percent (866 out of 900).

- General Administration (GA): For the three elements within this standard, the Contractor received a score of 89 percent (267 out of 300).
- Grievance Systems (GS): For the 17 elements within this standard, the Contractor received a score of 96 percent (1,624 out of 1,700).
- Adult, EPSDT, and Maternal Child Health (MCH): For the 15 elements within this standard, the Contractor received a score of 96 percent (1,433 out of 1,500).
- Medical Management (MM): For the 25 elements within this standard, the Contractor received a score of 97 percent (2,426 out of 2,500).
- Member Information (MI): For the nine elements within this standard, the Contractor received a score of 100 percent (900 out of 900).
- Quality Management (QM): For the 27 elements within this standard, the Contractor received a score of 99 percent (2,670 out of 2,700).
- Reinsurance (RI): For the four elements within this standard, the Contractor received a score of 100 percent (400 out of 400).
- Third-Party Liability (TPL): For the seven elements within this standard, the Contractor received a score of 86 percent (600 out of 700).

Strengths

For this OR, AHCCCS reviewed a total of 11 standards. Health Net was fully compliant (100 percent scores) in three of the 11 standards reviewed (CC, MI, and RI). The Contractor also demonstrated strong performance in the DS, GS, MCH, MM, and QM standards, with compliance scores between 96 percent and 99 percent.

For the CC standard, Health Net has an operational corporate compliance program as well as processes for identifying, reporting, and educating staff about suspected fraud, waste, and abuse. For the MI standard, the Contractor demonstrated compliance with the requirements for information distribution and provider assignment for members. Additionally, Health Net provided sufficient evidence for compliance with the RI standard (policies and procedures for processing and auditing reinsurance cases).

For the DS standard (scored at 96 percent) the Contractor had a process to evaluate its provider services staffing levels based on the needs of the provider community and to determine that provider services representatives are adequately trained. Health Net scored 96 percent for the GS standard as AHCCCS noted that appeal decisions are issued and carried out within required time frames and that member appeal policies allow for and require notification of the member regarding all rights granted under State and federal rules. AHCCCS noted that Health Net was in full compliance with most elements within the MCH standard (scored at 96 percent), including the element requiring that the Contractor establish and operate a maternity care program with goals directed at achieving optimal birth outcomes that meet AHCCCS minimum requirements. Further, Health Net received compliance for most elements in the MM standard and received an overall score of 97 percent for the standard. AHCCCS noted that Health Net established processes to assess, plan, implement, and evaluate utilization data management activities. For the QM standard (scored at 99 percent), AHCCCS determined that Health Net was in full compliance with elements relating to a structure and process in place to identify and investigate adverse

outcomes, including mortalities, for member and system improvement and for providing evidence that the governing body and the Contractor are accountable for all QM and QI program functions.

Opportunities for Improvement and Recommendations

The results of the OR demonstrated opportunities for Health Net to improve in various areas. For the CIS standard, for which Health Net received a score of 90 percent, AHCCCS identified several issues that needed improvement. For example, AHCCCS indicated that the Contractor's subcontracted remittances must include detailed descriptions of payments that were less than the billed charges, reasons for denials and adjustments, instructions and time frames for the submission of corrected claims as well as claim disputes, and the provider's rights for claim disputes. Additionally, during AHCCCS' review of claims, the following issues were identified: an incorrect application of interest due to a manual processing error, an incorrect calculation of interest applied to claims, claims resulting from overturned claim disputes processed after 15 days from the dates of decision, a claim incorrectly denied for a provider with valid AHCCCS registration, and claims paid to mid-level practitioners not being matched to the AHCCCS fee-for-service rate. Health Net was noncompliant in the GA standard (scored at 89 percent) as not all policies and procedures are reviewed annually. AHCCCS also found that Health Net filed no liens during the three-month period preceding the OR for the TPL standard, reflected in the TPL compliance score of 86 percent.

Although the DS, GS, MCH, MM, and QM standards received scores that complied with the 95 percent threshold of compliance established by AHCCCS, several opportunities for improvement were identified. For the DS standard, Health Net's provider manual did not include all requirements from AHCCCS Contractor Operations Manual (ACOM) 416. For example, information was not included in the Advance Directives, Encounter Validation, or Description of the Change of Contractor policies (ACOM 401); and expected response times for provider calls could not be located. In addition, the document ACOM 416 Crosswalk did not align with the requirements listed in ACOM 416, effective July 1, 2016.

For the GS standard, the following issues were found: it was unclear if appealed actions were reversed for several claim disputes; several claim disputes had incorrect or incomplete factual and legal basis for the decision; and two claim disputes were not resolved within the extension time frames. For the MCH standard, AHCCCS identified that the Contractor does not have processes to inform members about women's preventive health services or to inform primary care providers (PCPs) and obstetrician/gynecologist (OB/GYN) providers of the availability of women's preventive care services.

Health Net submitted policies for multiple elements in the MM standard that did not identify Health Net as the Contractor and in some cases used another Contractor's name. In addition, the following issues were identified for the same standard: policies did not include language on reporting fraud, waste, and abuse to AHCCCS; Health Net did not provide documentation of evidence that care coordination takes place for members involved in the justice system; the Contractor included only performance measures in the medical homes report cards (other metrics are not included); no evidence was provided on the implementation of strategies, investigations, or analysis regarding medical home provider monitoring; and, two notice of action (NOA) files were missing NOA letters.

For the QM standard, the following issues were identified: policies did not include the requirement to provide proactive care coordination for members who had multiple complaints or concerns regarding services or the AHCCCS program; a severity level variance scale was incorrectly referenced as an AHCCCS severity leveling system; the Contractor did not demonstrate how organizational providers who did not have adverse activity were evaluated and did not detail the evaluated QOC concerns and trends for those providers.

Corrective Action Plans

Health Net was required to propose CAPs for each deficiency found during the OR. Health Net submitted CAPs for nine standards on August 30, 2017. On September 27, 2017, AHCCCS accepted and/or closed the CAPs, excepting one (in which a second CAP submission was required). Health Net submitted requests for reconsideration for 11 issues identified during the OR, of which one request (for the RI standard) was accepted in full, one request (for the CIS standard) was accepted in part, and one request (for the MM standard) was accepted with the understanding that the Contractor would revise the policy to include contract-specific language. AHCCCS required that Health Net submit an update on any open CAPs on October 11, 2017. (The CAP resubmission that Health Net was required to provide was not available at the time of this report and is therefore not included.)

For the CIS standard, Health Net initiated systems updates that provided the required reason codes and detailed descriptions and worked with subcontractors to revise remittance language to include the required instructions and time frames. Health Net's internal audit process was enhanced to include monthly focused audits on interest payments for overturned claim disputes to ensure application of applicable interest. The Contractor also enhanced the work process to ensure that all overturned disputes are paid with interest, if applicable, within 15 business days of Health Net's Notice of Decision. Additionally, Health Net is developing the necessary workflows and documentation to support matching Contractor files with identification and reconciliation of newly added and removed records for accuracy and omission.

Although Health Net received scores above the 95 percent threshold for the DS, GS, MCH, MM, and QM standards, AHCCCS did identify several issues that needed to be addressed. Health Net was found deficient in the DS standard element that ensures that its provider manual contains all requirements listed in ACOM 416. Health Net updated its policies and provider manual and will notify providers of the updates. AHCCCS will close the CAP when Health Net provides documentation demonstrating that notification was provided to all providers and subcontractors. For the GS standard, Health Net must develop CAPs that comply with the following: issue provider claim dispute notices of decision letters that comply with rule and contract requirements; ensure that claims disputes include the correct and/or complete factual and legal basis for decisions; and ensure that all claim disputes are resolved no later than 30 days after receipt of the dispute, unless an extension is requested or approved by the provider. AHCCCS accepted all CAPs that Health Net proposed for this standard. To address these deficiencies, Health Net enhanced the work process to ensure that Notice of Decision letters include all contractually required information. Additionally, Health Net will update templates to include the specific factual and legal basis for the dispute, conduct weekly audits to ensure timely payments and resolution of disputes, report audit results to the appropriate parties, and address any identified issues. To close this CAP, the Contractor must provide documentation demonstrating that its provider community and subcontractors

were notified of the changes to its provider directory. Two issues in the requirements for the MCH standard were initially identified by AHCCCS. One issue, regarding the development and implementation of written processes to inform all PCPs and OB/GYN providers of the availability of women's preventive care services was adequately addressed by updating policies and the provider manual to include the requirements of this element; therefore, this part of the CAP was accepted and closed by AHCCCS. However, to close the second part of the CAP, AHCCCS required the Contractor to develop and implement written processes to inform all members of the availability of women's preventive health services. Health Net updated Health Net's member services handbook regarding women's preventive care services and will send each member notification of the update. AHCCCS noted that for this part of the CAP to be closed Health Net must demonstrate that the information provided to members is comprehensive and specific.

For standard MM, AHCCCS identified that the Contractor must develop CAPs that accomplish the following: develop policies and procedures that identify care coordination activities for members involved in the justice system, SMI decertification, or under court-ordered treatment; monitor the effectiveness of medical home providers; and include utilization data such as admissions, readmissions, and emergency visits as well as AHCCCS performance measures. AHCCCS accepted the CAPs that Health Net proposed for this standard. Health Net updated policies and procedures that identify care coordination activities and will implement updates to the Behavioral Health Program policy and train staff involved in the SMI certification and decertification processes. Health Net also updated the Medical Home policy and annual workplan and has established a process to generate reports on utilization data for discussion at the quarterly JOC meetings. Health Net will implement annual training of Health Net medical home staff on the updated policy and the AHCCCS performance measures. Health Net will also generate reports that will be reviewed by MM leadership for opportunities and interventions and that will be presented at quarterly MM committee meetings for monitoring, review, and discussion of the analysis.

For the QM standard, AHCCCS accepted Health Net's CAP to modify its policy to address the requirement to provide proactive care coordination for members who have multiple complaints or concerns regarding services or the AHCCCS program. Health Net modified its policy, AZ.QM.10, Quality of Care Resolution, to specify the steps for facilitating coordination of members' care. Health Net will complete all training related to policy revision and collect attestations.

For the GA standard, AHCCCS indicated that the Contractor must ensure that all policies and procedures are reviewed annually. Health Net's first CAP submission for this element was not accepted; therefore, AHCCCS requested a second submission of Health Net's proposed CAP for this element because the adequate documentation demonstrating annual review of policies and procedures was not provided. (The CAP resubmission that Health Net was required to provide was not available at the time of this report and is therefore not included.)

AHCCCS accepted and closed two of Health Net's CAPs, for the QM and TPL standards on September 27, 2017. Health Net completed CAP items for the elements regarding the evaluation of organizational providers in the areas of utilization management information; performance improvement and monitoring QOC concerns and trends in the re-credentialing process; and file liens on all total plan cases that exceed $250, including lien amendments and lien releases.

Summary

Health Net was fully compliant (100 percent score) in the CC, MI, and RI standards and within the 95 percent threshold of compliance for the DS, GS, MCH, MM, and QM standards.

The GA and TPL standards received the lowest scores (89 percent and 86 percent, respectively). CAPs were required for the CIS, DS, GA, GS, MCH, MM, QM, and TPL standards. CAPs were completed, accepted by AHCCCS, and closed for the QM and TPL standards; however, for the GS standard, AHCCCS required the Contractor to provide documentation that includes the dates in which annual reviews of policies and procedures were conducted prior to 2017.

Health Choice Arizona (HCA)

AHCCCS conducted an on-site review of HCA from April 24, 2017, through April 26, 2017. A copy of the draft version of the report was provided to the Contractor on June 7, 2017. HCA was given a period of one week in which to file a challenge to any findings that the health plan considered inaccurate, based on the evidence available at the time of review.

Findings

For the CYE 2016 review period, AHCCCS in CYE 2017 conducted a comprehensive OR considering 11 standards. Table 6-2 presents the total number of elements; the standard area scores; and the total number, if any, of required corrective actions for each standard area reviewed.

Table 6-3—Standard Areas and Compliance Scores for HCA

Standard Area	Total Number of Elements Scored	Standard Area Score	Required Corrective Actions
Corporate Compliance	5	93%	1
Claims and Information Systems	12	88%	5
Delivery Systems	9	71%	4
General Administration	3	100%	0
Grievance Systems	17	100%	0
Adult, EPSDT, and Maternal Child Health	15	72%	10
Medical Management	25	88%	4
Member Information	9	91%	1
Quality Management	27	95%	3
Reinsurance	4	100%	0
Third-Party Liability	7	100%	0

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

- Corporate Compliance (CC): For the five elements within this standard, the Contractor received a standard area score of 93 percent (467 out of 500).
- Claims and Information Systems (CIS): For the 12 elements within this standard, the Contractor received a score of 88 percent (1,052 out of 1,200).
- Delivery Systems (DS): For the nine elements within this standard, the Contractor received a score of 71 percent (640 out of 900).
- General Administration (GA): For the three elements within this standard, the Contractor received a score of 100 percent (300 out of 300).
- Grievance Systems (GS): For the 17 elements within this standard, the Contractor received a score of 100 percent (1,700 out of 1,700).
- Adult, EPSDT, and Maternal Child Health (MCH): For the 15 elements within this standard, the Contractor received a score of 72 percent (1,085 out of 1,500).
- Medical Management (MM): For the 25 elements within this standard, the Contractor received a score of 88 percent (2,193 out of 2,500).
- Member Information (MI): For the nine elements within this standard, the Contractor received a score of 91 percent (820 out of 900).
- Quality Management (QM): For the 27 elements within this standard, the Contractor received a score of 95 percent (2,560 out of 2,700).
- Reinsurance (RI): For the four elements within this standard, the Contractor received a score of 100 percent (400 out of 400).
- Third-Party Liability (TPL): For the seven elements within this standard, the Contractor received a score of 100 percent (700 out of 700).

Strengths

For this OR, AHCCCS reviewed 11 standards. HCA was fully compliant (100 percent scores) in four of the 11 standards reviewed (GA, GS, RI, and TPL). The Contractor also demonstrated solid performance in the QM standard, with a compliance score of 95 percent.

For the GA standard, HCA has a policy and procedure for the handling of records, maintains records within the required time frames, provides training to all staff on AHCCCS guidelines, and maintains a policy on policy development. For the GS standard, HCA maintains policies and procedures and implements processes compliant with rule and contract requirements regarding members' rights, standard and expedited member appeals, State fair hearings, and claim disputes. For the RI standard, AHCCCS found that HCA has policies, desk-level procedures, and appropriate training for processing and submission of transplant reinsurance cases; auditing of reinsurance; reinsurance overpayments against associated reinsurance encounters within 30 days of identification; and monitoring the appropriateness of reinsurance revenue.

For the TPL standard, HCA demonstrated its ability to discover the probable existence of a liable party not known to AHCCCS and to report that information to the AHCCCS-contracted vendor not later than 10 days from the date of discovery. Further, the following apply to HCA: identifies the existence of potentially liable parties through the use of trauma code edits and other procedures, does not pursue recovery on the case unless the case has been referred to the Contractor by AHCCCS (or by the AHCCCS-authorized representative), notifies the AHCCCS authorized representative upon the identification of reinsurance or fee-for-service payments made by AHCCCS on a total plan case, files liens on total plan casualty cases that exceed $250, and notifies AHCCCS to ensure that no reinsurance or fee-for-service payments have been made by AHCCCS prior to negotiating settlements on total plan cases.

For the QM standard (scored at 95 percent), HCA maintains policies and procedures and implements processes and training as related to the following: tracking and trending of quality of care issues; allegations of abuse and complaints; member and system resolution; system improvements; care coordination with other entities providing services to its members; and identifying and investigating adverse outcomes, services, and staff monitoring. This also includes credentialing and recredentialing of providers; utilizing member health-risk assessment surveys and data collection requirements; advance directives; ongoing medically necessary nursing services, medical management and referrals for members with behavioral health disorders or special healthcare needs; PIPs; and measuring and reporting Contractor performance using standard measures as required by the State.

Although HCA's score for the CIS and DS standards fell well below the 95 percent threshold, many strengths were noted by AHCCCS. HCA has policies and procedures that demonstrate the ability to accurately process all claims from providers and billers, to ensure that staff are trained on the claims process (including claim submission methods and where to proceed if a problem occurs in the claims submission process), and to provide policies and system screenshots demonstrating that the Contractor is able to check for primary insurance as well as additional coverage. Additionally, HCA's procedures detail how employees are to use the AHCCCS-supplied TPL information and how staff are to research and process claims with third party insurance. Further, HCA's policy on claims identifies the use of National Correct Coding Initiative (NCCI) edits, multiple procedure/surgical reductions, and global day evaluation and management (E/M) bundling in addition to several payment methodologies. HCA requires staff to check for AHCCCS updates to member files each day. For the DS standard, HCA submitted a draft provider inquiry desktop procedure that had been updated to reflect the process used when resolution of provider inquiries exceeds 30 days. The procedure also explains that HCA participates in discussions with providers to assist with resolution of provider inquiries.

Opportunities for Improvement and Recommendations

The results of the OR demonstrated opportunities for improvement as HCA was less than compliant in seven of the 11 standards reviewed. Scores for the CC, CIS, DS, MCH, MM, and MI standards ranged from 71 percent to 93 percent. AHCCCS found that for the CC standard (scored at 93 percent), HCA did not have a process for training new hires or annually training existing staff on how to report fraud, waste, and abuse to the AHCCCS OIG.

For the CIS standard (scored at 88 percent), several strengths were specified in AHCCCS' OR report on HCA; however, several opportunities for improvement were also identified. AHCCCS found that, during the OR review period, HCA was not in compliance with the following: documenting consistently when a billed amount is denied or adjusted in all cases; adequately addressing the application of coordination of benefits; and specifying in remittance advice to providers that disputes may be filed for payments or recoupments as well as for denials. Other issues identified during the claims review include: the interest terms applied to all hospital claims in the sample did not match the interest terms stated in the contracts, interest calculated based upon an incorrect number of days, and hospital interest incorrectly applied to a non-hospital claim. Additional documentation received from HCA failed to accurately describe how interest is applied to claims. Further, HCA processed claims (resulting from overturned claim disputes) after 15 days from dates of the decision, dispute information was not provided for one claim, inaccurate loading of contracted rates occurred, and inappropriate reimbursement to out-of-network providers occurred.

HCA received the lowest standard area score, 71 percent, for the DS standard. HCA's policies did not clearly identify more frequent monitoring for providers appearing on AHCCCS' 1800 Report or who have exceeded their capacity; and documentation submitted by HCA did not include information on any amendments of subcontracts or notification of subcontractors when modifications are made to AHCCCS guidelines, policies, and manuals. Further, the HCA's Letter of Agreement policy did not identify the process for coordinating the care or payment of claims for the out-of-network process or specifically address requirements for referrals to be made in accordance with appointment standards. The Provider Manual policy did not address distribution of the provider manual, and no documentation was provided to demonstrate that the Contractor ensured that providers and subcontractors were informed of availability of the provider manual.

Many opportunities for improvement were identified during the review of the MCH standard (in which HCA received a score of 72 percent). HCA did not demonstrate compliance with monitoring provider compliance of perinatal and postpartum depression screenings conducted at least once during the pregnancy and then again at the postpartum visit with appropriate counseling and referrals made if a positive screening was obtained. In addition, HCA did not have processes that ensured that physicians and other practitioners document in the medical record that each member of reproductive age was notified verbally or in writing of availability of family planning services or that all PCPs are informed about EPSDT services, including federal requirements, State regulations, and AHCCCS policy requirements. HCA did not implement processes to improve provider participation rates in providing EPSDT and well-child services.

Further, AHCCCS found that HCA did not demonstrate: that providers' use of the AHCCCS-approved EPSDT tracking forms is monitored, that a process is implemented to ensure use of AHCCCS-approved developmental screening tools according to intervals specified in AHCCCS policy, and that HCA reviews medical records for provider compliance with completing all elements of the EPSDT tracking form during each well-child visit. Additionally, the provider manual updated in 2017 did not include blood lead screening with targeted zip codes or venous draws for lead level greater than 10. HCA also did not demonstrate the following: monitoring providers to determine if oral health/dental services are provided according to the AHCCCS Dental Periodicity Schedule; ensuring that, during the EPSDT visit, an oral health screening is provided by the PCP or other practitioners; monitoring, tracking, and

evaluating PCP fluoride varnish applications for children less than two years of age; and monitoring EPSDT providers for participation in the Arizona State Immunization Information System (ASIIS) and the Vaccine for Children (VFC) program. The following issues were also noted: HCA submitted a provider toolkit with outdated items as related to coordination with Arizona Early Intervention Program (AzEIP); the Contractor did not demonstrate that a process was implemented to educate members on the availability of transportation services and assist members in using these services; and the Contractor did not demonstrate implementation of a process for transitioning a child (who is receiving nutritional therapy) to or from another Contractor or another service program. HCA did not demonstrate that it ensures that medical necessity for commercial oral nutritional supplements is determined on an individual basis by the member's PCP or attending physician using the AHCCCS-approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements," to obtain prior authorization from the Contractor; the Contractor does not monitor provider compliance of delivering well-woman preventive care services; and the updated provider manual does not list all women's preventive services.

For the MM standard, HCA received a score of 88 percent. The following issues were identified by AHCCCS during the OR review: two files were missing follow-up with the PCP; all the enrollment transition information (ETI) forms reviewed were not completed appropriately. HCA did not comply with the following: policies and procedures related to assisting homeless clinics to obtain prior authorization and referrals to specialists; the provision of medical home services to members, as the Network Development and Management Plan was not submitted; and, notice of action (NOA) files did not contain the necessary information. HCA did not submit policies and procedures for identifying, managing, and coordinating care for members with high needs and high costs, and it was not demonstrated that HCA reports to the appropriate actions and subsequent outcomes achieved as a result of using member-specific data.

AHCCCS assigned a score of 91 percent for the MI standard as HCA did not provide the required documentation that the new member packet had been distributed to new members and did not demonstrate that all information in the new member information packet had been approved by the appropriate regulatory agency.

Corrective Action Plans

In the report generated from HCA's OR, AHCCCS included requirements that HCA develop CAPs for issues that AHCCCS identified. HCA submitted the first CAP submission on August 17, 2017. AHCCCS agreed with some proposed steps contained in the CAP but did not accept all the CAPs, requiring HCA to resubmit additional steps. HCA proposed a second CAP submission on September 29, 2017; and AHCCCS accepted all CAPs; however, AHCCCS stated that HCA must demonstrate progress in each step until AHCCCS agrees that HCA has addressed the findings for each CAP.

For the first CAP submission, HCA submitted CAPs for the CC, CIS, DS, MCH, MM, MI, and QM standards. HCA completed the following steps to close the CAPs for the CC, MM, MI, and QM standards: developed or revised policies and procedures or documents; provided training; completed audits; distributed manuals, policies or flyers; changed the website; redesigned work flow processes. A second CAP submission was required for the CIS, DS, and MCH standards. (The six-month CAP update

that HCA was required to provide was not available at the time of this report and is therefore not included.)

AHCCCS identified three CAPs in the CIS standard, which required that HCA complete additional steps to close the CAPs. For the CIS standard—to ensure that HCA pays applicable interest on all claims, including overturned claim disputes and in lieu of contract terms specifying otherwise—to close the CAP AHCCCS requires HCA to provide documentation used for training; evidence of training provided to staff; and examples of appropriate interest applied to a hospital claim, a nonhospital claim, and an overturned claim dispute. To close the CAP on the requirement that HCA must ensure processing and paying all overturned claim disputes in a manner consistent with the decision within 15 business days of the decision, HCA must provide an example of the spreadsheet showing that monitoring is provided. Additionally, HCA must provide an explanation or example of when column "M" on the spreadsheet—"Action Item From Claims If Untimely"—is used; and, to ensure that HCA's information system contains the correct contracted rates in the absence of written negotiated rates, reimburse out-of-network providers according to State statute. To close the CAP, AHCCCS requires that HCA provide results of the completed audit that was implemented.

Four CAPs were identified in the DS standard, including the following: HCA must monitor appointment standards more frequently for providers on AHCCCS' 1800 Report and who have exceeded contracted capacity; ensure that it amends all subcontracts on their regular renewal schedule or within six calendar months of AHCCCS making changes to the minimum subcontract provisions (whichever comes first); and notify its subcontractors when modifications are made to AHCCCS guidelines, policies, and manuals. Further, HCA must refer members to out-of-network providers (in accordance with appointment standards) if unable to provide requested services in its network, including coordination of care and payment of such claims. HCA shall also demonstrate distribution of a provider manual that contains all requirements as per ACOM 416 and make providers and subcontractors aware of its availability. All CAPs were accepted; however, to close the CAP for appointments, HCA will need to provide documentation demonstrating the quarterly auditing of PCPs on the AHCCCS 1800 Report. To close the CAP on the distribution of the provider manual, HCA must provide documentation that all missing components from its provider manual are present by providing the provider manual and a crosswalk reflecting where the requirements are located within the provider manual.

For the MCH standard, ten CAPs were identified. In order to address these CAPs, HCA needed to develop and implement written processes to monitor provider compliance with perinatal depression screenings conducted at least once during the member's pregnancy, with appropriate counseling and referrals for a positive screen; ensure that physicians and other practitioners document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services; ensure that all PCPs are informed about EPSDT services (including federal requirements, state regulations, and AHCCCS policy requirements); and improve provider participation rates in providing EPSDT/well-child services.

For the same standard, AHCCCS established that HCA must develop and implement written processes which monitor providers' use of the AHCCCS-approved EPSDT tracking forms; ensure use of AHCCCS-approved developmental screening tools according to intervals specified in AHCCCS policy; and ensure that medical records are reviewed for provider compliance, with completion of all elements

in the EPSDT tracking form conducted during each well-child visit. Additionally, HCA must develop and implement written policies to monitor providers to determine if oral health/dental services are provided according to the AHCCCS Dental Periodicity Schedule; ensure, during the EPSDT visit, that an oral health screening is provided by the PCP or other practitioner; and monitor, track, and evaluate PCP fluoride varnish applications for children less than two years of age.

Further, HCA must develop and implement written policies to: monitor EPSDT providers for participation in the ASIIS and the VFC program; educate providers about AzEIP, including the need for providers to request authorization for medically necessary services from the Contractor; ensure that AHCCCS-registered AzEIP providers are reimbursed for providing medically necessary services to EPSDT enrolled members regardless of contract status; and educate members on the availability of and assist members in using transportation services.

In addition, HCA must develop and implement written processes for: transitioning a child (who is receiving nutritional therapy) to or from another Contractor or another service program; ensuring that medical necessity for commercial oral nutritional supplements is determined on an individual basis by the member's PCP or attending physician, using the AHCCCS-approved form "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" to obtain prior authorization from the Contractor; monitoring provider compliance of delivering well-woman preventive care services; and informing members about women's preventive health services.

AHCCCS accepted all CAPs; however, to close all CAPs, AHCCCS required HCA to align two policies with an audit tool to reflect the language of perinatal and postpartum depression screening and to provide documentation to demonstrate that the website and the member handbook were updated as identified in the proposed CAP.

For noncompliance identified in the MM standard, HCA was required to : complete all sections of the ETI forms without any blank spaces and attach a medication list if noted in the form; update policies annually; have a process, policy, or procedure for assisting homeless clinics with the prior authorization process; provide medical home services to members; and submit the policies referenced in this standard for review. HCA also needs to provide documentation that high-need, high-cost (HNHC) member outcomes are discussed at the MM committee meetings.

For noncompliance identified in the MI standards, HCA was required to ensure that its new member information packets meet AHCCCS standards for content and distribution. To comply, HCA delivered an unsealed, unopened new member information packet to AHCCCS.

To comply with the QM standard, HCA was required to: develop a process to ensure that provisional credentialing is completed within 14 calendar days of receipt of the completed application—to the date that the local medical director signs and approves the application—and monitor advance directives completed by members in home- and community-based settings (HCBSs) or behavioral health residential settings, to ensure confidentiality but not compromise availability.

AHCCCS accepted and closed all CAPs for the MM, MI, and QM standards.

Summary

For the GA, GS, RI, and TPL standards, HCA was fully compliant (100 percent scores). HCA was within the 95 percent threshold of compliance for the QM standard. The Contractor received scores below the 95 percent threshold in the CC, CIS, DS, MCH, MM, and MI standards. HCA scored lower on the DS and MCH standards, with scores of 71 percent and 72 percent respectively. By March 29, 2018, HCA will provide AHCCCS with an update on seven open CAPs. With few exceptions, AHCCCS expects all CAP steps to be completed within six months.

Care1st Health Plan Arizona, Inc. (Care1st)

AHCCCS conducted an on-site review of Care1st from November 7, 2016, through November 9, 2016. A copy of the draft version of the report was provided to the Contractor on December 29, 2016. Care1st was given a period of one week in which to file a challenge to any findings that the health plan considered inaccurate, based on the evidence available at the time of review.

Findings

For the CYE 2016 review period, AHCCCS in CYE 2017 conducted a comprehensive OR considering 11 standards. Table 6-4 presents the total number of elements; the standard area scores; and the total number, if any, of required corrective actions for each standard area reviewed.

Table 6-4—Standard Areas and Compliance Scores for Care1st

Standard Area	Total Number of Elements Scored	Standard Area Score	Required Corrective Actions
Corporate Compliance	5	72%	4
Claims and Information Systems	12	95%	3
Delivery Systems	9	100%	0
General Administration	3	100%	0
Grievance Systems	17	100%	0
Adult, EPSDT, and Maternal Child Health	15	100%	0
Medical Management	25	99%	0
Member Information	9	100%	0
Quality Management	27	100%	0
Reinsurance	4	100%	0
Third-Party Liability	7	100%	0

Table 6-4 illustrates the following compliance results for the 11 standards reviewed for the Care1st OR:

- Corporate Compliance: For the five elements within this standard, the Contractor received a standard area score of 72 percent (361 out of 500).

- Claims and Information Systems: For the 12 elements within this standard, the Contractor received a score of 95 percent (1,141 out of 1,200).
- Delivery Systems (DS): For the nine elements within this standard, the Contractor received a score of 100 percent (900 out of 900).
- General Administration (GA): For the three elements within this standard, the Contractor received a score of 100 percent (300 out of 300).
- Grievance Systems (GS): For the 17 elements within this standard, the Contractor received a score of 100 percent (1,700 out of 1,700).
- Adult, EPSDT, and Maternal Child Health (MCH): For the 15 elements within this standard, the Contractor received a score of 100 percent (1,500 out of 1,500).
- Medical Management (MM): For the 25 elements within this standard, the Contractor received a score of 99 percent (2,490 out of 2,500).
- Member Information (MI): For the nine elements within this standard, the Contractor received a score of 100 percent (900 out of 900).
- Quality Management (QM): For the 27 elements within this standard, the Contractor received a score of 100 percent (2,700 out of 2,700).
- Reinsurance (RI): For the four elements within this standard, the Contractor received a score of 100 percent (400 out of 400).
- Third-Party Liability (TPL): For the seven elements within this standard, the Contractor received a score of 100 percent (700 out of 700).

Strengths

For this OR, AHCCCS reviewed a total of 11 standards. Care1st was fully compliant (100 percent scores) with eight of the 11 standards reviewed (DS, GA, GS, MCH, MI, QM, RI, and TPL). The Contractor also demonstrated strong performance in the CIS and MM standards, with compliance scores of 95 percent and 99 percent, respectively.

Care1st received full compliance (100 percent) for the DS standard. To evaluate provider services staffing levels (based on the needs of the provider community), Care1st uses a methodology for determining the number of provider representatives needed as well as the provider call tracking and resolution time frames. Additionally, the Contractor develops, distributes, and maintains a provider manual that includes all requirements listed in ACOM 416 and informs providers and subcontractors of its availability. Care1st provided a policy on policy development which stated that policies are tracked to ensure that annual reviews are conducted.

For the GS standard, AHCCCS noted that Care1st issues and carries out appeal decisions within required time frames, transfers denied expedited appeal requests to the standard appeal review process, issues a written notice to the enrollee when an extension is taken, and provides oral notification of an expedited appeal resolution decision. Additionally, the Contractor resolves claim disputes and mails written notices of decision no later than 30 days after receipt of the dispute unless an extension is requested or approved by the provider. AHCCCS also noted that Care1st ensures that women's

preventive care services are provided according to the AHCCCS Medical Policy Manual, which complies with the MCH standard. Further, for the MI standard, AHCCCS noted that Care1st's new member information packets meet AHCCCS standards for content and distribution.

For the QM standard, AHCCCS noted that Care1st has a structure and process in place for quality of care and abuse or complaint tracking and trending for system improvement as well as for written policies and procedures. The Contractor monitors to ensure that providers discuss advance directives with all adult members receiving medical care. For the RI standard, AHCCCS established that Care1st had adequate policies and procedures for monitoring reinsurance cases to ensure consistency with AHCCCS requirements and for reporting reinsurance issues as discovered. For the TPL standard, for lien filings reviewed during three months prior to the OR, Care1st filed liens on total plan casualty cases that exceeded $250.

Care1st did not receive full compliance (100 percent) for the CIS or MM standards; however, the Contractor demonstrated strong compliance with most required elements. For example, Care1st ensures training on the specific rules and methodology for the processing of claims and has processes to identify resubmitted claims and to adjust claims for data corrections or revised payment. This was reflected in Care1st's CIS standard compliance score of 95 percent. Care1st also performed well in the MM standard, receiving a 99 percent score. Care1st demonstrated that it facilitates coordination of all services provided to a member when the member is transitioning between Contractors, has policies and procedures for providing and monitoring medical home services as well as contracts with medical homes to provide services, and monitors the effectiveness of medical homes.

Opportunities for Improvement and Recommendations

Results of the OR established opportunities for improvement as Care1st scored well below the compliance threshold for the CC standard (72 percent). AHCCCS noted that the Contractor's Fraud, Waste, and Abuse policy and Compliance 101 document do not specify how fraud, waste, and abuse are to be reported to AHCCCS nor give the option to the employee or others on how to report suspected or potential fraud, waste, and abuse to AHCCCS. AHCCCS also noted that Care1st did not submit sufficient evidence regarding instructions on reporting fraud, waste, and abuse to AHCCCS OIG for instances in which the Contractor conducts regular audits of its provider network and the data and other sources indicate potential fraud, waste, and abuse. The Contractor did not document the audit methodology or findings, deficiencies and implementation of corrective action, or how other administrative actions occur. Additionally, the Contractor did not submit sufficient evidence that checks of all managing employees and persons with ownership or control interest have been conducted monthly. For the CIS standard, AHCCCS identified that the Contractor's remittance advice did not contain the reason(s) for denials and adjustments and did not always explain payments in amounts less than billed charges.

Corrective Action Plans

In the report generated from the Care1st OR, AHCCCS included recommendations for Care1st that required the submission of seven CAPs. AHCCCS included the following findings and recommendations in the final OR report to Care1st.

Care1st submitted CAPs for the CC and CIS standards on February 17, 2016. AHCCCS accepted and/or closed all the CAPs Care1st submitted on March 14, 2017 and informed Care1st that AHCCCS must see demonstrated progress in the proposed steps until AHCCCS agrees that Care1st has addressed the findings for the five CAPs that remained open. AHCCCS expected that all CAP steps would be completed within six months. The first six-month CAP update submission was received by AHCCCS on August 15, 2017. On October 6, 2017, AHCCCS accepted and/or closed all CAPs that Care1st submitted, excepting one CAP for the CC standard (CC 4). Care1st must reassess the CAP and provide a six-month CAP update resubmission. (The six-month CAP update resubmission that Care1st was required to provide was not available at the time of this report and is therefore not included.)

On January 6, 2017, Care1st submitted eight requests for reconsideration, of which two (for elements in the GA and QM standards) were accepted in full. Scores for these standards were revised accordingly.

For the CC standard, the Contractor was found noncompliant with the elements that required the Contractor and its subcontractors to have processes for identifying, reporting, auditing, and conducting staff education on fraud, waste, and abuse. Care1st was required to: develop CAPs that would include how individuals may report concerns to AHCCCS in Care1st's Fraud, Waste, and Abuse policy and Compliance 101; develop training and supporting documentation; provide documentation that the Contractor conducts regular audits of its provider network when the data and other sources indicate potential fraud, waste, and abuse; provide documentation of audit methodology as well as of findings; note any deficiencies and implement corrective action and other administrative actions as appropriate; and provide evidence monthly of checks for all managing employees and persons concerning ownership or control interests.

Care1st proposed and completed three CAPs to update the Compliance 101 document and the Fraud, Waste, and Abuse policy (which was reviewed by the policy committee for approval and distribution to staff) to include how individuals may report fraud, waste, and abuse concerns to AHCCCS. The updated information was also included in employee training and the website. AHCCCS has accepted and closed two CAPs for this standard.

To complete the open CAP in the CC standard, Care1st will need to submit a plan to conduct regular audits of its provider network when data and other sources indicates potential fraud, waste, and abuse and to document the audit methodology as well as the findings, and noting any deficiencies and implementing corrective action or any other administrative actions as appropriate. Care1st must also submit documentation evidence that the Contractor has implemented these audits.

Summary

In summary, Care1st was in full compliance or within the 95 percent threshold of compliance for almost all standards reviewed. For the DS, GA, GS, MCH, MI, QM, RI, and TPL, the Contractor obtained full compliance (100 percent) scores. For the CIS and MM standards, the Contractor received an "at or above 95 percent" compliance score. The CC standard was the only standard to receive a non-compliant score (72 percent). On October 6, 2017, AHCCCS determined that Care1st did not satisfactorily complete one CAP. (The six-month CAP update resubmission that Care1st was required to provide was not available at the time of this report and is therefore not included.)

Outstanding CAPs From Plans With ORs in CYE 2016

The following is a presentation of the outstanding CAPs in CYE 2016 and CYE 2017 for the Contractors that received an OR in CYE 2016, including Comprehensive Medical and Dental Program (CMDP) and Mercy Care Plan (MCP). Phoenix Health Plan provided CAPs after the CYE 2016 OR, however is no longer a Contractor; therefore, the CAP summary will not be included in the report. An OR was not completed for Maricopa Health Plan because the entity was no longer operational nor in contract with AHCCCS during the review period. University Family Care (UFC) has not yet undergone a scheduled OR.

With few exceptions, AHCCCS expects all CAP steps to be completed within six months. The following are the CAP summaries for CMDP and MCP, both of which received ORs in CYE 2016:

Comprehensive Medical and Dental Program (CMDP)

Corrective Action Plans

Results of the CYE 2016 OR demonstrated opportunities for improvement as CMDP was less than fully compliant in 10 of the 11 standards reviewed. In the report generated from the CMDP's OR, AHCCCS included recommendations for CMDP that required the submission of 32 CAPs.

On November 4, 2016, CMDP submitted CAPs for all standards except the GS standard. AHCCCS did not accept several of the CAPs submitted and required CMDP to resubmit those CAPs.

CMDP resubmitted the CAPs by December 20, 2016; however, AHCCCS did not accept a few of the CAPs and issued a Notice of Concern to CMDP on January 27, 2017. On March 3, 2017, AHCCCS accepted all CAPs and informed CMDP that AHCCCS must see demonstrated progress in the proposed steps until AHCCCS agrees that CMDP has addressed the findings for the 26 CAPs that remained open. AHCCCS expected that all CAP steps would be completed within six months. The first six-month CAP update submission was received by AHCCCS by September 4, 2017. AHCCCS accepted and/or closed all CAPs that CMDP submitted, excepting eight: for the CIS, DS, QM, and TPL standards. CMDP must reassess the CAP and provide a six-month CAP update resubmission for five CAPs (DS 1, DS 3, DS 7, DS 9, and QM 28). (The six-month CAP update resubmission that CMDP was required to provide was not available at the time of this report and is therefore not included.) Additionally, by March 16, 2018, CMDP must provide a CAP update on three CAPs still open (CIS 2, CIS 5, and TPL 5).

In order to complete the CAPs that remain open, CMDP will need to: complete an upgrade of the information management system and demonstrating compliance; demonstrate utilization of provider calls when assessing staffing needs; provide the sign-in sheet for the provider inquiry training hosted by CMDP for provider service staff on March 30, 2017; submit a revised Provider Inquiry Process document that adequately addresses the CAP requirement; incorporate the requirements from ACOM 416 into CMDP's provider manual; submit documentation demonstrating that CMDP has identified opportunities for improvement using its health information system and has implemented a performance improvement project (PIP) to improve outcomes or results; submit a copy of the Timely Access to Care

PIP; and determine a method for demonstrating that CMDP appropriately files and releases liens on total plan causality cases that exceed $250 (while protecting the confidentiality of foster children).

Mercy Care Plan (MCP)

Corrective Action Plans

The results of the CYE 2016 OR demonstrated opportunities for improvement as MCP was less than fully compliant in six of the 11 standards reviewed. In the report generated from MCP's CYE 2016 OR, AHCCCS included recommendations for MCP that required the submission of 11 CAPs.

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

The first six-month CAP update submission was received by AHCCCS by April 25, 2017. On July 18, 2017, AHCCCS informed MCP that the CAPs submitted for the CC, CIS, and DS standards remained open. To close the five CAPs that remained open, MCP needed to reassess the CAPs and provide a six-month CAP update resubmission. The six-month CAP update resubmission was received by AHCCCS; and on July 18, 2017, AHCCCS informed MCP that the CAPs must be reassessed and a status update provided on the four CAPs that remain open for the CC and CIS standards. In the update, MCP must: provide evidence that the process for reporting fraud, waste, and abuse using the online form on the AHCCCS website is included in relevant documents; revise language on the remittance and send-back letter; provide status updates on the enhancement of MCP's claims processing system; and provide sufficient evidence that the claims team received education on the clean claim date adjustment process. (The status update that MCP was required to provide was not available at the time of this report and is therefore not included.)

Overall Comparative Results for Acute Care

Table 6-5—Acute Contractors Standard Area Scores

Standard Area	UHCCP-Acute	Health Net	HCA	Care1st
Corporate Compliance	100%	100%	93%	72%
Claims and Information Systems	99%	90%	88%	95%
Delivery Systems	96%	96%	71%	100%
General Administration	100%	89%	100%	100%
Grievance Systems	100%	96%	100%	100%

Standard Area	UHCCP-Acute	Health Net	HCA	Care1st
Adult, EPSDT, and Maternal Child Health	100%	96%	72%	100%
Medical Management	97%	97%	88%	99%
Member Information	100%	100%	91%	100%
Quality Management	99%	99%	95%	100%
Reinsurance	100%	100%	100%	100%
Third Party Liability	100%	86%	100%	100%

Findings

AHCCCS conducted the comprehensive OR for four Contractors for the CYE 2016 review period, in CYE 2017. The 11 standards reviewed were the same for each Contractor, as presented in Table 6-5.

Corporate Compliance

For the CC standard, UHCCP-Acute and Health Net received the highest scores, with 100 percent. HCA and Care1st received 93 percent and 72 percent, both under the 95 percent threshold for compliance. AHCCCS found deficiencies in the same element for these two Contractors and required the Contractors to provide sufficient documentation on educating staff and the provider network on fraud, waste, and abuse. Care1st completed CAPs for other elements in this standard. AHCCCS accepted and closed all CAPs, excepting one element that required Care1st to propose an adequate plan for conducting and documenting audits of its provider network in cases of indication of potential fraud, waste, and abuse.

Claims and Information Systems

UHCCP-Acute received the highest score for the CIS standard (99 percent) compared to the other three Contractors. Health Net and HCA underperformed in this standard, with scores under the 95 percent threshold. AHCCCS found deficiencies in three of the same elements for this standard for the three Contractors. The Contractors developed CAPs for elements that require that Contractor's remittance advice to providers contain the minimum required information; that Contractors must pay applicable interest on all claims, including overturned claim disputes; and that Contractors accept and integrate evidence of provider registration data provided by AHCCCS into claims and information systems. AHCCCS found additional deficiencies in the same standard for Health Net and HCA, which both require follow-up with AHCCCS to close the CAPs that remain open.

Delivery Systems

For the DS standard, Care1st received the highest score (100 percent). HCA was found deficient in a few elements under this standard and received a score of 71 percent. AHCCCS required a CAP for UHCCP-Acute, Health Net, and HCA in the same element, that which requires Contractors to develop, distribute, and maintain a provider manual and make providers and subcontractors aware of its availability. (CAPs for this element remain open for those three Contractors.) AHCCCS identified three additional deficiencies

in the same standard for HCA, of which two CAPs have been accepted and closed and one CAP requires follow-up to be closed.

General Administration

For the GA standard, the Contractors' performance was fully compliant for UHCCP-Acute, HCA, and Care1st; however, it was deficient, with an 89 percent score, for Health Net. AHCCCS is requiring Health Net to revise and resubmit a proposed CAP that ensures that all policies and procedures are reviewed annually.

Grievance Systems

For the GS standard, AHCCCS found that the Contractors performed exceedingly well, with three receiving full compliance scores (100 percent) and Health Net receiving a 96 percent score. Health Net proposed and implemented CAPs to address the issues, which AHCCCS has accepted and closed.

Adult, EPSDT, and Maternal Child Health

For the MCH standard, AHCCCS found that two Contractors, UHCCP-Acute and Care1st, were in full compliance (100 percent) with all required elements. Health Net received a compliant score (96 percent) and HCA received a 72 percent score (below the 95 percent compliance threshold). Health Net and HCA submitted CAPs that ensure that women's preventive care services are provided according to the AHCCCS Medical Policy Manual. AHCCCS has accepted these CAPs; however, both Contractors must provide follow-up to AHCCCS prior to the CAPs being closed. HCA was required to submit nine additional CAPs for this element. AHCCCS has accepted and closed eight of those CAPs.

Medical Management

For the MM standard, UHCCP-Acute, Health Net, and Care1st performed within the 95 percent compliance threshold; however, HCA scored 88 percent. AHCCCS found that two Contractors, Health Net and HCA, had deficiencies related to the provision of medical home services to members. All CAPs that HCA proposed to address deficiencies found in this standard have been accepted and closed by AHCCCS. UHCCP-Acute and Health Net must provide follow-up to AHCCCS to close the CAPs that remain open.

Member Information

For the MI standard, three Contractors, UHCCP-Acute, Health Net, and Care1st, performed remarkably well, receiving full compliance (100 percent) scores. However, HCA received a 91 percent score (below the 95 percent compliance threshold). HCA proposed a CAP to comply with the requirement that the Contractor's new member information packets must meet AHCCCS standards for content and distribution; AHCCCS accepted and closed that CAP.

Quality Management

The Contractors performed well for the QM standard, scoring at or above the 95 percent compliance threshold. One contractor, Care1st, received a full compliance (100 percent) score. AHCCCS found a few deficiencies within this standard for three Contractors: UHCCP-Acute, Health Net, and HCA; and all were required to propose CAPs to address the various issues. UHCCP-Acute and HCA have submitted and implemented CAPs that have been accepted and closed by AHCCCS. Health Net submitted two CAPs, of which one was accepted and closed. To close the second CAP, Health Net must provide documentation of training on any revised policies.

Reinsurance

All Contractors performed exceedingly well for the RI standard, receiving full compliance (100 percent) scores for the elements in this standard.

Third-Party Liability

Three Contractors—UHCCP-Acute, HCA, and Care1st—performed exceedingly well for the TPL standard, with full compliance (100 percent) scores. Health Net received an 86 percent score, below the 95 percent compliance threshold. Health Net adequately implemented CAP items that demonstrated compliance with appropriately filing and releasing liens on total plan casualty cases that exceed $250; therefore, AHCCCS accepted and closed the CAP.

Strengths

Although no Contractor obtained 100 percent for all standards combined, all Contractors obtained high scores in some standards. For example, the four Contractors obtained full compliance for the RI standard. Additionally, for the GS and QM standards, all four contractors obtained scores within the 95 percent compliance threshold.

Two of the four Contractors, Care1st and UHCCP-Acute, achieved full compliance (100 percent) scores for more than half the standards reviewed (eight standards and seven standards, respectively). One Contractor, UHCCP-Acute, received no noncompliance scores. One Contractor, Care1st, had only one standard below the 95 percent compliance threshold. The four Contractors were required to submit CAPs for all deficiencies found by AHCCCS during the OR. All Contractors have completed implementation for most CAPs; therefore, those CAPs have been closed by AHCCCS.

Opportunities for Improvement and Recommendations

All Contractors made progress in meeting the standards; however, opportunities for improvement do exist. The four Contractors proposed CAPs during the time frame allowed by AHCCCS according to the review period. AHCCCS accepted the activities proposed under each CAP (except for one CAP from Health Net) and requested that each Contractor provide CAP updates within six months of the acceptance of each CAP. AHCCCS required two Contractors, UHCCP-Acute and HCA, to provide six-

month CAP updates. Health Net was required to provide a revised CAP, and Care1st was required to resubmit a six-month update. (Submissions of these documents were not available at the time of reporting and are therefore not included in this report.)

Only four (UHCCP-Acute, Health Net, HCA, and Care1st) of the seven Contractors received ORs for this contract year. Based on the four Contractors reviewed, CC and CIS remain problematic; two out of the three contractors reviewed in CYE 2016 also had issues with these standards. For the CC standard, AHCCCS found deficiencies in the same element for two Contractors and required the Contractors to provide sufficient documentation of educating staff and the provider network related to fraud, waste, and abuse. For the CIS standard, the Contractors developed CAPs for elements requiring that Contractors' remittance advice to providers contain the minimum required information; that Contractors pay applicable interest on all claims, including overturned claim disputes; and that Contractors accept and integrate evidence of provider registration data provided by AHCCCS into its claims and information systems.

Based on AHCCCS' review of the Acute Care Contractors' performance conducted in CYE 2017 (for the CYE 2016 review period) and associated opportunities for improvement identified as a result of the comprehensive OR, HSAG recommends the following for Contractors:

- Contractors should conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should cross-reference existing policies, 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. For example, two Contractors had deficiencies in the fraud, waste, and abuse areas. Those Contractors should each develop a document that can be used to inform staff and the provider network about how to recognize and refer suspected fraud, waste, and abuse.
- Contractors should regularly monitor and ensure that updates are made to contracts with providers and that policy manual updates from AHCCCS are also timely included in Contractors' policies, procedures, and manuals (if impacted by the changes). 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 earlier 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 whether or not and

how metrics align with the State's goals for effectively managing medical home services to members.

- Contractors should implement control systems to address specific findings in the CIS standard that present a consistent compliance issue across Contractors related to the requirement that Contractors must pay applicable interest on all claims (including overturned claim disputes) and that Contractors' remittance advice to providers must contain the minimum required information.

Based on AHCCCS' review of the Acute Care Contractors' performance conducted in CYE 2017 (for the CYE 2016 review period) and associated opportunities for improvement identified as a result of the comprehensive OR, HSAG recommends the following for AHCCCS:

- AHCCCS should concentrate improvement efforts on the CC and CIS standards as both standards were problematic in CYE 2016 and CYE 2017 ORs. For example, AHCCCS should consider distributing technical assistance documents to all Contractors and holding in-person meetings with Contractors who scored lowest in these standards.
- AHCCCS could consider using the quarterly meetings with Contractors as forums to share lessons learned from both the State and Contractor perspectives. For example, for the CC standard, four of seven Contractors did not meet the AHCCCS performance threshold. AHCCCS should present identified best practices regarding fraud, waste, and abuse issues and facilitate a group discussion related to 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 with the CIS standard.
- AHCCCS could consider developing a template or checklist for the Contractors to ensure that Contractors include all minimum required information in remittance advise to providers. The element requiring that Contractors (and their subcontractors) must include the reason and detailed descriptions related to payments less than billed charges, denials, and adjustments on remittances has been out of compliance for both the CYE 2016 and CYE 2017 ORs for all but one Contractor. AHCCCS may also consider reviewing the data capture and transfer processes used for the claims processing systems to ensure alignment with the requirements set forth in the claims information systems standard. AHCCCS will be working with Contractors (in some cases, new Contractors) who will be providing integrated services, working with new populations, and operating in new geographic service areas; therefore, this is an important standard to target for compliance.

Summary

AHCCCS' Acute Care OR (conducted in CYE 2017 for the CYE 2016 review period) had positive results overall. All Contractors scored fully compliant in at least three standards; and one Contractor, Care1st, scored 100 percent, fully compliant in eight standards. Although HCA received the lowest scores for more than half the standards, the Contractor has satisfactorily addressed 75 percent of the deficiencies through the CAP process.

The GS, QM, and RI standards were strengths across Acute Care Contractors. The four Contractors scored within the 95 percent compliance threshold for these standards. The CC standard resulted in the highest number of noncompliant scores.

7. Performance Measure Performance

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

As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the functions associated with the mandatory activity of validating performance measures. In accordance with and satisfying the requirements of 42 CFR §438.364(a)(1–5), AHCCCS contracted with HSAG as an EQRO to use the information that AHCCCS obtained from the performance measure 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 the measure rates for CYE 2016, and AHCCCS approved the rates for inclusion in this report for the following measures for the Acute Care Contractors:

- *Adolescent Well-Care Visits*
- *Adults' Access to Preventive/Ambulatory Health Services*
- *Ambulatory Care (per 1,000 Member Months)—Emergency Department (ED) Visits—Total*
- *Annual Dental Visits—2–20 Years*
- *Annual Monitoring for Patients on Persistent Medications—Total*
- *Asthma in Younger Adults Admission Rate (per 100,000 Member Months)*
- *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*
- *Chronic Obstructive Pulmonary Disease (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 First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

For CMDP, AHCCCS calculated and approved the rates for inclusion for the following measures for CYE 2016:

- *Adolescent Well-Care Visits*
- *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*
- *Annual Dental Visits—2–20 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*
- *Chlamydia Screening in Women—Total*
- *Developmental Screening in the First Three Years of Life—Total*
- *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 Contractors' performance rates, HSAG organized, aggregated, and analyzed the performance data. From the analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality of, access to, and timeliness of care and services provided to AHCCCS members for CYE 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 performance measure rates.

HSAG designed a summary tool to organize and present the information and data that AHCCCS provided regarding the Contractors' performance on each AHCCCS-selected measure for the nine Acute Care Contractors, which now includes CMDP. 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, considering all Contractors.
- Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and, statewide, for all Contractors.

Methodology for Conducting the Review

For the CYE 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 measure.
- Calculated Contractor-specific performance rates and statewide aggregate rates for all Contractors for each measure.
- Reported Contractor performance results by individual Contractor and statewide aggregate.
- Compared Contractor performance rates with standards defined by AHCCCS' contract.

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

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

Performance measures used 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 Contractor-specific and statewide aggregate performance results for each measure to determine if performance rates met or exceeded corresponding AHCCCS MPSs. Relative rate changes and statistical analyses are presented to show the magnitude and direction of any change in rates from the previous measurement period and whether 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 formulated and presented its recommendations to improve Contractor performance rates.

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

Contractor-Specific Results—CYE 2016

AHCCCS provided data to HSAG on the CYE 2016 performance measure rates for eight Acute Care Contractors and for CMDP. The eight CYE 2016 Acute Care Contractors were Care1st, HCA, Health Net, MHP, MCP, PHP, UFC, and UHCCP-Acute. The performance measures reported for the Acute Care Contractors and CMDP are listed in the "Conducting the Review" section preceding. No discussion of CAPs is included in this section of the report for CYE 2016 data.

Care1st Health Plan Arizona, Inc. (Care1st)

Findings

Table 7-1 presents the performance measure rates for Care1st. 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—Care1st—Performance Measurement Results

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	42.7%	42.5%	-0.3%	P=.838	41.0%
Adults' Access to Preventive/Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	73.1%	73.3%	0.3%	P=.510	75.0%
Ambulatory Care (per 1,000 Member Months) [2]					
ED Visits—Total	55	55	—	—	—
Annual Dental Visits					
2–20 Years	65.0%	62.8%	-3.5%	**P<.001**	60.0%
Annual Monitoring for Patients on Persistent Medications					
Total	—	89.0%	—	—	75.0%
Asthma in Younger Adults Admission Rate (per 100,000 Member Months) [2]					
Asthma in Younger Adults Admission Rate	7.4	10.3	—	—	—
Breast Cancer Screening					
Breast Cancer Screening	45.7%	51.0%	11.5%	**P=.001**	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	49.6%	51.8%	4.4%	**P<.001**	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	94.1%	92.6%	-1.7%	**P=.016**	93.0%

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value) [1]	Minimum Performance Standard
25 Months–6 Years	87.8%	85.9%	-2.2%	**P<.001**	84.0%
7–11 Years	91.6%	90.4%	-1.4%	**P=.007**	83.0%
12–19 Years	88.6%	87.3%	-1.5%	**P=.012**	82.0%
Chlamydia Screening in Women					
Total	50.9%	48.9%	-3.8%	P=.117	63.0%
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)[2]					
COPD or Asthma in Older Adults Admission Rate	51.2	42.8	—	—	—
Developmental Screening in the First Three Years of Life					
Total	17.3%	23.6%	36.7%	**P<.001**	55.0%
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)[2]					
Diabetes Short-Term Complications Admission Rate	20.8	6.3	—	—	—
Heart Failure Admission Rate (per 100,000 Member Months)[2]					
Heart Failure Admission Rate	24.1	24.1	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	29.7	—	—	—
Maternity	—	8.2	—	—	—
Surgery	—	13.1	—	—	—
Medicine	—	11.0	—	—	—
Plan All-Cause Readmissions[2]					
Total	13.8%	11.8%	-14.5%	**P=.037**	—
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	66.3%	63.7%	-3.9%	P=.060	65.0%
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	70.4%	66.9%	-5.0%	**P<.001**	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

Care1st exceeded the MPSs for CYE 2016 for eight of 14 performance measure rates (*Adolescent Well-Care Visits*; *Annual Dental Visits—2–20 Years*; *Annual Monitoring for Patients on Persistent Medications—Total*; *Breast Cancer Screening*; *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*). Of note, the performance measure rates for *Breast Cancer Screening* and *Plan All-Cause Readmissions* demonstrated statistically significant improvements from CYE 2015 to CYE 2016.

Opportunities for Improvement

Six of the 14 performance measures (*Adults' Access to Preventive/Ambulatory Health Services*; *Cervical Cancer Screening*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*) fell below the MPSs for CYE 2016, indicating opportunities for improvement for Care1st. Of note, although the rates for *Cervical Cancer Screening* and *Developmental Screening in the First Three Years of Life* demonstrated statistically significant increases from CYE 2015 to CYE 2016, the rates fell below the MPSs by 12.2 percentage points and 31.4 percentage points, respectively.

Summary

Overall, performance for Care1st varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rates for *Adolescent Well-Care Visits*; *Annual Monitoring for Patients on Persistent Medications—Total*; *Breast Cancer Screening*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* exceeded the established MPSs for CYE 2016, whereas the performance measure rates for *Cervical Cancer Screening*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* fell below the MPSs. Care1st demonstrated positive performance in the **access** area, exceeding the CYE 2016 MPS for the *Annual Dental Visits—2–20 Years* and *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years* measure indicators. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

Health Choice Arizona (HCA)

Findings

Table 7-2 presents performance measure rates for HCA. The table displays CYE 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—HCA—Performance Measurement Results

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	36.7%	34.8%	-5.2%	**P<.001**	41.0%
Adults' Access to Preventive/Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	78.0%	74.8%	-4.1%	**P<.001**	75.0%
Ambulatory Care (per 1,000 Member Months) [2]					
ED Visits—Total	62	58	—	—	—
Annual Dental Visits					
2–20 Years	62.1%	57.6%	-7.3%	**P<.001**	60.0%
Annual Monitoring for Patients on Persistent Medications					
Total	—	87.5%	—	—	75.0%
Asthma in Younger Adults Admission Rate (per 100,000 Member Months) [2]					
Asthma in Younger Adults Admission Rate	8.2	7.1	—	—	—
Breast Cancer Screening					
Breast Cancer Screening	48.0%	48.8%	1.7%	P=.355	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	47.6%	44.5%	-6.4%	**P<.001**	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	94.4%	90.2%	-4.5%	**P<.001**	93.0%
25 Months–6 Years	85.1%	82.3%	-3.3%	**P<.001**	84.0%
7–11 Years	89.2%	88.6%	-0.6%	P=.095	83.0%
12–19 Years	86.9%	85.7%	-1.3%	**P=.001**	82.0%
Chlamydia Screening in Women					
Total	49.1%	48.6%	-1.2%	P=.482	63.0%

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value) [1]	Minimum Performance Standard
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)[2]					
COPD or Asthma in Older Adults Admission Rate	56.6	51.5	—	—	—
Developmental Screening in the First Three Years of Life					
Developmental Screening in the First Three Years of Life	20.6%	24.1%	17.2%	**P<.001**	55.0%
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)[2]					
Diabetes Short-Term Complications Admission Rate	19.6	17.2	—	—	—
Heart Failure Admission Rate (per 100,000 Member Months)[2]					
Heart Failure Admission Rate	22.0	22.9	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	28.5	—	—	—
Maternity	—	7.8	—	—	—
Surgery	—	12.3	—	—	—
Medicine	—	10.9	—	—	—
Plan All-Cause Readmissions[2]					
Total	12.6%	11.5%	-8.4%	P=.099	—
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	63.1%	57.2%	-9.5%	**P<.001**	65.0%
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	58.7%	56.2%	-4.4%	**P<.001**	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

HCA exceeded the MPSs for CYE 2016 for three of the 14 performance measure rates (*Annual Monitoring for Patients on Persistent Medications—Total*; and *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*).

Opportunities for Improvement

Eleven of the 14 performance measure rates fell below the MPSs for CYE 2016, indicating opportunities for improvement for HCA. Nine measure rates (*Adolescent Well Care Visits*; *Adults' Access to Preventive/Ambulatory Health Services—Total*; *Annual Dental Visits—2–20 Years*; *Cervical Cancer Screening*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *25 Months–6 Years*, and *12–19 Years*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) demonstrated statistically significant declines from CYE 2015 to CYE 2016. Of note, although the rate for *Developmental Screening in the First Three Years of Life* demonstrated a statistically significant increase from CYE 2015 to CYE 2016, the rate fell below the MPS by 30.9 percentage points.

Summary

Overall, performance for HCA varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rates for *Adolescent Well Care Visits*; *Breast Cancer Screening*; *Cervical Cancer Screening*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPSs, indicating opportunities for improvement. Related to **access**, HCA performance measure rates for *Adults' Access to Preventive/Ambulatory Health Services—Total*; *Annual Dental Visits—2–20 Years*; and *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, and *25 Months–6 Years* fell below the MPSs, indicating opportunities for improvement. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

Health Net Access (Health Net)

Findings

Table 7-3 presents performance measure rates for Health Net. The table displays CYE 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—Health Net—Performance Measurement Results

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	24.7%	29.0%	17.5%	**P<.001**	41.0%
Adults' Access to Preventive /Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	66.9%	70.4%	5.3%	**P<.001**	75.0%
Ambulatory Care (per 1,000 Member Months) [2]					
ED Visits—Total	51	51	—	—	—
Annual Dental Visits					
2–20 Years	41.2%	40.4%	-1.8%	P=.191	60.0%
Annual Monitoring for Patients on Persistent Medications					
Total	—	87.7%	—	—	75.0%
Asthma in Younger Adults Admission Rate (per 100,000 Member Months) [2]					
Asthma in Younger Adults Admission Rate	5.5	7.1	—	—	—
Breast Cancer Screening					
Breast Cancer Screening	34.4%	50.3%	46.2%	P=.074	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	34.1%	45.0%	32.2%	**P<.001**	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	91.1%	88.2%	-3.1%	**P=.003**	93.0%
25 Months–6 Years	77.3%	79.3%	2.6%	**P=.024**	84.0%
7–11 Years	80.1%	83.0%	3.6%	P=.368	83.0%
12–19 Years	68.3%	78.0%	14.2%	**P<.001**	82.0%
Chlamydia Screening in Women					
Total	45.1%	46.8%	3.7%	P=.299	63.0%

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	Minimum Performance Standard
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)[2]					
COPD or Asthma in Older Adults Admission Rate	30.1	42.8	—	—	—
Developmental Screening in the First Three Years of Life					
Developmental Screening in the First Three Years of Life	14.8%	20.7%	39.5%	**P<.001**	55.0%
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)					
Diabetes Short-Term Complications Admission Rate	14.2	12.2	—	—	—
Heart Failure Admission Rate (per 100,000 Member Months)[2]					
Heart Failure Admission Rate	17.7	19.1	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	27.2	—	—	—
Maternity	—	6.5	—	—	—
Surgery	—	12.6	—	—	—
Medicine	—	9.7	—	—	—
Plan All-Cause Readmissions[2]					
Total	13.8%	12.6%	-8.6%	P=.321	—
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	41.6%	51.3%	23.2%	**P<.001**	65.0%
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	50.7%	50.7%	0.0%	P=.995	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

Health Net met or exceeded the MPSs for CYE 2016 for three of 14 performance measure rates (*Annual Monitoring for Patients on Persistent Medications—Total*; *Breast Cancer Screening*; and *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*). Of note, seven performance measure rates (*Adolescent Well-Care Visits*; *Adults' Access to Preventive/Ambulatory Health Services—Total*; *Cervical Cancer Screening*; *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *12–19 Years*; and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*) demonstrated statistically significant increases from CYE 2015 to CYE 2016.

Opportunities for Improvement

Eleven of the 14 performance measures fell below the MPSs for CYE 2016, indicating opportunities for improvement for Health Net. Of note, one performance measure rate (*Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*) also demonstrated a statistically significant decline from CYE 2015 to CYE 2016. Although the rate for *Developmental Screening in the First Three Years of Life* demonstrated a statistically significant increase from CYE 2015 to CYE 2016, the rate fell below the MPS by 34.3 percentage points.

Summary

Overall, performance for Health Net varied across the areas of **quality** and **access.** For the **quality** area, *Adolescent Well-Care Visits*; *Cervical Cancer Screening*; C*hlamydia Cancer Screening —Total*; *Developmental Screening in the First Three Years of Life*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPSs, indicating opportunities for improvement. For the **access** area, *Adults' Access to Preventive/Ambulatory Health Services—Total*; *Annual Dental Visits—2–20 Years*; and *Children and Adolescents' Access to Primary Care Practitioners—12-24 Months, 25 Months–6 Years* and *12–19 Years* fell below the MPSs, indicating opportunities for improvement. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

Maricopa Health Plan (MHP)

Findings

Table 7-4 presents performance measure rates for MHP. The table displays CYE 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—MHP—Performance Measurement Results

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	40.9%	40.1%	-2.0%	P=.213	41.0%
Adults' Access to Preventive /Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	70.9%	70.9%	0.0%	P=.972	75.0%
Ambulatory Care (per 1,000 Member Months)[2]					
ED Visits—Total	61	58	—	—	—
Annual Dental Visits					
2–20 Years	62.0%	55.6%	-10.4%	**P<.001**	60.0%
Annual Monitoring for Patients on Persistent Medications					
Total	—	89.0%	—	—	75.0%
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)[2]					
Asthma in Younger Adults Admission Rate	7.1	5.9	—	—	—
Breast Cancer Screening					
Breast Cancer Screening	50.8%	53.2%	4.7%	P=.107	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	46.7%	47.4%	1.5%	P=.257	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	92.9%	89.8%	-3.3%	**P=.001**	93.0%
25 Months–6 Years	87.1%	83.0%	-4.7%	**P<.001**	84.0%
7–11 Years	89.1%	88.3%	-0.9%	P=.169	83.0%
12–19 Years	86.3%	85.0%	-1.5%	**P=.040**	82.0%
Chlamydia Screening in Women					
Total	41.2%	40.7%	-1.1%	P=.778	63.0%

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value) [1]	Minimum Performance Standard
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)[2]					
COPD or Asthma in Older Adults Admission Rate	59.8	51.0	—	—	—
Developmental Screening in the First Three Years of Life					
Developmental Screening in the First Three Years of Life	11.5%	17.4%	51.1%	**P<.001**	55.0%
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)[2]					
Diabetes Short-Term Complications Admission Rate	26.3	17.3	—	—	—
Heart Failure Admission Rate (per 100,000 Member Months)[2]					
Heart Failure Admission Rate	34.8	30.2	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	29.9	—	—	—
Maternity	—	6.7	—	—	—
Surgery	—	13.7	—	—	—
Medicine	—	11.6	—	—	—
Plan All-Cause Readmissions[2]					
Total	15.4%	13.7%	-11.3%	P=.093	—
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	58.3%	60.2%	3.2%	P=.267	65.0%
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	70.2%	63.0%	-10.3%	**P<.001**	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

MHP exceeded the MPSs for CYE 2016 for four of 14 performance measure rates (*Annual Monitoring for Patients on Persistent Medications—Total*; *Breast Cancer Screening*; and *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*).

Opportunities for Improvement

Ten of the 14 performance measures fell below the MPSs for CYE 2016, indicating opportunities for improvement for MHP. Additionally, five performance measures (*Annual Dental Visits—2-20 Years*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *25 Months–6 Years*, and *12–19 Years*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) also demonstrated statistically significant declines from CYE 2015 to CYE 2016. Of note, although the rate for *Developmental Screening in the First Three Years of Life* demonstrated a statistically significant increase from CYE 2015 to CYE 2016, the rate fell below the MPS by 37.6 percentage points.

Summary

Overall, performance for MHP varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rates for *Adolescent Well-Care Visits*; *Cervical Cancer Screening*; C*hlamydia Cancer Screening—Total*; *Developmental Screening in the First Three Years of Life*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPSs for CYE 2016. MHP demonstrated positive performance in the **access** area, exceeding the CYE 2016 MPS for *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* measures. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

Mercy Care Plan (MCP)

Findings

Table 7-5 presents performance measure rates for MCP. The table displays CYE 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 7-5—MCP—Performance Measurement Results

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	40.6%	41.2%	1.5%	**P=.042**	41.0%
Adults' Access to Preventive /Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	82.2%	79.9%	-2.8%	**P<.001**	75.0%
Ambulatory Care (per 1,000 Member Months)[2]					
ED Visits—Total	60	60	—	—	—
Annual Dental Visits					
2–20 Years	65.7%	56.2%	-14.5%	**P<.001**	60.0%
Annual Monitoring for Patients on Persistent Medications					
Total	—	88.5%	—	—	75.0%
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)[2]					
Asthma in Younger Adults Admission Rate	8.8	7.6	—	—	—
Breast Cancer Screening					
Breast Cancer Screening	58.3%	59.1%	1.3%	P=.250	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	56.5%	56.8%	0.5%	P=.295	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	96.2%	93.0%	-3.3%	**P<.001**	93.0%
25 Months–6 Years	89.6%	87.4%	-2.4%	**P<.001**	84.0%
7–11 Years	93.1%	92.2%	-1.1%	**P<.001**	83.0%
12–19 Years	90.3%	89.3%	-1.1%	**P<.001**	82.0%
Chlamydia Screening in Women					
Total	51.6%	46.0%	-10.8%	**P<.001**	63.0%

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value) [1]	Minimum Performance Standard
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)[2]					
COPD or Asthma in Older Adults Admission Rate	58.1	46.6	—	—	—
Developmental Screening in the First Three Years of Life					
Developmental Screening in the First Three Years of Life	19.6%	25.5%	30.1%	**P<.001**	55.0%
Diabetes Short-Term Complications Admission Rate[2]					
Diabetes Short-Term Complications Admission Rate	21.3	15.4	—	—	—
Heart Failure Admission Rate (per 100,000 Member Months)[2]					
Heart Failure Admission Rate	22.2	22.5	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	30.9	—	—	—
Maternity	—	9.7	—	—	—
Surgery	—	13.1	—	—	—
Medicine	—	11.4	—	—	—
Plan All-Cause Readmissions[2]					
Total	12.8%	12.4%	-3.2%	P=.407	—
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	69.3%	63.0%	-9.2%	**P<.001**	65.0%
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	65.8%	62.6%	-4.9%	**P<.001**	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

MCP met or exceeded the MPSs for CYE 2016 for eight of 14 performance measure rates (*Adolescent Well-Care Visits*; *Adults' Access to Preventive/Ambulatory Health Services*; *Annual Monitoring for Patients on Persistent Medications—Total*; *Breast Cancer Screening*; 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 rate for *Adolescent Well-Care Visits* demonstrated a statistically significant increase from CYE 2015 to CYE 2016.

Opportunities for Improvement

Six of the 14 performance measures (*Annual Dental Visits—2-20 Years*; *Cervical Cancer Screening*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) fell below the MPSs for CYE 2016, indicating opportunities for improvement for MCP. Additionally, nine of the 14 performance measure rates demonstrated statistically significant declines from CYE 2015 to CYE 2016. Of note, although the rate for *Developmental Screening in the First Three Years of Life* demonstrated a statistically significant increase from CYE 2015 to CYE 2016, the rate fell below the MPS by 29.5 percentage points.

Summary

Overall, performance for MCP varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rate for *Adolescent Well-Care Visits*; *Annual Monitoring for Patients on Persistent Medications—Total*; and *Breast Cancer Screening* exceeded the established MPSs for CYE 2016, whereas the performance measure rates for *Cervical Cancer Screening*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPSs. MCP demonstrated positive performance in the **access** area, exceeding the CYE 2016 MPSs for the *Adults' Access to Preventive/Ambulatory Health Services* measure and *Children and Adolescents' Access to Primary Care Practitioners* measure indicators. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

Phoenix Health Plan, LLC (PHP)

Findings

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

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	50.6%	48.9%	-3.3%	**P=.005**	41.0%
Adults' Access to Preventive /Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	81.1%	79.6%	-1.8%	**P<.001**	75.0%
Ambulatory Care (per 1,000 Member Months)[2]					
ED Visits—Total	54	52	—	—	—
Annual Dental Visits					
2–20 Years	71.8%	67.6%	-5.8%	**P<.001**	60.0%
Annual Monitoring for Patients on Persistent Medications					
Total	—	88.8%	—	—	75.0%
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)[2]					
Asthma in Younger Adults Admission Rate	5.5	5.9	—	—	—
Breast Cancer Screening					
Breast Cancer Screening	49.5%	45.7%	-7.7%	**P=.014**	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	62.5%	61.9%	-0.9	P=.466	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	97.4%	96.0%	-1.4%	**P=.037**	93.0%
25 Months–6 Years	92.3%	90.0%	-2.5%	**P<.001**	84.0%
7–11 Years	95.0%	93.9%	-1.2%	**P=.001**	83.0%
12–19 Years	92.8%	90.8%	-2.2%	**P<.001**	82.0%
Chlamydia Screening in Women					
Total	46.5%	51.5%	10.8%	**P=.001**	63.0%

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value) [1]	Minimum Performance Standard
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)[2]					
COPD or Asthma in Older Adults Admission Rate	66.4	52.9	—	—	—
Developmental Screening in the First Three Years of Life					
Developmental Screening in the First Three Years of Life	17.3%	25.6%	48.0%	**P<.001**	55.0%
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)[2]					
Diabetes Short-Term Complications Admission Rate	13.0	11.7	—	—	—
Heart Failure Admission Rate (per 100,000 Member Months)[2]					
Heart Failure Admission Rate	21.0	21.1	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	18.5	—	—	—
Maternity	—	6.1	—	—	—
Surgery	—	7.2	—	—	—
Medicine	—	7.6	—	—	—
Plan All-Cause Readmissions[2]					
Total	12.6%	10.0%	-20.7%	**P=.028**	—
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	69.0%	64.8%	-6.1%	**P=.014**	65.0%
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	73.6%	68.9%	-6.3%	**P<.001**	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

PHP exceeded the MPSs for CYE 2016 for nine of 14 performance measure rates (*Adolescent Well-Care Visits*; *Adults' Access to Preventive/Ambulatory Health Services*; *Annual Dental Visits—2–20 Years*; *Annual Monitoring for Patients on Persistent Medications—Total*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*). Of note, the performance measure rate for *Plan All-Cause Readmissions* demonstrated a statistically significant improvement from CYE 2015 to CYE 2016.

Opportunities for Improvement

Five of the 14 performance measure rates (*Breast Cancer Screening*; *Cervical Cancer Screening*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*) fell below the corresponding MPSs for CYE 2016, indicating opportunities for improvement for PHP. Additionally, 10 performance measure rates demonstrated statistically significant declines from CYE 2015 to CYE 2016. Of note, although the rate for *Developmental Screening in the First Three Years of Life* demonstrated a statistically significant increase from CYE 2015 to CYE 2016, the rate fell below the MPS by 29.4 percentage points.

Summary

Overall, performance for PHP varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rates for *Adolescent Well-Care Visits*; *Annual Monitoring for Patients on Persistent Medications—Total*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* exceeded the established MPSs for CYE 2016, whereas the performance measure rates for *Breast Cancer Screening*; *Cervical Cancer Screening*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* fell below the MPSs. PHP demonstrated positive performance in the **access** area, exceeding the CYE 2016 MPSs for the *Adults' Access to Preventive/Ambulatory Health Services*; *Annual Dental Visits—2–20 Years*; and all four *Children and Adolescents' Access to Primary Care Practitioners* measure indicators. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

University Family Care (UFC)

Findings

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

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	40.2%	37.6%	-6.6%	**P<.001**	41.0%
Adults' Access to Preventive /Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	76.8%	74.7%	-2.8%	**P<.001**	75.0%
Ambulatory Care (per 1,000 Member Months)[2]					
ED Visits—Total	57	52	—	—	—
Annual Dental Visits					
2–20 Years	60.7%	54.6%	-10.0%	**P<.001**	60.0%
Annual Monitoring for Patients on Persistent Medications					
Total	—	86.1%	—	—	75.0%
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)[2]					
Asthma in Younger Adults Admission Rate	7.3	5.7	—	—	—
Breast Cancer Screening					
Breast Cancer Screening	47.0%	54.5%	15.9%	**P<.001**	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	52.0%	53.1%	2.1%	**P=.015**	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	95.1%	90.5%	-4.9%	**P<.001**	93.0%
25 Months–6 Years	86.9%	83.1%	-4.4%	**P<.001**	84.0%
7–11 Years	89.9%	88.7%	-1.3%	**P=.010**	83.0%
12–19 Years	89.4%	88.0%	-1.5%	**P=.001**	82.0%
Chlamydia Screening in Women					
Total	51.3%	49.7%	-3.2%	P=.132	63.0%
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)[2]					
COPD or Asthma in Older Adults Admission Rate	37.6	32.6	—	—	—

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	Minimum Performance Standard
Developmental Screening in the First Three Years of Life					
Developmental Screening in the First Three Years of Life	18.4%	23.2%	26.0%	**P<.001**	55.0%
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)[2]					
Diabetes Short-Term Complications Admission Rate	23.0	15.9	—	—	—
Heart Failure Admission Rate (per 100,000 Member Months)[2]					
Heart Failure Admission Rate	18.0	17.9	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	24.8	—	—	—
Maternity	—	7.0	—	—	—
Surgery	—	10.1	—	—	—
Medicine	—	9.8	—	—	—
Plan All-Cause Readmissions[2]					
Total	11.2%	9.8%	-12.4%	P=.083	—
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	55.4%	55.0%	-0.8%	P=.774	65.0%
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	65.0%	58.8%	-9.6%	**P<.001**	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

UFC exceeded the MPSs for CYE 2016 for four of 14 performance measure rates (*Annual Monitoring for Patients on Persistent Medications—Total*; *Breast Cancer Screening*; and *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*). Of note, the performance measure rate for *Breast Cancer Screening* demonstrated a statistically significant increase from CYE 2015 to CYE 2016.

Opportunities for Improvement

Ten of the 14 performance measure rates fell below the MPSs for CYE 2016, indicating opportunities for improvement for UFC. Additionally, eight performance measure rates demonstrated statistically significant declines from CYE 2015 to CYE 2016. Of note, although the rate for *Developmental Screening in the First Three Years of Life* demonstrated a statistically significant increase from CYE 2015 to CYE 2016, the rate fell below the MPS by 31.8 percentage points.

Summary

Overall, performance for UFC varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rates for *Adolescent Well-Care Visits*; *Cervical Cancer Screening*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPSs, indicating opportunities for improvement. UFC demonstrated positive performance in the **access** area, exceeding the CYE 2016 MPSs for *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* measure indicators. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

UnitedHealthcare Community Plan-Acute (UHCCP-Acute)

Findings

Table 7-8 presents performance measure rates for UHCCP-Acute. The table displays CYE 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 7-8—UHCCP-Acute—Performance Measurement Results

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	39.4%	36.8%	-6.6%	**P<.001**	41.0%
Adults' Access to Preventive /Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	80.7%	78.0%	-3.4%	**P<.001**	75.0%
Ambulatory Care (per 1,000 Member Months) [2]					
ED Visits—Total	59	55	—	—	—
Annual Dental Visits					
2–20 Years	63.9%	61.3%	-4.0%	**P<.001**	60.0%

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	Minimum Performance Standard
Annual Monitoring for Patients on Persistent Medications					
Total	—	83.3%	—	—	75.0%
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)[2]					
Asthma in Younger Adults Admission Rate	10.8	6.1	—	—	—
Breast Cancer Screening					
Breast Cancer Screening	57.6%	55.2%	-4.2%	**P<.001**	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	50.8%	48.3%	-4.9%	**P<.001**	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	95.5%	92.0%	-3.7%	**P<.001**	93.0%
25 Months–6 Years	87.8%	84.9%	-3.4%	**P<.001**	84.0%
7–11 Years	91.4%	90.7%	-0.8%	**P=.002**	83.0%
12–19 Years	89.4%	88.4%	-1.1%	**P<.001**	82.0%
Chlamydia Screening in Women					
Total	39.4%	47.0%	19.3%	**P<.001**	63.0%
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)[2]					
COPD or Asthma in Older Adults Admission Rate	60.7	43.2	—	—	—
Developmental Screening in the First Three Years of Life					
Developmental Screening in the First Three Years of Life	17.9%	22.3%	24.5%	**P<.001**	55.0%
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)[2]					
Diabetes Short-Term Complications Admission Rate	17.6	13.3	—	—	—
Heart Failure Admission Rate (per 100,000 Member Months)[2]					
Heart Failure Admission Rate	24.7	22.4	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	26.1	—	—	—
Maternity	—	7.0	—	—	—
Surgery	—	11.4	—	—	—
Medicine	—	9.9	—	—	—
Plan All-Cause Readmissions[2]					
Total	10.4%	9.3%	-11.3%	**P=.005**	—

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value) [1]	Minimum Performance Standard
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	56.9%	54.6%	-4.0%	**P=.006**	65.0%
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	63.1%	59.0%	-6.4%	**P<.001**	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

UHCCP-Acute exceeded the MPSs for CYE 2016 for seven of 14 performance measure rates (*Adults' Access to Preventive/Ambulatory Health Services*; *Annual Dental Visits—2–20 Years*; *Annual Monitoring for Patients on Persistent Medications—Total*; *Breast Cancer Screening*; *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*). Of note, the performance measure rate for *Plan All-Cause Readmissions* demonstrated a statistically significant improvement from CYE 2015 to CYE 2016.

Opportunities for Improvement

Seven of the 14 performance measure rates (*Adolescent Well-Care Visits*; *Cervical Cancer Screening*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) fell below the MPSs for CYE 2016, indicating opportunities for improvement for UHCCP-Acute. Additionally, 11 performance measure rates demonstrated statistically significant declines from CYE 2015 to CYE 2016. Of note, although the rate for *Developmental Screening in the First Three Years of Life* demonstrated a statistically significant increase from CYE 2015 to CYE 2016, the rate fell below the MPS by 32.7 percentage points.

Summary

Overall, performance for UHCCP-Acute varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rates for *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15*

Months of Life—Six or More Well-Child Visits; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPSs and demonstrated statistically significant declines in performance from CYE 2015 to CYE 2016, indicating opportunities for improvement. UHCCP-Acute demonstrated positive performance in the **access** area, exceeding the CYE 2016 MPS for five of the six measures within this domain (*Adults' Access to Preventive/Ambulatory Health Services*; *Annual Dental Visits—2–20 Years*; and *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years* measure indicators). There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

Comprehensive Medical and Dental Program (CMDP)

Findings

Table 7-9 presents performance measure rates for CMDP. 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 7-9—CMDP—Performance Measurement Results

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	64.3%	68.3%	6.2%	**P=.002**	41.0%
Ambulatory Care (per 1,000 Member Months) [2]					
ED Visits—Total	46	42	—	—	—
Annual Dental Visits					
2–20 Years	68.3%	68.0%	-0.6%	P=.604	65.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	99.0%	98.3%	-0.6%	P=.233	93.0%
25 Months–6 Years	93.0%	93.2%	0.2%	P=.800	84.0%
7–11 Years	94.3%	96.0%	1.8%	P=.089	83.0%
12–19 Years	96.1%	95.9%	-0.2%	P=.819	82.0%
Chlamydia Screening in Women					
Total	54.4%	52.6%	-3.3%	P=.646	63.0%
Developmental Screening in the First Three Years of Life					
Developmental Screening in the First Three Years of Life	26.7%	30.0%	12.4%	**P=.017**	55.0%
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	13.5	—	—	—
Maternity	—	2.1	—	—	—

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value) [1]	Minimum Performance Standard
Surgery	—	4.6	—	—	—
Medicine	—	8.2	—	—	—
Plan All-Cause Readmissions [2]					
Total	NA	NA	—	—	—
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	69.8%	70.7%	1.3%	P=.520	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

CMDP exceeded the MPSs for CYE 2016 for seven of nine performance measure rates (*Adolescent Well Care Visits*; *Annual Dental Visits—2–20 Years*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*). Of note, the performance measure rate for *Adolescent Well Care Visits* demonstrated a statistically significant increase from CYE 2015 to CYE 2016.

Opportunities for Improvement

CMDP fell below the MPSs for two performance measure rates, *Chlamydia Screening in Women—Total* and *Developmental Screening in the First Three Years of Life*, by 10.4 percentage points and 25 percentage points, respectively, indicating opportunities for improvement.

Summary

Overall, performance for CMDP demonstrated strengths related to **quality** and **access** as seven measure rates exceeded the MPSs for CYE 2016. Two of these performance measure rates also demonstrated statistically significant increases in performance. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

Comparative Results for Acute Care Contractors—CYE 2016

Findings

Table 7-10 presents the aggregate performance measure rates for the nine Acute Care 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 7-10—Acute Care Contractors—Performance Measurement Results

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	39.9%	39.2%	-1.7%	**P<.001**	41.0%
Adults' Access to Preventive /Ambulatory Health Services					
Adults' Access to Preventive/Ambulatory Health Services	78.3%	76.8%	-1.9%	**P<.001**	75.0%
Ambulatory Care (per 1,000 Member Months) [2]					
ED Visits—Total	59	56	—	—	—
Annual Dental Visits					
2–20 Years	63.7%	58.6%	-8.0%	**P<.001**	60.0%
Annual Monitoring for Patients on Persistent Medications					
Total	—	86.7%	—	—	75.0%
Asthma in Younger Adults Admission Rate (per 100,000 Member Months) [2]					
Asthma in Younger Adults Admission Rate	8.5	6.9	—	—	—
Breast Cancer Screening					
Breast Cancer Screening	52.2%	53.8%	2.9%	**P<.001**	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	50.9%	50.6%	-0.5%	P=.073	64.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	95.1%	92.1%	-3.1%	**P<.001**	93.0%
25 Months–6 Years	87.7%	85.4%	-2.6%	**P<.001**	84.0%
7–11 Years	91.5%	90.6%	-1.0%	**P<.001**	83.0%
12–19 Years	89.3%	88.0%	-1.4%	**P<.001**	82.0%
Chlamydia Screening in Women					
Total	46.8%	47.4%	1.3%	P=.072	63.0%

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (*p* value) [1]	Minimum Performance Standard
COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)[2]					
COPD or Asthma in Older Adults Admission Rate	54.2	44.8	—	—	—
Developmental Screening in the First Three Years of Life					
Developmental Screening in the First Three Years of Life	18.3%	23.7%	29.2%	**P<.001**	55.0%
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)[2]					
Diabetes Short-Term Complications Admission Rate	19.7	14.3	—	—	—
Heart Failure Admission Rate (per 100,000 Member Months)[2]					
Heart Failure Admission Rate	23.0	22.4	—	—	—
Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)					
Total Inpatient	—	27.6	—	—	—
Maternity	—	7.7	—	—	—
Surgery	—	11.9	—	—	—
Medicine	—	10.5	—	—	—
Plan All-Cause Readmissions[2]					
Total	12.1%	11.2%	-7.6%	**P<.001**	—
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	62.1%	57.7%	-7.1%	**P<.001**	65.0%
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	64.6%	61.0%	-5.5%	**P<.001**	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

The Acute Care Contractors exceeded the MPSs for CYE 2016 for six of 14 performance measure rates (*Adults' Access to Preventive/Ambulatory Health Services*; *Annual Monitoring for Patients on Persistent Medications—Total*; *Breast Cancer Screening*; and *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*). Of note, the performance measure rates for *Breast Cancer Screening* and *Plan All-Cause Readmissions* demonstrated statistically significant improvements from CYE 2015 to CYE 2016.

Opportunities for Improvement

Eight of the 14 performance measure rates (*Adolescent Well-Care Visits*; *Annual Dental Visits—2–20 Years*; *Cervical Cancer Screening*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) fell below the MPSs for CYE 2016, indicating opportunities for improvement for the Acute Care Contractors. Additionally, nine performance measure rates demonstrated statistically significant declines from CYE 2015 to CYE 2016.

Summary

Overall, performance for the Acute Care Contractors varied across the areas of **quality** and **access**. For the **quality** area, the performance measure rates for *Adolescent Well-Care Visits*; *Cervical Cancer Screening*; *Chlamydia Screening in Women—Total*; *Developmental Screening in the First Three Years of Life*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* fell below the MPSs, indicating opportunities for improvement. *Breast Cancer Screening* and *Plan All-Cause Readmission* performance measure rates demonstrated positive performance within the **quality** area, as these rates demonstrated statistically significant improvement from CYE 2015 to CYE 2016. The Acute Care Contractors demonstrated varied performance in the **access** area, the performance measure rates for *Annual Dental Visits—2–20 Years* and *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* fell below the MPSs, while *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years* measure rates exceeded the CYE 2016 MPS. Of note, all four *Children and Adolescents' Access to Primary Care Practitioners* measure indicators demonstrated statistically significant declines in performance. There were no performance measure rates related to **timeliness**; therefore, this area was not discussed.

8. Performance Improvement Project Performance

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

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

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

Conducting the Review

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

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

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

In CYE 2015 (October 1, 2014, through September 30, 2015), AHCCCS implemented a new PIP, *E-Prescribing*, for all lines of business. The baseline measurement period covered CYE 2014 (data from October 1, 2013, through September 30, 2014), to be followed by two remeasurement periods: Remeasurement 1 (October 1, 2015, through September 30, 2016) and Remeasurement 2 (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 assists pharmacies in identifying potential problems related to medication management and potential reactions members may encounter, especially for those taking multiple medications.

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

Objectives for Conducting the Review

In its objectives for evaluating Contractor PIPs, AHCCCS:

- Ensures that each Contractor had an ongoing performance improvement program of projects that focused on clinical and/or nonclinical areas for the services it furnished to members.
- Ensures that each Contractor measured performance using objective and quantifiable quality indicators.
- Ensures that each Contractor implemented 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. 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.medicaid.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 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 each Acute Care and CMDP Contractor.

Contractor-Specific Results

AHCCCS provided HSAG with its CYE 2016 Contractor PIP qualitative analysis and interventions for seven Acute Care Contractors and CMDP. The Acute Care and CMDP Contractors for which data were provided were Care1st, HCA, MCP, PHP, UFC, UHCCP, Health Net, and CMDP. The interventions reported during CYE 2016 for the Acute Care Contractors and for CMDP were for the *E-Prescribing* PIP, which, to improve patient safety, focused on increasing the number of providers ordering prescriptions electronically and increasing the percentage of prescriptions submitted electronically rather than via paper or other method.

During CYE 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. AHCCCS expected that provider and member education efforts during Remeasurement 1 would result in rate increases for Indicator 1 and Indicator 2.

This section includes Contractors' PIP Remeasurement 1 results as calculated by AHCCCS, along with specific activities during Remeasurement 1, from October 1, 2015, through September 30, 2016. 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 Contractor level and reported in one of two age bands (ages 0 through 64 and age 65 and over). When AHCCCS originally calculated the aggregate rate per line of business, the numerators and denominators were noted to be added together and then divided by the number of Contractors included for that line of business. In addition, AHCCCS calculations did not include a combined rate of prescribing providers for all prescribers per Contractor (versus the 0 through 64 and 65 and over age bands indicated previously).

To ensure accuracy and consistency among 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 Contractor level as well as unduplicated provider prescribing and e-prescribing rates at the line-of-business and AHCCCS aggregate levels.

Care1st Health Plan Arizona, Inc. (Care1st)

Findings

Table 8-1 presents the baseline and Remeasurement 1 results for the *E-Prescribing* PIP for Care1st's members. The table also presents relative percentage changes from baseline and statistical significance of changes in rates.

Table 8-1—Care1st *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement Period 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	48.80%	56.72%	NA	7.93%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	41.23%	48.79%	NA	7.57%	**P<.001**

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-1 shows that, during the baseline period, 48.80 percent of Care1st's providers prescribed at least one prescription electronically and 41.23 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For Remeasurement 1, 56.72 percent of Care1st providers prescribed at least one prescription electronically and 48.79 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. Care1st's Remeasurement 1 rate for Indicator 1 demonstrated a relative percentage change from baseline of 7.93 percent and for Indicator 2 demonstrated a relative percentage change from baseline of 7.57 percent. Care1st demonstrated statistically significant and substantively large improvements in the performance of the indicators for this PIP.

Care1st submitted the following qualitative analysis:

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

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

- Explore funding sources to assist selected providers with technical upgrades/other fees, to gain e-prescribing functionality.
- Complete implementation of e-prescribing incentives into contracts with value-based purchasing (VBP) groups (e.g., Primary Care Medical Homes [PCMHs]).
- Send fax blasts to providers reinforcing the legality of e-prescribing controlled substances, listing the benefits of e-prescribing, and outlining steps to begin electronic prescriptions for controlled substances (EPCS); the same blast fax was used multiple times to reinforce provider/staff education through consistent messaging.
- Target high-volume prescribers for education with a focus on EPCS through AzAHP E-Rx workgroup (workgroup) collaboration since providers contract with multiple health plans.
- Conduct provider forum presentations in Maricopa and Pima counties including information on e-prescribing along with the same message from fax blasts to reinforce provider/staff education.
- Mailed to all Acute and Division of Developmental Disabilities member households the Care1st *Summer 2016 Member Newsletter*, with an article, "The Safest Way to Get Your Medication," which informed members about the benefits of e-prescribing.
- Develop an e-prescribing education and outreach program strategy through the workgroup to improve the adoption and use of e-prescribing among the AHCCCS Acute, Long Term Care, and Behavioral Health provider networks and to assist providers in advancing through the Meaningful Use stages.
- Mine data with assistance of AHCCCS to determine changes (compared to data mining completed in 2015) and identify opportunities for further improvement (high-volume prescribers with low rates of e-prescribing, including EPCS).
- Develop a physician education flyer for use by all AHCCCS Contractors through the workgroup.

Strengths

Care1st has educated prescribers on the advantages of e-prescribing, explored funding options to assist selected providers with technical upgrades and other fees in order to have e-prescribing functionality, and incorporated e-prescribing into newsletters and articles informing members about the benefits of e-prescribing.

Opportunities for Improvement and Recommendations

HSAG recommends that Care1st continue to monitor outcomes associated with the reported interventions. Care1st 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

Care1st's *E-Prescribing* PIP Indicator 1 first remeasurement rate of 56.72 percent and 48.79 percent for Indicator 2 demonstrated improvement over the respective baseline rates. Both rates increased by statistically and substantively significant amounts. Care1st may want 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 continue to increase by statistically significant amounts during the second remeasurement period.

Health Choice Arizona (HCA)

Findings

Table 8-2 presents the baseline and Remeasurement 1 results for the *E-Prescribing* PIP for HCA's members. The table also presents the relative percentage changes from baseline and the statistical significance of changes in rates.

Table 8-2—HCA *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement Period 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	56.69%	56.73%	NA	0.04%	P=.939
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	43.46%	45.79%	NA	2.33%	**P<.001**

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-2 shows that 56.69 percent of HCA's providers prescribed at least one prescription electronically and that 43.46 percent of prescriptions were sent by an AHCCCS-contracted provider electronically during the baseline period. For Remeasurement 1, 56.73 percent of HCA providers prescribed at least one prescription electronically and 45.79 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. HCA's rate for Remeasurement 1 for Indicator 1 demonstrated a relative percentage change from baseline of 0.04 percent and for Indicator 2 demonstrated a relative percentage change from baseline of 2.33 percent. HCA's rate for Indicator 1 did not improve by a statistically significant amount, with a relative percentage change from baseline of less than 0.05 percent. However, HCA did demonstrate a statistically significant improvement for Indicator 2.

HCA submitted the following qualitative analysis:

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

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

- The e-prescribe strategy was reassigned to the quality director and new medical director for HCA.
- An analysis of ACOM 321/e-prescribing PIP was conducted and educational material was created.
- IRR was completed on three internal reports.
- Initiated an e-prescribing subcommittee.
- Educated network representatives.
- Network representatives initiated educational outreach as well as an environmental scan of e-prescribing capabilities of providers in the network.
- Initiated rapid Plan-Do-Study-Act (PDSA) cycles every two weeks for laser focus on the initiative for the upcoming year.
- Health Current educational flyer was uploaded to HCA's provider website.

Strengths

HCA showed strength in its interventions by recognizing that, although the measure had shown modest improvement for Indicator 2, room existed for additional improvement in the measure. For Indicator 1, the measure needs to make progress to achieve statically significant improvement over the baseline rate. Additional interventions deployed should show a sufficient return by the next measurement cycle.

Opportunities for Improvement and Recommendations

Although the overall rate for the eligible population demonstrated statistically significant improvement over the baseline rate for Indicator 2, the rate for Indicator 1 did not. HCA added more aggressive interventions to achieve the needed increase in the measure. HSAG recommends that HCA continue those interventions and monitor results every two weeks.

Summary

HCA's Remeasurement 1 rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 56.73 percent, and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically) the rate was 45.79 percent. Only Indicator 2 increased by a statistically significant amount. HCA may want to monitor the progress of the PIP interventions employed to increase Indicator 1's rate and adjust interventions as needed to ensure that both rates continue to increase by a statistically significant amount during the second remeasurement period. In addition, HCA may want to develop other solid interventions to increase both rates as studies have demonstrated a correlation between e-prescribing and patient safety.

Health Net Access (Health Net)

Findings

Table 8-3 presents the baseline and Remeasurement 1 results for the *E-Prescribing* PIP for Health Net's members. The table also presents relative percentage changes from baseline and statistical significance of changes in rates.

Table 8-3—Health Net *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement Period 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	51.37%	62.54%	NA	11.17%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	36.18%	48.79%	NA	12.61%	**P<.001**

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-3 shows that, during the baseline period, 51.37 percent of Health Net's providers prescribed at least one prescription electronically and 36.18 percent of the prescriptions were sent by an AHCCCS-contracted provider electronically. For Remeasurement1, 62.54 percent of Health Net's providers prescribed at least one prescription electronically and 48.79 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the Remeasurement 1 period, Health Net demonstrated for Indicator 1 a relative percentage change from baseline of 11.17 percent and demonstrated for Indicator 2 a relative percentage change from baseline of 12.61 percent. MCP demonstrated statistically significant and substantively large improvements in performance for this PIP.

Health Net submitted the following qualitative analysis:

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

information on controlled substances. Additionally, flyers that have been developed by the workgroup through the Health Current have been distributed widely to providers.

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

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

Strengths

Health Net analyzed the data from the survey the workgroup conducted and developed interventions to address the education barrier to e-prescribing. Health Net has educated prescribers on the advantages of e-prescribing by distributing information on Health Current webinars and/or forums and by collaborating with pharmacy services to distribute a workgroup educational flyer to contracted providers. Finally, Health Net is an active collaborator within the workgroup.

Opportunities for Improvement and Recommendations

HSAG recommends that Health Net monitor the outcomes associated with the reported interventions. Health Net 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

Health Net's *E-Prescribing* PIP first remeasurement rate for Indicator 1 was 62.54 percent and for Indicator 2 was 48.79 percent. Both indicator rates increased by statistically and substantively significant amounts. Health Net may want 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.

Maricopa Health Plan (MHP)

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

Mercy Care Plan (MCP)

Findings

Table 8-4 presents the baseline Remeasurement 1 results for the *E-Prescribing* PIP for MCP's members. The table also presents relative percentage changes from baseline and statistical significance of changes in rates.

Table 8-4—MCP *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement Period 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	50.27%	58.64%	NA	8.37%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	40.10%	45.80%	NA	5.70%	**P<.001**

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-4 shows that, during the baseline period, 50.27 percent of MCP's providers prescribed at least one prescription electronically and 40.10 percent of prescriptions were sent by an AHCCCS-contracted provider electronically For Remeasurement 1, 58.64 percent of MCP's providers prescribed at least one prescription electronically and 45.80 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For MCP's Remeasurement 1 period, Indicator 1 demonstrated a relative percentage change from baseline of 8.37 percent and Indicator 2 demonstrated a relative percentage change from baseline of 5.70 percent. MCP demonstrated statistically significant and substantively large improvements in performance for this PIP.

MCP submitted the following qualitative analysis:

- A survey of providers was conducted by all Contractors in the Arizona Association of Health Plans. The findings by MCP are as follows:

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

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

- Developed member educational materials to communicate the benefits of e-prescribing.
- Provided updated information on each practice's e-prescribing rate to the practice representatives and had them discuss the results with each practice periodically, making it specific to individual doctors and concentrating on outlier low users.
- Developed and posted a provider toolkit to educate providers on the benefits and value of e-prescribing.
- Worked with CVS to send a fax blast to pharmacies reminding them of the importance of accurately reporting controlled substance prescription monitoring program (CSPMP) data.

Strengths

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

Opportunities for Improvement and Recommendations

HSAG recommends that MCP continue to monitor the outcomes associated with the reported interventions. HSAG also recommends, as these are both patient safety issues, that MCP develop more interventions based on received data, to increase both the rates of providers that prescribe prescriptions electronically and the rates of prescriptions sent electronically . In addition, HSAG recommends that MCP continue the collaboration among Contractors in the workgroup to improve performance for these indicators.

Summary

The Remeasurement 1 rate for MCP's *E-Prescribing* PIP Indicator 1 was 58.64 percent and for Indicator 2 was 45.80 percent, both demonstrating improvement over respective baseline rates. Both indicators increased by statistically significant amounts. MCP may want 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.

Phoenix Health Plan, LLC (PHP)

Findings

Table 8-5 presents the baseline and Remeasurement 1 results for the *E-Prescribing* PIP for PHP's members. The table also presents relative percentage changes from baseline and statistical significance of changes in rates.

Table 8-5—PHP *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement Period 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	46.14%	56.57%	NA	10.53%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	40.52%	49.68%	NA	9.15%	**P<.001**

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-5 shows that, during the baseline period, 46.14 percent of PHP's providers prescribed at least one prescription electronically and 40.52 percent of the prescriptions were sent by an AHCCCS-contracted provider electronically. For Remeasurement 1, 56.57 percent of PHP's providers prescribed at least one prescription electronically and 49.68 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For Remeasurement 1, PHP demonstrated for Indicator 1 a relative percentage change from baseline of 10.53 percent and for Indicator 2 a relative percentage change from baseline of 9.15 percent. PHP demonstrated statistically significant and substantively large improvements in performance for this PIP.

PHP submitted the following qualitative analysis:

- PHP conducted a qualitative provider survey at a PHP provider forum. Provider office staff in attendance documented what they perceived to be barriers to the adoption of e-prescribing in their offices. PHP compiled and analyzed the survey results, then used those results to develop interventions that began in early 2015 and will continue at least through the end of the measurement

period in 2017. For example, PHP identified the cost of an EHR as a barrier; and the intervention was to connect offices with a non-profit organization that could educate the providers on no-cost e-prescribing software and inform the providers of incentives that could offset the cost of more sophisticated systems.

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

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

Strengths

PHP performed an analysis of the results of a provider survey and learned that the cost of an EHR is a barrier but that interventions to improve both indicators would aim at connecting offices with a non-profit organization that could educate the providers about no-cost e-prescribing software and inform the providers of incentives that could offset the cost of more sophisticated systems. Additionally, PHP has used other strong interventions like attending e-prescribing conferences to increase expertise and implementing a P4P incentive model.

Opportunities for Improvement and Recommendations

HSAG recommends that PHP continue to monitor the outcomes associated with the reported interventions. PHP needs to sustain the improvement for an additional measurement cycle and has an opportunity for improvement for both indicators. HSAG also recommends, as these are patient safety issues, that PHP develop more interventions based on received data to increase performance for both indicators. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors in the workgroup to improve performance for these indicators.

Summary

PHP's *E-Prescribing* PIP Indicator 1 Remeasurement 1 rate of 56.67 percent and Indicator 2 Remeasurement 1 rate of 49.68 percent demonstrated improvement over the respective baseline rates. Both rates increased by statistically and substantively significant amounts. PHP may want 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 continue to increase by statistically significant amounts during the second remeasurement period. In addition, PHP may want to develop other interventions to increase both rates as studies have demonstrated a correlation between e-prescribing and patient safety.

UnitedHealthcare Community Plan-Acute (UHCCP-Acute)

Findings

Table 8-6 presents the baseline and Remeasurement 1 results for the *E-Prescribing* PIP for UHCCP-Acute members. The table also presents relative percentage changes from baseline and statistical significance of changes in rates.

Table 8-6—UHCCP-Acute *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement Period 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	63.75%	70.79%	NA	7.04%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	44.32%	53.10%	NA	8.77%	**P<.001**

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-6 shows that, during the baseline period, 63.75 percent of UHCCP-Acute's providers prescribed at least one prescription electronically and that 44.32 percent of the prescriptions were sent by an AHCCCS-contracted provider electronically. For the Remeasurement 1 period, 70.79 percent of UHCCP-Acute providers prescribed at least one prescription electronically and 53.10 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For Remeasurement 1, the UHCCP-Acute Indicator 1 rate demonstrated a relative percentage change from baseline of 7.04 percent and the Indicator 2 rate demonstrated a relative percentage change from baseline of 8.77 percent. UHCCP-Acute demonstrated statistically significant and substantively large improvements in performance for this PIP.

UHCCP-Acute submitted the following qualitative analysis:

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

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

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

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

Strengths

UHCCP-Acute analyzed the data from the surveys conducted and developed interventions to address the education barrier to e-prescribing. UHCCP-Acute has educated prescribers on the advantages of e-prescribing and has offered assistance in connecting with e-prescribing vendors. In addition, UHCCP-Acute has incorporated *E-Prescribing* PIP presentations and information into provider forums.

Opportunities for Improvement and Recommendations

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

Summary

For Remeasurement 1, UHCCP-Acute's *E-Prescribing* PIP Indicator 1 rate of 70.79 percent and Indicator 2 rate of 53.10 percent demonstrated improvement over the respective baseline rates. Both rates increased by statistically and substantively significant amounts. UHCCP-Acute may want 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 continue to increase by statistically significant amounts during the second remeasurement period. In addition, as studies have demonstrated a correlation between e-prescribing and patient safety, UHCCP-Acute may want to develop other interventions to increase both rates.

University Family Care (UFC)

Findings

Table 8-7 presents the baseline and Remeasurement 1 results for the *E-Prescribing* PIP for UFC's members. The table also presents relative percentage changes from baseline and statistical significance of changes in rates.

Table 8-7—UFC *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement Period 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	48.45%	55.61%	NA	7.15%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	47.34%	56.71%	NA	9.36%	**P<.001**

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-7 shows that, during the baseline period, 48.45 percent of UFC's providers prescribed at least one prescription electronically and that 47.34 percent of prescriptions ordered were sent by an AHCCCS-contracted provider electronically. For the Remeasurement 1 period, 55.61 percent of UFC' providers prescribed at least one prescription electronically and 56.57 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For Remeasurement 1, UFC's Indicator 1 demonstrated a relative percentage change of 7.15 percent from baseline, and Indicator 2 demonstrated a relative percentage change from baseline of 9.36 percent. UFC demonstrated statistically significant and substantively large improvements in performance for this PIP.

UFC submitted the following qualitative analysis:

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

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

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

Strengths

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

Opportunities for Improvement and Recommendations

HSAG recommends that UFC continue to monitor the outcomes associated with the reported interventions. HSAG also recommends that, to increase both indicator rates as these are both patient safety issues, UFC develop more interventions based on received data. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors in the workgroup to improve performance for these indicators.

Summary

UFC's *E-Prescribing* PIP Remeasurement 1 rate of 55.61 percent for Indicator 1 and 56.71 percent for Indicator 2 demonstrated improvement over the respective baseline rates. Both rates increased by statistically and substantively significant amounts. UFC may want to monitor the progress of the PIP interventions employed to increase provider prescribing electronically and prescriptions sent electronically and to adjust interventions as needed to ensure that the rates continue to increase by a statistically significant amount during the second remeasurement period. In addition, as studies have demonstrated a correlation between e-prescribing and patient safety, UFC may want to develop other solid interventions to increase both rates.

Comprehensive Medical and Dental Program (CMDP)

Findings

Table 8-8 presents the baseline and Remeasurement 1 results for the *E-Prescribing* PIP for CMDP's members. The table also presents relative percentage changes from baseline and statistical significance of changes in rates.

Table 8-8—CMDP *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2013, through Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, through Sept. 30, 2016	Remeasurement Period 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	47.65%	55.31%	NA	7.66%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	46.69%	56.56%	NA	9.87%	**P<.001**

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-8 shows that 47.65 percent of CMDP's providers prescribed at least one prescription electronically and that 46.69 percent of prescriptions were sent by an AHCCCS provider electronically within the baseline year. For Remeasurement 1, 55.31 percent of CMDP providers prescribed at least one prescription electronically and 56.56 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For CMDP, for Remeasurement 1 for Indicator 1 demonstrated a relative percentage change of 7.66 percent from baseline and Indicator 2 demonstrated a relative percentage change of 9.87 percent from baseline. CMDP demonstrated statistically significant and substantively large improvements in performance for this PIP.

CMDP submitted the following qualitative analysis:

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

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

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

Strengths

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

Opportunities for Improvement and Recommendations

HSAG recommends that CMDP continue to monitor the outcomes associated with the reported interventions. CMDP 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

For Remeasurement 1, CMDP's *E-Prescribing* PIP rate for Indicator 1 of 55.31 percent and rate for Indicator 2 of 56.56 percent demonstrated improvement over the respective baseline rates. Both rates increased by statistically and substantively significant amounts. CMDP may want to monitor the

progress of the PIP interventions employed to increase provider prescribing electronically and prescriptions sent electronically and to adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.

Comparative Results for Acute Care and CMDP Contractors

Findings

Figure 8-1 presents seven Acute Care and CMDP Contractors' comparison rates for the *E-Prescribing* PIP Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically. The figure presents baseline and Remeasurement 1 rates for each Acute Care and CMDP 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 Acute Care and CMDP Contractors

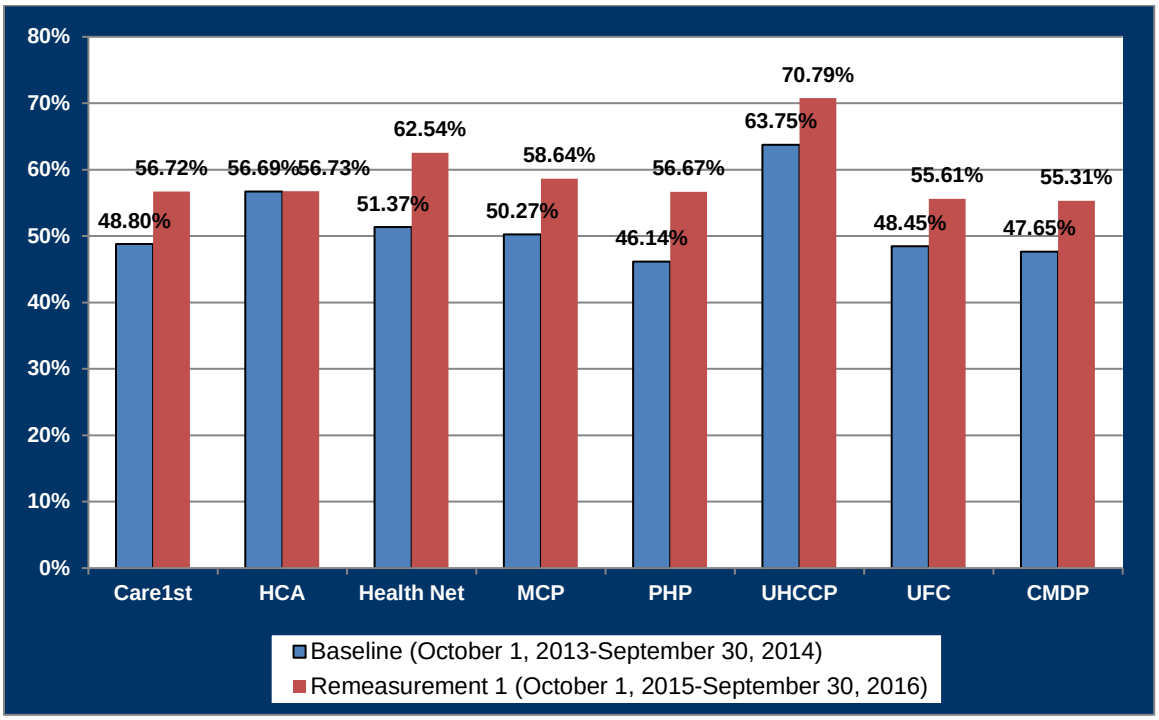


Figure 8-1 shows that each Contractor tasked with the PIP (with the exception of HCA) exceeded the respective baseline rate by a statistically significant amount at the first remeasurement. HCA's rate for Indicator 1 improved, but not by a statistically significant amount with a relative percentage change from baseline of less than 0.05 percent. UHCCP had the highest percentage of providers who prescribed at least one prescription electronically. Although not presenting the highest rate for Indicator 1, Health Net showed the greatest relative percentage change from baseline, with an 11.17 percent increase. These

findings indicate that seven of eight Contractors need only sustain their gains for a single additional remeasurement cycle.

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

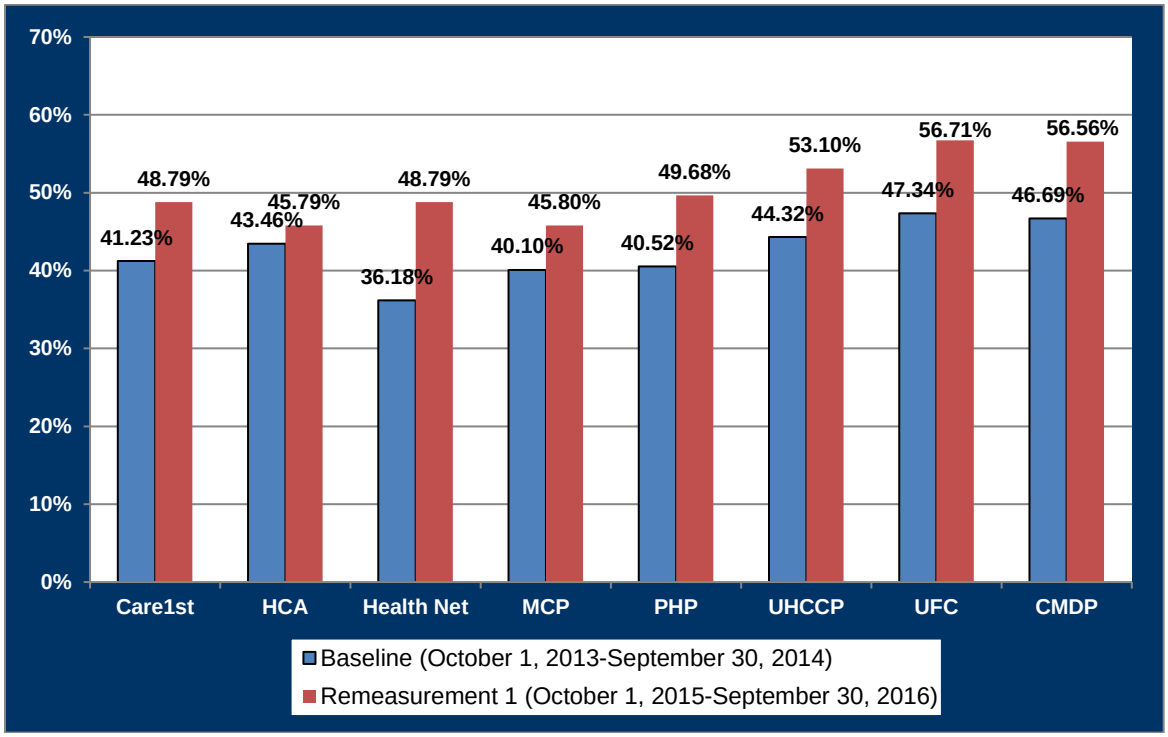


Figure 8-2 shows that each Contractor tasked with the PIP exceeded the respective baseline rate by a statistically significant amount at the first remeasurement. Although CMDP had the highest percentage of prescriptions sent electronically, Health Net again had the highest percentage of change from baseline, with 12.61 percent. 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 Acute and CMDP Contractors' *E-Prescribing* PIP. All Contractors participated in the completion of two surveys as part of the e-prescribing workgroup formed with other Arizona Contractors. The surveys asked providers to identify contributing factors to e-prescribing rates, to identify best practices or barriers, and requested that Arizona EHR vendors determine their system capabilities for e-prescribing controlled substances. In addition, all Contractors provided education to providers, with several Contractors including members in their education interventions. Several Contractors targeted high-volume prescribers and provided incentives to encourage e-prescribing. One Contractor notified providers quarterly about rates, while others conducted on-site visits to encourage e-prescribing. Although HCA improved the rate for Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription

electronically) the improvement did not show a statistical significance. Overall, however, all Contractors improved rates during the Remeasurement 1 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 quality improvement (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 PDSA cycles should help to remove barriers to successfully achieving improvement in the PIP indicator rates Finally, the Contractors should continue to identify and prioritize barriers, to develop robust interventions for the *E-Prescribing* PIP.
- 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 and consider including in the workgroup additional stakeholders who may help with improvement of the PIP indicators' 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.
- 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

HCA was the only Contractor without statistically significant improvement for Indicator 1 in the first remeasurement period. All other Acute and CMDP 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.

9. Consumer Assessment of Healthcare Providers and Systems Results

CAHPS—Adult and Child Survey

During 2016–2017, as an optional EQR activity, AHCCCS elected to conduct member satisfaction surveys of adult and child Medicaid members enrolled in the AHCCCS Acute Care Medicaid managed care program (i.e., Acute Care program). AHCCCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Surveys.

This section of the EQR technical report presents Contractor-specific adult and child Medicaid CAHPS survey results for each participating Acute Care Contractor and the CMDP Contractor as well as statewide aggregate adult and child CAHPS survey results for the Acute Care program.[9-1]

Methodology for Conducting CAHPS Surveys

Overview

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with healthcare. These surveys cover topics important to consumers, such as communication skills of providers and accessibility of services. The CAHPS survey is recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both standardized administration of survey instruments and comparability of the resulting data.

Objectives

As part of its objectives to measure, report, compare, and continually improve Contractor performance, AHCCCS elected to conduct CAHPS surveys of adult and child Medicaid members served by the Acute Care and CMDP Contractors. The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on adult Medicaid members' and parents' or caretakers' (of Acute Care and CMDP child members) levels of satisfaction with their healthcare experiences.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of, to adult members, the *CAHPS 5.0 Adult Medicaid Health Plan Survey* with the HEDIS supplemental item set and administration of, to child members, the *CAHPS 5.0 Child Medicaid Health Plan Survey* with the HEDIS supplemental item set and the Children with Chronic Conditions (CCC) measurement set. Adult members eligible for the

[9-1] CMDP contracts with AHCCCS to provide services to the child Medicaid population only. As such, CMDP was included in the CAHPS Child Medicaid Health Plan Survey administration only (i.e., adult Medicaid CAHPS results are not available for CMDP).

survey were 18 years of age or older as of December 31, 2016; and child members eligible for the survey had to be 17 years or younger as of December 31, 2016.[9-2]

A mixed-mode methodology for data collection (i.e., mailed surveys, followed by telephone interviews with members who did not respond to the mailed surveys) was used. Adult members and parents/caretakers of child members completed the surveys from December 2016 to March 2017. The CAHPS surveys were administered in English and Spanish. Members identified, through administrative data, as Spanish-speaking were mailed a Spanish version of the survey. The cover letter provided with the Spanish version of the CAHPS questionnaire included a text box with a toll-free number that members could call to request a survey in another language (i.e., English). Members not identified as Spanish-speaking received an English version of the survey. The cover letter included with the English version of the survey contained on the reverse side a Spanish cover letter informing members that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire.

The *CAHPS 5.0 Adult Medicaid Health Plan Survey* with the HEDIS supplemental item set includes a set of 58 core questions that cover 11 measures of satisfaction. The *CAHPS 5.0 Child Medicaid Health Plan Survey* with HEDIS supplemental and CCC measurement sets includes 83 core questions that cover 16 measures of satisfaction. These measures include four global ratings, five composite measures, two individual item measures, and five CCC composite measures/items (included in the child Medicaid CAHPS survey only). The global ratings reflect overall satisfaction with the health plan, healthcare, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Getting Needed Care* and *Getting Care Quickly*). The individual item measures are individual questions that look at a specific area of care (i.e., *Coordination of Care* and *Health Promotion and Education*).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response).

For each composite score, the percentage of respondents who chose a positive response was calculated. CAHPS composite measure response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A positive, or top-box, response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

For each individual item, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A positive or top-box response for the individual items was defined as a response of "Usually/Always" or "Yes." The percentage is referred to as a question summary rate (or top-box response).

[9-2] For purposes of the 2017 CAHPS surveys, the age criteria for CMDP child members eligible for inclusion in the CAHPS Child Medicaid Health Plan Survey was modified to include members up to 21 years of age or younger as of December 31, 2016. Please note, this deviates from standard NCQA HEDIS specifications, which define eligible child members as 17 years of age or younger as of December 31 of the measurement year.

Additionally, to assess the overall performance of the Acute Care and CMDP Contractors' adult and child Medicaid populations members, each CAHPS global rating (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*), four of the CAHPS composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*), and one individual item measure (*Coordination of Care*) were scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[9-3] The resulting three-point mean scores were compared to NCQA's *2017 HEDIS Benchmarks and Thresholds for Accreditation*.[9-4] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, for which one is the lowest possible rating and five is the highest possible rating using the following percentile distributions:[9-5]

★★★★★	Indicates a score at or above the 90th percentile.
★★★★	Indicates a score at or between the 75th and 89th percentiles.
★★★	Indicates a score at or between the 50th and 74th percentiles.
★★	Indicates a score at or between the 25th and 49th percentiles.
★	Indicates a score below the 25th percentile.

For purposes of this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Additionally, for purposes of this report, the Acute Care and CMDP Contractor-specific survey findings for the adult and general child Medicaid populations were compared to 2016 NCQA CAHPS Adult and Child Medicaid national averages, respectively. For the Contractor-specific results, a statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted with colors. A cell is highlighted in yellow if the lower bound of the confidence interval was higher than the national average. However, if the upper bound of the confidence interval was lower than the national average, the cell is highlighted in red.

Description of Data Obtained

HSAG calculated Contractor-specific adult and child Medicaid CAHPS survey results for the Acute Care Contractors and child Medicaid CAHPS survey results for the CMDP Contractor. The following sections describe HSAG's findings, conclusions, and recommendations for each Acute Care Contractor as well as presenting statewide comparative results across the Acute Care Contractors.

[9-3] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2016.

[9-4] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA, May 4, 2017.

[9-5] NCQA does not provide benchmarks and thresholds for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, overall member satisfaction ratings could not be determined for these CAHPS measures.

Contractor-Specific Results

Care1st Health Plan Arizona, Inc. (Care1st)

Findings

Table 9-1 presents the 2016 CAHPS survey results for Care1st's adult and general child Medicaid populations. The table displays the following information: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings) for each CAHPS survey measure.[9-6]

Table 9-1—Adult and General Child CAHPS Results for Care1st

	Adult Results		General Child Results	
CAHPS Measure	**2016 Top-Box Rate**	**Star Rating and Three-Point Mean**	**2016 Top-Box Rate**	**Star Rating and Three-Point Mean**
Global Ratings				
Rating of Health Plan	55.3%	★★ 2.40	71.6%	★★★★ 2.64
Rating of All Health Care	48.7%	★★ 2.34	68.1%	★★★★★ 2.59
Rating of Personal Doctor	62.6%	★★★ 2.52	72.6%	★★★★ 2.66
Rating of Specialist Seen Most Often	63.0%	★★★ 2.52	78.0%+	★★★★★+ 2.72
Composite Measures				
Getting Needed Care	78.2%	★ 2.26	86.2%	★★★★ 2.51
Getting Care Quickly	81.6%	★★★ 2.42	88.5%	★★ 2.59
How Well Doctors Communicate	89.9%	★★★★ 2.58	92.3%	★★ 2.67
Customer Service	92.9%	★★★★ 2.60	92.0%	★★★★★ 2.63
Shared Decision Making	82.0%+	NA	72.8%+	NA
Individual Item Measures				
Coordination of Care	80.9%+	★+ 2.32	68.8%+	★+ 2.20

[9-6] NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Health Promotion and Education	72.2%	NA	68.2%	NA

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average.
Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average.
NA indicates that results are not available for the CAHPS measure.
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If fewer than 100 responded for a CAHPS measure, caution should be exercised when interpreting the results.

Adult Medicaid

Comparison of Care1st's adult Medicaid CAHPS scores to the 2016 NCQA national adult Medicaid averages revealed that the Contractor scored:

- Statistically significantly higher than the 2016 NCQA national adult Medicaid average on one measure, *Customer Service*.

Child Medicaid

Comparison of Care1st's child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid averages revealed that the Contractor scored:

- Statistically significantly higher than the 2016 NCQA national child Medicaid average on one measure, *Customer Service*.
- Statistically significantly lower than the 2016 NCQA national child Medicaid average on one measure, *Coordination of Care*.

Health Choice Arizona (HCA)

Findings

Table 9-2 presents the 2016 CAHPS survey results for HCA's adult and general child Medicaid populations. The table displays the following information: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings) for each CAHPS survey measure.[9-7]

Table 9-2—Adult and General Child CAHPS Results for HCA

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	53.1%	★ 2.33	67.7%	★★★ 2.60
Rating of All Health Care	49.8%	★ 2.31	71.4%	★★★★★ 2.63
Rating of Personal Doctor	59.1%	★★ 2.43	75.7%	★★★★★ 2.70
Rating of Specialist Seen Most Often	61.1%	★★ 2.48	54.7%+	★+ 2.42
Composite Measures				
Getting Needed Care	78.2%	★ 2.25	81.7%	★ 2.30
Getting Care Quickly	77.4%	★ 2.32	88.4%	★★ 2.58
How Well Doctors Communicate	88.2%	★★ 2.52	93.7%	★★★★ 2.74
Customer Service	90.6%	★★ 2.53	84.8%+	★+ 2.48
Shared Decision Making	79.2%	NA	78.3%+	NA
Individual Item Measures				
Coordination of Care	71.5%	★ 2.22	80.3%+	★★+ 2.36

9-7 NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Health Promotion and Education	73.4%	NA	66.4%	NA

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average.
Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average.
NA indicates that results are not available for the CAHPS measure.
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If fewer than 100 responded for a CAHPS measure, caution should be exercised when interpreting the results.

Adult Medicaid

Comparison of HCA's adult Medicaid CAHPS scores to the 2016 NCQA national adult Medicaid averages revealed that the Contractor scored:

- Statistically significantly lower than the 2016 NCQA national adult Medicaid averages on two measures: *Rating of Personal Doctor* and *Coordination of Care*.

Child Medicaid

Comparison of HCA's child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid averages revealed that the Contractor scored:

- Statistically significantly lower than the 2016 NCQA national child Medicaid average on one measure, *Rating of Specialist Seen Most Often*.

Health Net Access (Health Net)

Findings

Table 9-3 presents the 2016 CAHPS survey results for Health Net's adult and general child Medicaid populations. The table displays the following information: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings) for each CAHPS survey measure.[9-8]

Table 9-3—Adult and General Child CAHPS Results for Health Net

	Adult Results		General Child Results	
CAHPS Measure	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	54.1%	★★ 2.36	65.8%	★★★ 2.60
Rating of All Health Care	54.4%	★★★ 2.38	71.1%	★★★★★ 2.64
Rating of Personal Doctor	61.3%	★★ 2.45	74.2%	★★★★★ 2.69
Rating of Specialist Seen Most Often	65.0%	★★★ 2.52	61.5%+	★★+ 2.54
Composite Measures				
Getting Needed Care	84.3%	★★ 2.33	80.7%	★★ 2.41
Getting Care Quickly	81.4%	★★ 2.36	86.6%	★★ 2.60
How Well Doctors Communicate	90.2%	★★★★ 2.58	93.6%	★★★ 2.70
Customer Service	87.7%	★★★ 2.54	89.1%+	★★★★+ 2.59
Shared Decision Making	79.4%+	NA	73.3%+	NA
Individual Item Measures				
Coordination of Care	74.8%	★ 2.14	80.7%+	★+ 2.33

[9-8] NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Health Promotion and Education	67.6%	NA	69.7%	NA

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average.
Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average.
NA indicates that results are not available for the CAHPS measure.
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If fewer than 100 responded for a CAHPS measure, caution should be exercised when interpreting the results.

Adult Medicaid

Comparison of Health Net's adult Medicaid CAHPS scores to the 2016 NCQA national adult Medicaid averages revealed that the Contractor did not score statistically significantly higher or lower than the 2016 NCQA national adult Medicaid averages for any measures.

Child Medicaid

Comparison of Health Nets' child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid averages revealed that the Contractor did not score statistically significantly higher or lower than the 2016 NCQA national child Medicaid averages for any measures.

Maricopa Health Plan (MHP)

Findings

Table 9-4 presents the 2016 CAHPS survey results for MHP's adult and general child Medicaid populations. The table displays the following information: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings) for each CAHPS survey measure.[9-9]

Table 9-4—Adult and General Child CAHPS Results for MHP

	Adult Results		General Child Results	
CAHPS Measure	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	60.3%	★★★★ 2.49	76.0%	★★★★★ 2.70
Rating of All Health Care	65.3%	★★★★★ 2.54	72.2%	★★★★★ 2.68
Rating of Personal Doctor	64.4%	★★★ 2.52	74.9%	★★★★★ 2.69
Rating of Specialist Seen Most Often	61.9%+	★★+ 2.50	64.1%+	★★+ 2.56
Composite Measures				
Getting Needed Care	83.4%	★★★ 2.38	77.7%+	★+ 2.26
Getting Care Quickly	86.7%	★★★ 2.44	85.1%	★★ 2.55
How Well Doctors Communicate	91.4%	★★★★ 2.61	91.0%	★★ 2.64
Customer Service	90.1%+	★★★+ 2.57	84.2%+	★+ 2.47
Shared Decision Making	72.8%+	NA	83.9%+	NA
Individual Item Measures				
Coordination of Care	80.0%+	★★+ 2.36	83.0%+	★★★+ 2.42

[9-9] NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Health Promotion and Education	69.8%	NA	72.4%	NA

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average.
Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average.
NA indicates that results are not available for the CAHPS measure.
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If fewer than 100 responded for a CAHPS measure, caution should be exercised when interpreting the results.

Adult Medicaid

Comparison of MHP's adult Medicaid CAHPS scores to the 2016 NCQA national adult Medicaid averages revealed that the Contractor scored:

- Statistically significantly higher than the 2016 NCQA national adult Medicaid averages on two measures: *Rating of All Health Care* and *Getting Care Quickly*.

Child Medicaid

Comparison of MHP's child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid averages revealed that the Contractor scored:

- Statistically significantly higher than the 2016 NCQA national child Medicaid average on one measure, *Rating of Health Plan*.

Mercy Care Plan (MCP)

Findings

Table 9-5 presents the 2016 CAHPS survey results for MCP's adult and general child Medicaid populations. The table displays the following information: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings) for each CAHPS survey measure.[9-10]

Table 9-5—Adult and General Child CAHPS Results for MCP

	Adult Results		General Child Results	
CAHPS Measure	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	64.8%	★★★★★ 2.56	76.4%	★★★★★ 2.71
Rating of All Health Care	56.5%	★★★★★ 2.46	76.3%	★★★★★ 2.69
Rating of Personal Doctor	67.7%	★★★★★ 2.58	78.8%	★★★★★ 2.74
Rating of Specialist Seen Most Often	65.9%	★★★ 2.54	64.9%+	★★+ 2.54
Composite Measures				
Getting Needed Care	83.3%	★★★★ 2.42	83.6%	★★ 2.43
Getting Care Quickly	84.2%	★★★★ 2.45	88.0%	★★ 2.59
How Well Doctors Communicate	89.5%	★★★★ 2.61	94.1%	★★★ 2.71
Customer Service	85.5%+	★★+ 2.50	85.8%	★★ 2.51
Shared Decision Making	83.8%	NA	79.8%+	NA
Individual Item Measures				
Coordination of Care	77.8%	★ 2.22	73.8%+	★+ 2.21

[9-10] NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Health Promotion and Education	69.0%	NA	70.2%	NA

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average.
Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average.
NA indicates that results are not available for the CAHPS measure.
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If fewer than 100 responded for a CAHPS measure, caution should be exercised when interpreting the results.

Adult Medicaid

Comparison of MCP's adult Medicaid CAHPS scores to the 2016 NCQA national adult Medicaid averages revealed that the Contractor scored:

- Statistically significantly higher than the 2016 NCQA national adult Medicaid averages on three measures: *Rating of Health Plan*, *Getting Care Quickly*, and *Shared Decision Making*.

Child Medicaid

Comparison of MCP's child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid averages revealed that the Contractor scored:

- Statistically significantly higher than the 2016 NCQA national child Medicaid averages on two measures: *Rating of Health Plan* and *Rating of All Health Care*.

Phoenix Health Plan, LLC (PHP)

Findings

Table 9-6 presents the 2016 CAHPS survey results for PHP's adult and general child Medicaid populations. The table displays the following information: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings) for each CAHPS survey measure.[9-11]

Table 9-6—Adult and General Child CAHPS Results for PHP

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	59.2%	★★★★ 2.48	77.9%	★★★★★ 2.71
Rating of All Health Care	52.2%	★★★ 2.41	76.9%	★★★★★ 2.72
Rating of Personal Doctor	65.7%	★★★★ 2.54	74.3%	★★★★★ 2.71
Rating of Specialist Seen Most Often	57.3%	★ 2.42	64.9%+	★★+ 2.55
Composite Measures				
Getting Needed Care	82.1%	★★ 2.32	81.0%	★ 2.31
Getting Care Quickly	83.5%	★★★ 2.44	84.8%	★ 2.48
How Well Doctors Communicate	87.5%	★★★ 2.55	91.4%	★★ 2.64
Customer Service	89.2%	★★ 2.50	91.1%	★★★★★ 2.64
Shared Decision Making	74.9%	NA	80.8%+	NA
Individual Item Measures				
Coordination of Care	77.8%	★ 2.28	77.2%+	★+ 2.23

[9-11] NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Health Promotion and Education	74.0%	NA	64.1%	NA

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average.
Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average.
NA indicates that results are not available for the CAHPS measure.
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If fewer than 100 responded for a CAHPS measure, caution should be exercised when interpreting the results.

Adult Medicaid

Comparison of PHP's adult Medicaid CAHPS scores to the 2016 NCQA national adult Medicaid averages revealed that the Contractor scored:

- Statistically significantly lower than the 2016 NCQA national adult Medicaid average on one measure, *Rating of Specialist Seen Most Often*.

Child Medicaid

Comparison of PHP's child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid averages revealed that the Contractor scored:

- Statistically significantly higher than the 2016 NCQA national child Medicaid averages on two measures: *Rating of Health Plan* and *Rating of All Health Care*.
- Statistically significantly lower than the 2016 NCQA national child Medicaid average on one measure, *Health Promotion and Education*.

UnitedHealthcare Community Plan-Acute (UHCCP-Acute)

Findings

Table 9-7 presents the 2016 CAHPS survey results for UHCCP-Acute's adult and general child Medicaid populations. The table displays the following information: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings) for each CAHPS survey measure.[9-12]

Table 9-7—Adult and General Child CAHPS Results for UHCCP-Acute

	Adult Results		General Child Results	
CAHPS Measure	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	65.9%	★★★★★ 2.54	74.5%	★★★★★ 2.68
Rating of All Health Care	62.5%	★★★★★ 2.53	75.1%	★★★★★ 2.70
Rating of Personal Doctor	65.7%	★★★★ 2.54	78.5%	★★★★★ 2.72
Rating of Specialist Seen Most Often	73.5%	★★★★★ 2.64	67.2%+	★★★+ 2.60
Composite Measures				
Getting Needed Care	86.7%	★★★★ 2.44	90.7%	★★★★★ 2.56
Getting Care Quickly	79.5%	★★ 2.38	88.2%	★★★ 2.61
How Well Doctors Communicate	89.8%	★★★★ 2.60	93.9%	★★★★ 2.74
Customer Service	88.7%	★★★ 2.56	88.9%+	★★★+ 2.57
Shared Decision Making	78.9%	NA	74.1%+	NA
Individual Item Measures				
Coordination of Care	77.1%	★ 2.26	87.1%+	★★★★★+ 2.52

[9-12] NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Health Promotion and Education	75.9%	NA	72.9%	NA

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average.
Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average.
NA indicates that results are not available for the CAHPS measure.
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If fewer than 100 responded for a CAHPS measure, caution should be exercised when interpreting the results.

Adult Medicaid

Comparison of UHCCP-Acute's adult Medicaid CAHPS scores to the 2016 NCQA national adult Medicaid averages revealed that the Contractor scored:

- Statistically significantly higher than the 2016 NCQA national adult Medicaid averages on four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Getting Needed Care*.

Child Medicaid

Comparison of UHCCP-Acute's child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid averages revealed that the Contractor scored:

- Statistically significantly higher than the 2016 NCQA national child Medicaid averages on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Needed Care*.

University Family Care (UFC)

Findings

Table 9-8 presents the 2016 CAHPS survey results for UFC's adult and general child Medicaid populations. The table displays the following information: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings) for each CAHPS survey measure.[9-13]

Table 9-8—Adult and General Child CAHPS Results for UFC

	Adult Results		General Child Results	
CAHPS Measure	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	61.9%	★★★★ 2.48	69.6%	★★★ 2.61
Rating of All Health Care	61.0%	★★★★★ 2.51	67.4%	★★★★★ 2.62
Rating of Personal Doctor	71.5%	★★★★★ 2.63	75.9%	★★★★★ 2.70
Rating of Specialist Seen Most Often	69.6%	★★★★★ 2.62	74.0%+	★★★★+ 2.62
Composite Measures				
Getting Needed Care	85.3%	★★★★★ 2.45	87.0%	★★ 2.43
Getting Care Quickly	84.3%	★★★★ 2.46	89.2%	★★ 2.56
How Well Doctors Communicate	92.7%	★★★★★ 2.65	93.7%	★★★ 2.71
Customer Service	89.4%	★★★★ 2.59	90.5%+	★★★★+ 2.61
Shared Decision Making	75.5%	NA	80.9%+	NA
Individual Item Measures				
Coordination of Care	79.6%	★★★ 2.41	81.4%+	★+ 2.33

[9-13] NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Health Promotion and Education	77.0%	NA	75.3%	NA

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average.
Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average.
NA indicates that results are not available for the CAHPS measure.
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If fewer than 100 responded for a CAHPS measure, caution should be exercised when interpreting the results.

Adult Medicaid

Comparison of UFC's adult Medicaid CAHPS scores to the 2016 NCQA national adult Medicaid averages revealed that the Contractor scored:

- Statistically significantly higher than the 2016 NCQA national adult Medicaid averages on four measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Getting Care Quickly*.

Child Medicaid

Comparison of UFC's child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid averages revealed that the Contractor did not score statistically significantly higher or lower than the 2016 NCQA national child Medicaid averages for any measures.

Comprehensive Medical and Dental Program (CMDP)

Findings

Table 9-9 presents the 2016 CAHPS survey results for CMDP's general child Medicaid population.[9-14] The table displays the following information: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings) for each CAHPS survey measure.[9-15]

Table 9-9—General Child CAHPS Results for CMDP

CAHPS Measure	General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean
Global Ratings		
Rating of Health Plan	55.1%	★ 2.38
Rating of All Health Care	68.2%	★★★★★ 2.61
Rating of Personal Doctor	76.4%	★★★★★ 2.72
Rating of Specialist Seen Most Often	62.5%+	★★+ 2.56
Composite Measures		
Getting Needed Care	87.6%	★★★★ 2.52
Getting Care Quickly	91.4%	★★★★ 2.67
How Well Doctors Communicate	96.3%	★★★★★ 2.83
Customer Service	86.2%+	★★★+ 2.53
Shared Decision Making	78.4%+	NA

[9-14] As previously noted, CMDP contracts with AHCCCS to provide services to the child Medicaid population only. As such, CMDP was included in the *CAHPS 5.0 Child Medicaid Health Plan Survey* administration only (i.e., adult Medicaid CAHPS results are not available for CMDP).

[9-15] NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

CAHPS Measure	General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean
Individual Item Measures		
Coordination of Care	82.7%+	★★+ 2.38
Health Promotion and Education	77.1%	NA

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average.
Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average.
NA indicates that results are not available for the CAHPS measure.
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If fewer than 100 responded for a CAHPS measure, caution should be exercised when interpreting the results.

Child Medicaid

Comparison of CMDP's child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid averages revealed that the Contractor scored:

- Statistically significantly higher than the 2016 NCQA national child Medicaid average on one measure, *How Well Doctors Communicate*.
- Statistically significantly lower than the 2016 NCQA national child Medicaid average on one measure, *Rating of Health Plan*.

Comparative Results for Acute Care and CMDP Contractors

HSAG calculated and reported the Acute Care and CMDP Contractors' 2016 CAHPS survey results for the adult and child Medicaid populations, as applicable.[9-16]

Findings

Table 9-10 presents the 2016 adult and child Medicaid CAHPS survey results for all Acute Care Contractors and CMDP for members enrolled in the Medicaid program (i.e., Acute Care program in aggregate).[9-17] The table displays the following information: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings) for each CAHPS survey measure.[9-18]

Table 9-10—Adult and Child Medicaid CAHPS Results for Acute Care and CMDP Contractors

	Adult Results		General Child Results	
CAHPS Measure	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	61.2%	★★★ 2.46	73.1%	★★★★ 2.64
Rating of All Health Care	57.3%	★★★★ 2.44	73.4%	★★★★★ 2.65
Rating of Personal Doctor	65.1%	★★★★ 2.53	76.9%	★★★★★ 2.70
Rating of Specialist Seen Most Often	67.0%	★★★ 2.54	65.4%	★★ 2.57
Composite Measures				
Getting Needed Care	83.3%	★★★ 2.36	85.2%	★★ 2.41
Getting Care Quickly	81.5%	★★★ 2.41	87.9%	★★ 2.58

[9-16] As previously noted, CMDP contracts with AHCCCS to provide services to the child Medicaid population only. As such, CMDP was included in the *CAHPS 5.0 Child Medicaid Health Plan Survey* administration only (i.e., adult Medicaid CAHPS results are not available for CMDP).

[9-17] The adult Medicaid CAHPS results are based on the combined results of the eight Acute Care Contractors serving the adult Medicaid population—which include Care1st Health Plan of Arizona, Inc.; Health Choice Arizona; Health Net Access; Maricopa Health Plan; Mercy Care Plan; Phoenix Health Plan; UnitedHealthcare Community Plan-Acute; and University Family Care. The general child Medicaid CAHPS survey results are based on the combined results of the eight Acute Care Contractors and CMDP.

[9-18] NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, three-point mean scores are not presented, and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

CAHPS Measure	Adult Results		General Child Results	
	2016 Top-Box Rate	Star Rating and Three-Point Mean	2016 Top-Box Rate	Star Rating and Three-Point Mean
How Well Doctors Communicate	89.8%	★★★★ 2.59	93.5%	★★★ 2.71
Customer Service	88.7%	★★★ 2.55	87.6%	★★★ 2.57
Shared Decision Making	79.5%	NA	77.6%	NA
Individual Item Measures				
Coordination of Care	77.0%	★ 2.27	79.7%	★ 2.33
Health Promotion and Education	72.9%	NA	70.5%	NA

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average.
Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average.
NA indicates that results are not available for the CAHPS measure.
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If fewer than 100 respond for a CAHPS measure, caution should be exercised when interpreting the results

Adult Medicaid

Comparison of the Acute Care program's aggregate adult Medicaid CAHPS scores to the 2016 NCQA national adult Medicaid averages revealed that the Contractors scored:

- Statistically significantly higher than the 2016 NCQA national adult Medicaid averages on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Needed Care*.
- Statistically significantly lower than the 2016 NCQA national adult Medicaid average on one measure, *Coordination of Care*.

Child Medicaid

Comparison of the Acute Care program's aggregate child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid averages revealed that the Contractors scored:

- Statistically significantly higher than the 2016 NCQA national child Medicaid averages on two measures: *Rating of Health Plan* and *Rating of All Health Care*.
- Statistically significantly lower than the 2016 NCQA national child Medicaid average on one measure, *Rating of Specialist Seen Most Often*.

Recommendations

HSAG identified general recommendations that may be considered to improve Contractor performance and which are based on the most up-to-date information in CAHPS literature. Each Contractor should evaluate these general recommendations in the context of their operational and quality improvement activities.[9-19]

Perform Root Cause Analyses

The Contractors could conduct root cause analyses of study indicators identified as areas of low performance. This type of analysis is typically conducted to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies. If used to study deficiencies in care or services provided to members, root cause analyses would enable the Contractors to better understand the nature and scope of problems, identify causes and their interrelationships, identify specific populations for targeted interventions, and establish potential performance improvement strategies and solutions. Methods commonly used to conduct root cause analyses include process flow mapping, used to define and analyze processes and to identify opportunities for process improvement; and the four-stage Plan-Do-Study-Act (PDSA) problem-solving model, used for continuous process improvement.[9-20]

Conduct Frequent Assessments of Targeted Interventions

Continuous quality improvement (CQI) is a cyclical, data-driven process, similar to the PDSA problem-solving model and in which small-scale, incremental changes are identified, implemented, and measured to improve a process or system. Changes that demonstrate improvement can then be standardized and implemented on a broader scale. To support continuous, cyclical improvement, the Contractors should frequently measure and monitor targeted interventions. Key data should be collected and reviewed regularly to provide timely, ongoing feedback regarding the effectiveness of interventions in achieving desired results. A variety of methods may be used for CQI data collection and analysis, including surveys, interviews, focus groups, "round table" sessions, document reviews, and benchmarking.

Use Health Information Technology

Contractors that use health information technology to its fullest have stronger patient-tracking capabilities and coordinated care. Health information technology would allow Contractors access to real-time data (e.g., the outcomes of face-to-face visits with patients) and can better facilitate documentation, communication, decision support, and automated reminders, thus ensuring that patients

[9-19] AHRQ Web site. *CAHPS Improvement Guide.* Available at: https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html. Accessed on: February 7, 2018.
[9-20] Plan-Do-Study-Act (PDSA) Worksheet. *Institute for Healthcare Improvement.* Available at: http://www.ihi.org/knowledge/Pages/Tools/PlanDoStudyActWorksheet.aspx. Accessed on: February 7, 2018.

are receiving the care that they need. Furthermore, using health information technology may help to increase the number of patients who receive copies of their care plans.

Share Data

Interoperable health information technology and electronic medical record systems are key to successful Contractors. Pediatricians and hospitals operating within each organization should have effective communication processes in place to ensure that information is shared timely. Systems should be designed to enable effective and efficient coordination of care as well as reporting on various aspects of quality improvement.

Contractors could enable providers to share data about each patient electronically and to store data in a central data warehouse so that all entities can easily access information. Contractors could organize patients' health and utilization information into summary reports that track patients' interventions and outstanding needs. Contractors should: pursue joint activities that facilitate coordinated, effective care (such as an urgent care option in the emergency department); and combine medical and behavioral health services in primary care clinics.

Facilitate Coordinated Care

Contractors should assist in facilitating the process of coordinated care among providers and care coordinators to ensure that patients are receiving the care and services most appropriate for their healthcare needs. Coordinated care is most effective when care coordinators and providers organize efforts to deliver similar messages to patients. Patients are more likely to play an active role in the management of their healthcare and to benefit from care coordination efforts if they are receiving the same information from both care coordinator and providers. Improving the system-level coordination among providers and care coordinators will enhance the service and care received by patients. Additionally, providing patient registries or clinical information systems that allow providers and care coordinators to enter information on patients (e.g., notes from a telephone call or a physician visit) can help to reduce duplication of services and facilitate care coordination.