Arizona Health Care Cost Containment System

**AHCCCS**
Arizona Health Care Cost Containment System

# Contract Year Ending 2018
# External Quality Review Annual Report

*for*

# Acute Care and Comprehensive
# Medical and Dental Program

*July 2019*

**HSAG** HEALTH SERVICES ADVISORY GROUP

# Contents

## Overview of the Contract Year Ending (CYE) 2018 External Review

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 draws conclusions about the quality of, timeliness of, and access to healthcare services that MCOs 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 (PMs) 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.

In addition, during CYE 2018, as an optional EQR activity, the Arizona Health Care Cost Containment System (AHCCCS) elected to conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] member satisfaction surveys of KidsCare members enrolled in the AHCCCS Acute Care program. In January 2014, about 2,600 children remained enrolled in the KidsCare program; however, an enrollment freeze that started January 1, 2010, remained in effect, and the number of enrolled children declined. Applications for KidsCare resumed July 26, 2016, for coverage that began September 1, 2016. Due to the increasing number of participating members, AHCCCS was able to resume efforts to measure performance through formal processes including performance measure calculations and CAHPS surveys.

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. AHCCCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Surveys. Results of this survey will be included within the CYE 2019 EQR report.

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[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.

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

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

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

HSAG is an EQRO that meets the competence and independence requirements set forth in 42 CFR §438.354. HSAG has extensive experience and expertise in both conducting the mandatory activities 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 the manner in which the data from all activities conducted were aggregated and analyzed.
- For each external quality review (EQR)-related activity conducted:
  – Objectives.
  – Technical method of data collection and analysis.
  – Description of the data obtained.
  – Conclusions drawn from the data.
- An assessment of each Contractor's strengths and weaknesses.
- Recommendations for improving the quality of care furnished by each Contractor including how the State can target goals and objectives in the quality strategy, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid members.

- Methodologically appropriate comparative information about all Contractors (described in §438.310[c][2]), consistent with guidance included in the EQR protocols.
- An assessment of the degree to which each Contractor 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 15 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 introduction to the annual technical report, including a description of the EQR mandatory activities.
- Section 3—An overview of AHCCCS' background including the Medicaid managed care history, AHCCCS' strategic plan with key accomplishments for CYE 2018, and AHCCCS' quality strategy.
- 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 2018.
- Section 5—An overview of the Contractors' best and emerging practices for CYE 2018.
- Section 6 (Organizational Assessment and Structure Performance)—A presentation of the CYE 2018 Contractor-specific operational review (OR) results, including HSAG's associated findings and recommendations for one Contractor and CAP updates for five Contractors (CMDP's information for the CAP updates was not available at the time of this report and is therefore not included).
- Section 7 (Performance Measure Results)—A presentation of results for AHCCCS-selected performance measures for each Acute Care Contractor, Comprehensive Medical and Dental Program (CMDP), and each KidsCare Contractor, as well as HSAG's associated findings and recommendations for CYE 2017.
- Section 8 (Performance Improvement Project Performance)—A presentation of Contractor-specific CYE 2017 PIP rates as well as qualitative analyses and interventions for the Acute Care Contractors and CMDP.

Please see appendices A, B, and C for an overview of the AHCCCS methodology for the OR, PM, and PIP activities, including objectives, descriptions of data obtained, technical methods of data collection and analysis, scoring methodology, and corrective action statements.

## Contractors Reviewed

During the CYE 2016 review cycle, AHCCCS contracted with the Acute Care Contractors[1-3] listed below 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 (HNA)
- Mercy Care Plan (MCP)
- University Family Care (UFC)
- UnitedHealthcare Community Plan-Acute (UHCCP-Acute)
- Arizona Department of Child Safety/Comprehensive Medical and Dental Program (CMDP)

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

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

## Organizational Assessment and Structure Standards

AHCCCS conducted a comprehensive OR for one Contractor (UFC) during CYE 2018. AHCCCS conducted comprehensive ORs for three Contractors (MCP, CMDP, and Phoenix Health Plan) in CYE 2016 and for four Contractors (UHCCP-Acute, HNA, HCA, and Care1st) in CYE 2017. Between CYE 2017 and CYE 2018, AHCCCS monitored the progress of all Contractors in implementing their CAPs for the recommendations from the CYE 2016 OR review cycle. The CAP updates included in this report are for the five Contractors whose CAPs were issued in CYE 2016 and CYE 2017 and were open as of the CYE 2017 Annual Report. (As of this CYE 2018 Annual Report, AHCCCS continues to review documentation related to open CAPs for CMDP as well as UFC, and HNA; therefore, a formal response will occur outside of the review cycle.)

The CYE 2016 review cycle (which includes CYE 2016, CYE 2017, and CYE 2018 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.

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[1-3] Note: Title 42 CFR §438.2 defines "managed care organization (MCO)," in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." CMS designates all AHCCCS Contractors as MCOs. Unless citing Title 42 CFR, this report will refer to AHCCCS' MCOs as Contractors.

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 review cycle. 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 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 UFC's scores in the 11 standard areas for the comprehensive OR. Table 1-1 lists the standards; the standard area percentage scores; and the total number, if any, of required corrective actions for each standard.

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

| Standard Area | Standard Area Percentage Score | Required Corrective Actions |
|---|---|---|
| Corporate Compliance (CC) | 100% | 0 |
| Claims and Information Systems (CIS) | 95% | 2 |
| Delivery Systems (DS) | 74% | 5 |
| General Administration (GA) | 100% | 0 |
| Grievance Systems (GS) | 100% | 0 |

| Standard Area | Standard Area Percentage Score | Required Corrective Actions |
|---|---|---|
| Adult, EPSDT*, and Maternal Child Health (MCH) | 74% | 11 |
| Medical Management (MM) | 94% | 3 |
| Member Information (MI) | 96% | 1 |
| Quality Management (QM) | 96% | 5 |
| Reinsurance (RI) | 100% | 0 |
| Third-Party Liability (TPL) | 100% | 0 |

*Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The strongest performances were in the CC, GA, GS, RI, and TPL standards, wherein UFC received 100 percent standard area scores and no CAPs. Although not fully compliant, UFC received standard area scores at or above the 95 percent threshold for the CIS, MI, and QM standards. Standards requiring the fewest CAPs were CC, GA, GS, RI, and TPL with no CAPs required and only a total of six CAPs required for CIS (2), MM (3), and MI (1). Standards with greatest opportunity for improvement based on number of CAPs required were DS, MCH, and QM. For the DS, MCH, and MM standards, UFC scored below the 95 percent threshold.

AHCCCS accepted all CAPs that UFC proposed in UFC's first CAP submission; however, to close the CAPs, UFC must provide follow-up documentation for each CAP.

## Overall Compliance Scores for the CYE 2016 OR Review Cycle

AHCCCS conducted ORs in CYE 2016, 2017, and 2018 for the CYE 2016 review cycle. Following in Table 1-2 are the standard area scores for all Acute Contractors over the CYE 2016 three-year review cycle:

**Table 1-2—Acute Contractors' Standard Area Scores for the CYE 2016 OR Review Cycle**

| Standard Area | Care1st | HCA | HNA | MCP | UFC | UHCCP-Acute | CMDP |
|---|---|---|---|---|---|---|---|
| Corporate Compliance | 72% | 93% | 100% | 93% | 100% | 100% | 62% |
| Claims and Information Systems | 95% | 88% | 90% | 93% | 95% | 99% | 95% |
| Delivery Systems | 100% | 71% | 96% | 98% | 74% | 96% | 77% |
| General Administration | 100% | 100% | 89% | 100% | 100% | 100% | 89% |
| Grievance Systems | 100% | 100% | 96% | 99% | 100% | 100% | 100% |
| Adult, EPSDT, and Maternal Child Health | 100% | 72% | 96% | 100% | 74% | 100% | 91% |
| Medical Management | 99% | 88% | 97% | 91% | 94% | 97% | 95% |

| Standard Area | Care1st | HCA | HNA | MCP | UFC | UHCCP-Acute | CMDP |
|---|---|---|---|---|---|---|---|
| **Member Information** | 100% | 91% | 100% | 100% | 96% | 100% | 95% |
| **Quality Management** | 100% | 95% | 99% | 97% | 96% | 99% | 86% |
| **Reinsurance** | 100% | 100% | 100% | 100% | 100% | 100% | 94% |
| **Third-Party Liability** | 100% | 100% | 86% | 100% | 100% | 100% | 71% |

As indicated in Table 1-2, Care1st received a standard area score of 100 percent for most standards (eight) and received only one standard area score below the 95 percent compliance threshold. For UHCCP-Acute, seven standards received scores of 100 percent and no standards received scores below the 95 percent compliance threshold. CMDP received standard area scores below the 95 percent compliance threshold for most standards (seven) and received 100 percent compliance for only one standard. For HCA, six standards fell below 95 percent.

Table 1-3 details the number of Contractors with standard area scores that met or exceeded the 95 percent compliance threshold, as well as the number that fell below the 95 percent compliance threshold for the ORs conducted in CYE 2016, 2017, and 2018 for the CYE 2016 review cycle.

**Table 1-3—Number of Acute Contractors Meeting Compliance Thresholds**

| Standard Area | Number of Contractors That Received Full Compliance (100%)* | Number of Contractors at or Above the 95% Compliance Threshold | Number of Contractors Below the 95% Compliance Threshold |
|---|---|---|---|
| **Corporate Compliance** | 3 | 3 | 4 |
| **Claims and Information Systems** | 0 | 4 | 3 |
| **Delivery Systems** | 1 | 4 | 3 |
| **General Administration** | 5 | 5 | 2 |
| **Grievance Systems** | 5 | 7 | 0 |
| **Adult, EPSDT, and Maternal Child Health** | 3 | 4 | 3 |
| **Medical Management** | 0 | 4 | 3 |
| **Member Information** | 4 | 6 | 1 |
| **Quality Management** | 1 | 6 | 1 |
| **Reinsurance** | 6 | 6 | 1 |
| **Third-Party Liability** | 5 | 5 | 2 |

*This column is a subgroup of the "Number of Contractors at or Above the 95% Compliance Threshold" column.

Strongest performances were in the GA, GS, MI, RI, and TPL standards, based on the number of Contractors achieving full compliance (100 percent). With the exception of the CC standard, most Contractors (four or more of seven) scored at or above the 95 percent threshold on all standards. For the

GS standard, all Contractors scored at or above the 95 percent compliance threshold. For the MI, QM, and RI standards, only one Contractor scored below the 95 percent compliance threshold.

The lowest performance occurred in five standards (CC, CIS, DS, MCH, MM), as more than two Contractors scored below the 95 percent compliance threshold. The CC standard had the most Contractors (four) that scored below the 95 percent compliance threshold. Notably, for two standards (CIS and MM) no Contractor received full compliance (100 percent).

## Outstanding Corrective Action Plans

Between CYE 2017 and CYE 2018, AHCCCS monitored progress of the remaining Contractors in implementing CAPs from the 2016 OR review cycle. All CAPs that remained open from ORs conducted in CYE 2016 and CYE 2017 were closed, with the exception of CMDP and HNA. All of UFC's CAPs for the OR conducted in CYE 2018 were accepted; AHCCCS has informed UFC about the follow-up documentation that UFC will need to provide in order to close the open CAPs.

## Overall Strengths

Over the three-year review cycle, the majority of the Contractors met or exceeded the 95 percent compliance threshold in all standards except for CC. Based on the highest number of Contractors that received full compliance on the standards reviewed, strongest Contractor performances occurred in the GA, GS, MI, RI, and TPL standards. Additionally, for the MI, QM, and RI standards, only one Contractor scored below the 95 percent compliance threshold. No Contractors received a score below the 95 percent threshold for the GS standard.

## Overall Opportunities for Improvement and Recommendations

Based on results from the CYE 2016 review cycle (including activities conducted in CYE 2016, 2017, and 2018), Contractors had the lowest performance in five standards (CC, CIS, DS, MCH, MM), as more than two Contractors scored below the 95 percent compliance threshold. The standard for which the most Contractors (four) scored below the 95 percent compliance threshold was the CC standard. Notably, for two standards (CIS and MM) no Contractor received a full compliance (100 percent) standard area score.

Based on AHCCCS' review of the Acute Care Contractors' performance during the comprehensive CYE 2016 OR review cycle conducted in CYE 2016, 2017, and 2018 , HSAG recommends the following for Contractors:

- Contractors should continue to conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations.
- Contractors should continue to regularly monitor and ensure that updates are made to contracts with providers and that policy manual updates from AHCCCS are also timely and included in Contractors' policies, procedures, and manuals (if impacted by the changes). Contractors should continue to 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 continue to assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes.

- Contractors should continue to implement control systems to address specific findings in the CIS standard 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. This remains a consistent compliance issue across Contractors.

Based on AHCCCS' review of the Acute Care Contractors' performance during the comprehensive CYE 2016 OR review cycle conducted in CYE 2016, CYE 2017, and CYE 2018 , HSAG recommends the following for AHCCCS:

- AHCCCS should concentrate improvement efforts on the CC, CIS, MCH, and MM standards as these standards were problematic for Contractors during the three-year review cycle. For example, AHCCCS should consider distributing technical assistance (TA) documents to all Contractors and holding in-person meetings with Contractors that 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 advice 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. 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) that 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.

## *Performance Measures*

### Aggregate Results for CYE 2017

AHCCCS collected data and reported Contractor performance for a set of performance measures for the CYE 2017 measurement period. For CYE 2017, AHCCCS selected 12 performance measures (15 measure indicator rates) for the Acute Care Contractors, five performance measures (eight measure

indicator rates) for CMDP, and four performance measures (seven measure indicator rates) for the KidsCare Contractors—all to be reported in the annual report. The following tables display the aggregate performance measure rates with established minimum performance standards (MPS) for the Acute Care Contractors, CMDP, and the KidsCare Contractors. An MPS had not yet been established for all reported performance measure rates. Contractor-specific results for performance measures with an MPS are included in Section 7, with additional performance measures (i.e., without an established MPS) included in Appendix B of this report.

In addition to children and adults enrolled in AHCCCS' Acute Care Medicaid managed care program, children enrolled in KidsCare (Arizona's Children's Health Insurance Program [CHIP]) also receive services through the same managed care Contractors. In January 2014, about 2,600 children remained enrolled in the KidsCare program; however, an enrollment freeze that started January 1, 2010, continued to remain in effect, and the number of enrolled children declined. Applications for KidsCare resumed July 26, 2016, for coverage that began September 1, 2016. Due to the increasing number of participating members, AHCCCS is able to resume its efforts to measure performance through formal processes, including performance measure calculations and CAHPS surveys. This report incorporates performance for Contractors serving KidsCare members. As CYE 2017 was the first time the KidsCare Contractors reported performance measure rates, no historical data were available.

Throughout the report, references to "significant" changes in performance indicate statistically significant differences between performance from CYE 2016 to CYE 2017. The threshold for a significant result is traditionally reached when the $p$ value is ≤0.05.

## Findings

Table 1-4, Table 1-5, and Table 1-6 present the CYE 2016 and CYE 2017 aggregate performance measure results with an MPS for the Acute Care Contractors, CMDP, and KidsCare Contractors. Of note, the Acute Care aggregate rates include all members who met the enrollment criteria for the Acute Care program regardless of Contractor; therefore, members enrolled in CMDP, Maricopa Health Plan, and Phoenix Health Plan were included in the Acute Care aggregate rate calculations in addition to those members enrolled in the six Acute Care Contractors. The tables display the following information: CYE 2016 performance, where available; CYE 2017 performance; the relative percentage change between CYE 2016 and CYE 2017 rates, where available; the significance of the relative percentage change, where available; and the AHCCCS MPS. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded the CYE 2017 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

**Table 1-4—CYE 2016 and CYE 2017 Aggregate Performance Measure Results—Acute Care Contractors**

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Access to Care** | | | | | |
| *Annual Dental Visits* | | | | | |
| 2–20 Years | 58.6% | 60.8% | 3.8% | **P<0.001** | 60.0% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | |
| 12–24 Months | 92.1% | 93.1% | 1.1% | **P<0.001** | 93.0% |
| 25 Months–6 Years | 85.4% | 82.9% | -2.9% | **P<0.001** | 84.0% |
| 7–11 Years | 90.6% | 89.0% | -1.8% | **P<0.001** | 83.0% |
| 12–19 Years | 88.0% | 86.4% | -1.8% | **P<0.001** | 82.0% |
| **Pediatric Health** | | | | | |
| *Adolescent Well-Care Visits* | | | | | |
| Adolescent Well-Care Visits | 39.2% | 39.2% | 0.0% | P=0.683 | 41.0% |
| *Well-Child Visits in the First 15 Months of Life* | | | | | |
| Six or More Well-Child Visits | 57.7% | 59.5% | 3.1% | **P<0.001** | 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 | 61.0% | 60.7% | -0.5% | P=0.164 | 66.0% |
| **Preventive Screening** | | | | | |
| *Breast Cancer Screening[2]* | | | | | |
| Breast Cancer Screening | — | 54.4% | — | — | 50.0% |
| *Cervical Cancer Screening* | | | | | |
| Cervical Cancer Screening | 50.6% | 50.5% | -0.2% | P=0.265 | 64.0% |
| *Chlamydia Screening in Women* | | | | | |
| Total | 47.4% | 48.3% | 1.9% | **P=0.004** | 63.0% |
| **Utilization** | | | | | |
| *Ambulatory Care (per 1,000 Member Months)* | | | | | |
| ED Visits—Total* | 56.3 | 53.4 | -5.1% | — | 55.0 |
| *Plan All-Cause Readmissions* | | | | | |
| Total* | 11.2% | 12.0% | 7.1% | **P=0.001** | 11.0% |

\* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 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] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the CYE 2016 rate was not displayed due to technical specification changes, or that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate.

Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

**Table 1-5—CYE 2016 and CYE 2017 Performance Measure Results—CMDP**

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Access to Care** | | | | | |
| *Annual Dental Visits* | | | | | |
| *2–20 Years* | 68.0% | 73.8% | 8.5% | **P<0.001** | 60.0% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | |
| *12–24 Months* | 98.3% | 97.9% | -0.4% | P=0.562 | 93.0% |
| *25 Months–6 Years* | 93.2% | 91.8% | -1.5% | P=0.053 | 84.0% |
| *7–11 Years* | 96.0% | 96.8% | 0.8% | P=0.299 | 83.0% |
| *12–19 Years* | 95.9% | 97.1% | 1.3% | P=0.111 | 82.0% |
| **Pediatric Health** | | | | | |
| *Adolescent Well-Care Visits* | | | | | |
| *Adolescent Well-Care Visits* | 68.3% | 72.3% | 5.9% | **P=0.002** | 41.0% |
| *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* | 70.7% | 74.5% | 5.4% | **P=0.006** | 66.0% |

[1] *Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 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.*

Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

**Table 1-6—CYE 2017 Aggregate Performance Measure Results—KidsCare Contractors**

| Performance Measure | CYE 2017 Performance | MPS |
|---|---|---|
| **Access to Care** | | |
| *Annual Dental Visits* | | |
| *2–20 Years* | 74.3% | 60.0% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | |
| *12–24 Months* | 97.4% | 93.0% |
| *25 Months–6 Years* | 92.3% | 84.0% |
| *7–11 Years* | 100.0% | 83.0% |
| *12–19 Years* | 95.1% | 82.0% |
| **Pediatric Health** | | |
| *Adolescent Well-Care Visits* | | |
| *Adolescent Well-Care Visits* | 61.1% | 41.0% |
| *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* | 75.8% | 66.0% |

Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

## Conclusions

For CYE 2017, the Acute Care aggregate performance measure rates for the **quality** area indicated opportunities for improvement, with six of seven (85.7 percent) measure rates (*Adolescent Well-Care Visits*; *Cervical Cancer Screening*; *Chlamydia Screening in Women*; *Plan All-Cause Readmissions*; *Well-Child Visits in the First 15 Months of Life*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) falling below the MPS. *Breast Cancer Screening* was the only performance measure rate within the **quality** area that exceeded the MPS for the Acute Care aggregate.

The Acute Care aggregate demonstrated positive performance in the **access** area, exceeding the MPS for four of five (80.0 percent) performance measure rates (*Annual Dental Visits*; and *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *7–11 Years*, and *12–19 Years*). However, three of five (60.0 percent) performance measure rates (*Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*) demonstrated significant declines from CYE 2016 to CYE 2017.

Compared to the CYE 2017 MPS, CMDP's and the KidsCare aggregate performance in the **quality** and **access** areas indicated strength as all performance measure rates exceeded the MPS.

There were no performance measure rates related to **timeliness**; therefore, this area was not discussed. Additionally, the utilization performance measure rate (*Ambulatory Care*) for the Acute Care aggregate should be monitored for informational purposes.

## Recommendations

HSAG recommends that AHCCCS work with the Acute Care Contractors to increase rates for the performance measures that failed to meet the CYE 2017 MPS related to pediatric health and screenings for cervical cancer and chlamydia in women. AHCCCS and the Acute Care Contractors should conduct root cause analyses for the low rates of well-child and well-care visits and appropriate screenings for women to determine the nature and scope of the issue (e.g., provider billing issues, barriers to care, community perceptions). Once the causes are identified, AHCCCS and the Acute Care Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase comprehensive visits for children and adolescents that follow the American Academy of Pediatrics' (AAP's) *Recommendations for Preventive Pediatric Health Care*.[1-4] Additionally, AHCCCS and the Acute Care Contractors should ensure that members receive screenings in accordance with the U.S. Preventive Services Task Force (USPSTF) screening recommendations for cervical cancer and chlamydia in women.[1-5,1-6]

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[1-4] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: Apr. 2, 2019.

[1-5] U.S. Preventive Services Task Force. *Cervical Cancer: Screening*. Available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2?ds=1&s=cervical cancer. Accessed on: Apr. 5, 2019.

[1-6] U.S. Preventive Services Task Force. *Chlamydia and Gonorrhea: Screening*. Available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/chlamydia-and-gonorrhea-screening?ds=1&s=chlamydia. Accessed on: Apr. 5, 2019.

## *Performance Improvement Projects (PIPs)*

In CYE 2015, AHCCCS implemented a new PIP, *E-Prescribing*, for all lines of business. The baseline year for this PIP was CYE 2014, which is reflective of October 1, 2013, through September 30, 2014. The subsequent year was an "Intervention" year in which each Contractor implemented strategies and interventions to improve performance. AHCCCS conducted annual measurements to evaluate Contractor performance, with the first remeasurement reflective of CYE 2016 and the second reflective of CYE 2017.

Electronic prescribing (e-prescribing) was meant to improve the quality of healthcare for members as well as efficiency for providers. E-prescribing is a clinician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. Thus, clinicians can safely and efficiently manage patients' medications while reducing risk of error. Additional benefits include reducing phone calls between clinicians and pharmacies, and providing patients convenience by helping them to avoid additional trips to pharmacies to drop off prescriptions.

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 in the number of prescriptions submitted electronically, followed by sustained improvement for one year.

AHCCCS considered that a Contractor demonstrated improvement when it achieved one of the following:

- Met or exceeded the AHCCCS overall average for the baseline measurement if the Contractor's baseline rate was below the average and the increase was statistically significant.
- Demonstrated a statistically significant increase if its baseline rate was at or above the AHCCCS overall average for the baseline measurement.
- Was the highest-performing Contractor in any remeasurement, and maintained or improved its rate in a successive measurement.

AHCCCS considered that a Contractor demonstrated sustained improvement when it achieved one of the following:

- Maintained or increased improvements in performance for at least one year after those improvements were first achieved.
- Demonstrated how the improvement could be reasonably attributable to interventions undertaken by the organization (i.e., improvement occurred due to the project and its interventions, rather than an unrelated reason).

In addition, the AHCCCS Quality Improvement Team implemented multiple process improvement efforts during CYE 2018, including AHCCCS Medical Policy Manual (AMPM) PIP policy updates, implementation of a revised PIP reporting template structure to capture the evolution and progress of the

Contractor throughout the PIP cycle, as well as the creation of an AHCCCS PIP-specific review checklist that enhances interrater reliability for coordinator reviews and the provision of more extensive feedback to the Contractors.

Of those Contractors included within the PIP from CYE 2014 to CYE 2017, all demonstrated improvement in Remeasurement Year 1 as well as sustained improvement in Remeasurement Year 2 for both indicators. For Indicator 1, Providers Who Prescribed at Least One Prescription Electronically, HNA demonstrated the most improvement in the overall relative change from baseline with a score of 29.57 percent; and for Indicator 2, Percentage of Prescriptions Prescribed Electronically, HNA demonstrated the most improvement with a score of 50.64 percent for the overall relative percentage change from baseline, almost a 20 percent difference from the second highest score.

## Findings

This report is inclusive of the Remeasurement 2 (October 1, 2016, through September 30, 2017) reporting period for the *E-Prescribing* PIP. The Contractors implemented many solid interventions to improve rates for both indicators.

Figure 1-1 represents the overall relative percentage change for all Acute and CMDP Contractors for Indicator 1; the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically.

**Figure 1-1—Performance Improvement Projects—*E-Prescribing:* Indicator 1: The Percentage of Providers Who Prescribed at Least One Prescription Electronically—All Acute and CMDP Contractors***
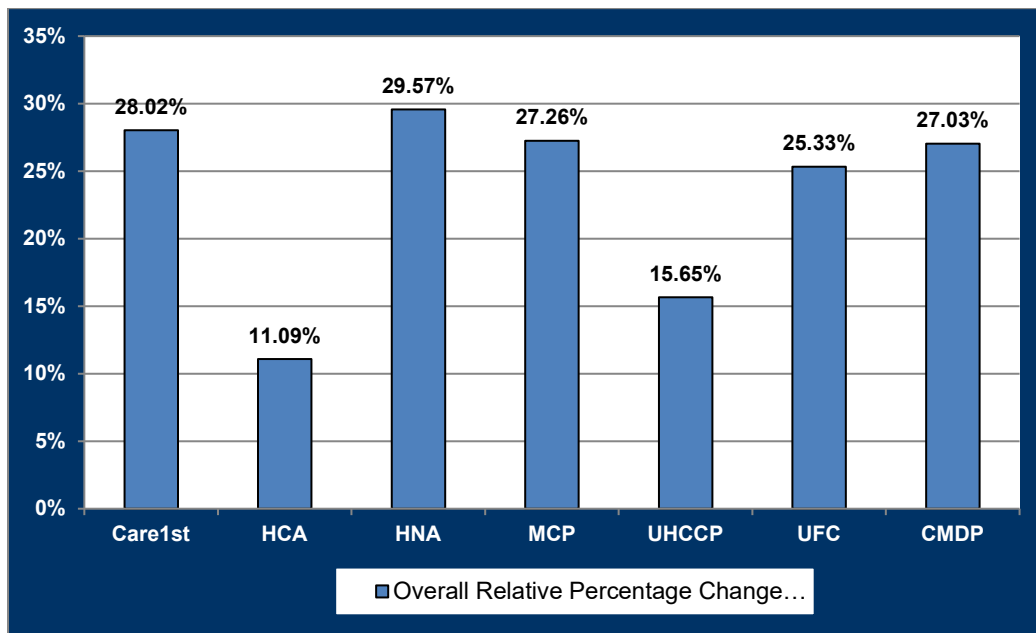


*Percentage totals have been rounded.

Figure 1-1 shows that, for Indicator 1,the Contractor with the greatest improvement was HNA, with an overall relative percentage change from baseline of 29.57 percent. The Contractor with the greatest opportunity for improvement was HCA, with an overall relative percentage change from baseline of 11.09 percent. All Contractors tasked with the PIP exceeded respective baseline rates by statistically significant amounts at the second remeasurement for Indicator 1.

Figure 1-2 represents the overall relative percentage change for all Acute and CMDP Contractors for Indicator 2; the percentage of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically.

**Figure 1-2—Performance Improvement Projects—*E-Prescribing:* Indicator 2: The Percentage of Prescriptions Sent Electronically—All Acute and CMDP Contractors \***
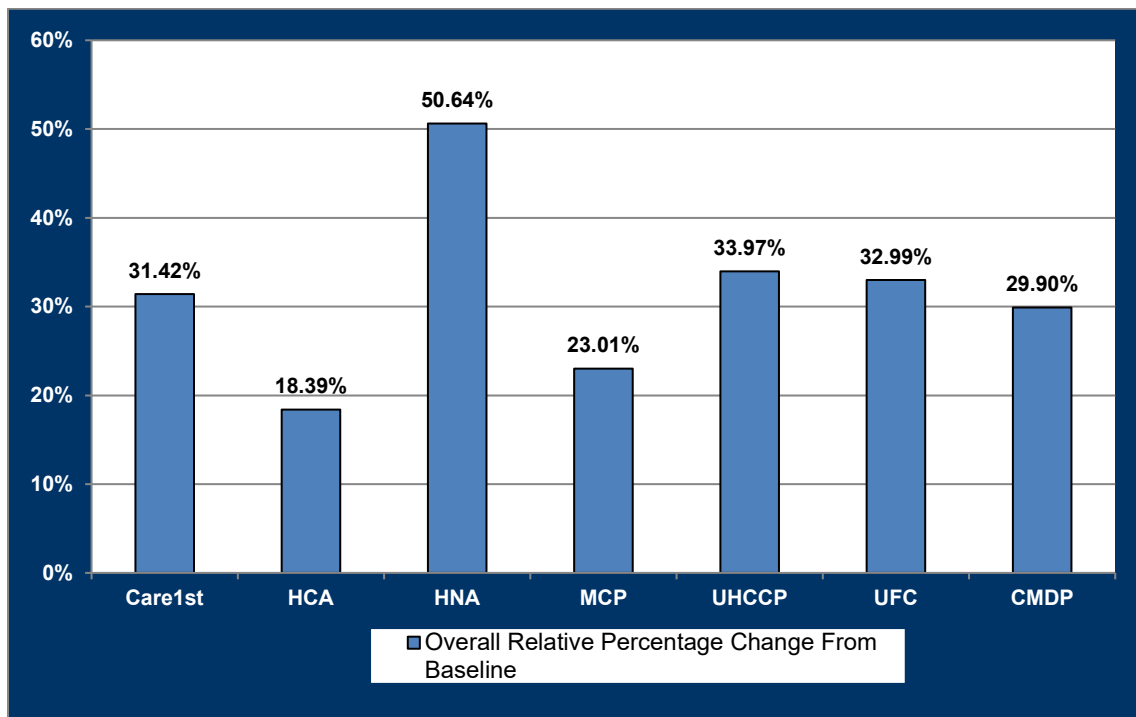


*Percentage totals have been rounded.

Figure 1-2 shows that the Contractor with the greatest improvement was HNA, with an overall relative percentage change from baseline of 50.64 percent. The Contractor with the greatest opportunity for improvement was HCA, with a relative percentage change from baseline of 18.39 percent. All Contractors tasked with the PIP exceeded respective baseline rates by statistically significant amounts at the second remeasurement for Indicator 2. This finding indicates that the Contractors need only sustain their gains for an additional remeasurement cycle.

## Conclusions

All Contractors achieved statistically significant improvement for both Indicator 1 and Indicator 2 in the second remeasurement period. Contractors implemented strong interventions in CYE 2017 for the *E-*

*Prescribing* PIP. All Contractors participated in an e-prescribing workgroup formed with other Arizona Contractors, Arizona Alliance of Health Plans (AzAHP) and Health Current (collectively referred to as "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.

### Recommendations

This is the last measurement year for the *E Prescribing* PIP. 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 consolidate the gains made for this PIP. In addition, HSAG recommends that AHCCCS continue to encourage the collaboration among Contractors in the e-prescribing workgroup to improve these indicators.

## Overall Assessment of Progress in Meeting EQRO Recommendations

During previous years, HSAG made recommendations in the annual reports for each activity conducted. Table 1-7 is a summary of the follow-up actions per activity that AHCCCS completed in response to HSAG's recommendations during State fiscal year (SFY) 2016–2017. Many of the Contractors have added rates in responses to the recommendations. Please note that AHCCCS has not approved or validated these rates.

**Table 1-7—HSAG Recommendations With AHCCCS Actions**

| HSAG Recommendation | AHCCCS Action |
|---|---|
| **Operational Review** | |
| • AHCCCS should consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives.<br>• AHCCCS should present identified best practices on the predominant issues for Contractors' issues and facilitate a group discussion about Contractors' policies and procedures. In addition, AHCCCS should consider conducting a root cause analysis with the Contractors to determine why Contractors continue to have difficulty complying with specific standards. | The AHCCCS Medical Management (MM) Team presented all the changes that have been made in the AHCCCS Medical Policy Manual (AMPM) and intends to conduct an ad-hoc notice of action (NOA) audit in December 2018. In preparation for the integrated contract rollout, the AHCCCS MM Team held multiple workgroup meetings to discuss various topics (care coordination, crisis, emergency department wait times, autism spectrum disorder [ASD], Tribal Regional Behavioral Health Authority [T-RBHA] coordination). In addition, ongoing workgroups with the multispecialty integrated |

| HSAG Recommendation | AHCCCS Action |
|---|---|
|  | clinics (MSICs) and AHCCCS Complete Care (ACC) plans to discuss transition of Children's Rehabilitative Services (CRS) members also occurred. <br><br> AHCCCS Maternal Child Health/Early and Periodic Screening, Diagnostic, and Treatment (MCH/EPSDT) quarterly Contractor meetings included the following agenda items: blood lead update, pregnancy risk monitoring systems, importance of early relationships, introduction to behavioral health guides and manuals, behavioral assessment, policy review and behavioral health tools, mental health advocacy, trauma, behavioral health tools, AHCCCS quality management (QM) portal demo, congenital syphilis, children's system of care, Division of Health Care Advocacy and Advancement overview, and expectations for CYE 2019. |
| 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 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. <br><br> 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 | All requirements for the remit are found in contract and policy. It should be noted that most issues found on the last round of OR reviews of remits were related to the subcontractor, not specific to the Contractors. This was the first round of ORs for which AHCCCS reviewed and scored subcontractor remits as well. |

| HSAG Recommendation | AHCCCS Action |
|---|---|
| geographic service areas; therefore, this is an important standard to target for compliance. | |
| Within the CYE 2017 EQRO reports, HSAG included an indication that AHCCCS should consider distributing TA documents to all Contractors and holding TA in-person meetings with Contractors who scored lowest in the OR standards, including guidance on how to complete a CAP. | TA was provided to all Contractors prior to the CYE 2016 OR cycle. This TA went over changes made to the OR process and included guidance on how to complete a CAP. Prior to the next OR Cycle, AHCCCS intends to hold another OR Kickoff/TA session with all Contractors. During this meeting, information on how to complete a CAP will be restated. Additionally, the AHCCCS QI Team created a QI-specific CAP checklist that is currently awaiting AHCCCS Policy Committee review and approval. It is expected that this checklist will assist Contractors in the identification and inclusion of essential elements required by the Contractors when seeking AHCCCS review and approval for mandated CAPs required based on Contractor performance related to performance measures and CAHPS surveys. |
| AHCCCS should consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. AHCCCS should present identified best practices on the predominant issues for Acute Care Contractors and facilitate a group discussion on Contractors' policies and procedures. In addition, AHCCCS should consider conducting a root cause analysis with the Contractors to determine why many Contractors continue to have difficulty complying with specific standards. | Evaluation of root cause concerns with Contractors not compliant with specific OR standards will be reviewed after the next round of ORs. This will be the first round of ORs since the request for proposal (RFP), in which a number of changes were made to Contract requirements. |
| 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 TA documents to all Contractors and holding in-person | TA is something that can be considered in the future with the Contractors. OR elements are reviewed and may be changed with each cycle. In addition, AHCCCS conducts an OR kickoff meeting with the Contractors to provide a summary of changes and expectations and to |

| HSAG Recommendation | AHCCCS Action |
|---|---|
| meetings with Contractors who scored lowest in these standards. | address questions raised by the Contractors related to the review process. |
| No recommendation; however, AHCCCS is reviewing all standards. | AHCCCS is reviewing all standards for the upcoming ORs beginning January 2019 and making revisions as necessary. |
| **Performance Measures** | |
| No recommendation; however, AHCCCS conducted a series of TA and educational sessions. | AHCCCS conducted a series of web-based TA and education sessions aimed at providing contracted QM, quality improvement, and other clinical staff a foundation for the following topics and addressing barriers which may be impacting the Contractors' abilities to achieve meaningful improvement. Topics included the following: introduction to Children's Rehabilitative Services (CRS); Immunizations, Parts 1, 2, and 3—schedules and statutes; vaccines for Children/Arizona State Immunization Information System (VFC/ASIIS) and audit results; dental data overview, varnish, sealants, and dental preventative participation; system of care overview; and newborn screening. |
| **Performance Improvement Projects** | |
| AHCCCS may want to consider offering and facilitating training opportunities to enhance the Contractors' capacities to implement robust interventions and QI processes and strategies for the *E-Prescribing* PIP. Increasing the Contractors' efficacy with QI tools such as root cause analyses, key driver diagrams, process mapping, failure modes and effects analysis (FMEA), and Plan-Do-Study-Act (PDSA) cycles should help to remove barriers to successfully achieving improvement in the PIP indicator rates. | Based on the CYE 2017 closeout of the *E-Prescribing* PIP, AHCCCS was unable to implement those recommendations by HSAG specific to this PIP as the final reports were not received until June 2018. However, AHCCCS is currently considering how the associated recommendations can be incorporated into other AHCCCS-mandated activities, current and upcoming, related to the Contractors' PIP and performance measure evaluation and analysis efforts. |
| 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. | Based on the CYE 2017 closeout of the *E-Prescribing* PIP, as the final reports were not received until June 2018, AHCCCS was unable to implement those recommendations by HSAG specific to this PIP. |

| HSAG Recommendation | AHCCCS Action |
|---|---|
| AHCCCS may want to use the quarterly meetings with Contractors as opportunities to identify and address, related to the PIP process, systemwide barriers which may be impacting ability to achieve meaningful improvement. | AHCCCS used various Contractor quarterly meetings as opportunities to identify and address a wide array of topics, providing education and the setting to address barriers that may impact the Contractors' abilities to achieve meaningful improvement in various focus areas.<br><br>AHCCCS also introduced its Back to Basics efforts that included the selection of a child and adolescent preventative care measure PIP with the ability to help Contractors address a notable decline in rates specific to well-child/well-care visits. To help address barriers related to a notable systemwide decline specific to child and adolescent well care and immunization rates, in addition to the Back to Basics PIP discussed previously, AHCCCS also initiated a series of web-based TA and education sessions aimed at providing Contractor QM, QI, and other clinical staff a foundation for the topics found within the "MCH and EPSDT Learning Opportunities" section of the Performance Measures as well as addressing barriers which may be impacting the Contractors' abilities to achieve meaningful improvement. |
| AHCCCS should consider including in the workgroup additional stakeholders who may help with improvement of the PIP's indicators rates. | Based on the CYE 2017 close out of the *E-Prescribing* PIP, as the final reports were not received until June 2018, AHCCCS was unable to implement those recommendations by HSAG specific to this PIP. However, AHCCCS is currently considering how the associated recommendations can be incorporated into the AHCCCS QI PIP-related activities. |
| AHCCCS should continue the collaboration among Contractors in the workgroup to improve the PIP study indicator rates. | Based on the CYE 2017 closeout of the *E-Prescribing* PIP, as the final reports were not received until June 2018, AHCCCS was unable to implement those recommendations by HSAG specific to this PIP. However, AHCCCS is currently considering how the |

| HSAG Recommendation | AHCCCS Action |
|---|---|
| | associated recommendations can be incorporated into the AHCCCS QI PIP-related activities. |
| For systemwide barriers, AHCCCS may consider the following: facilitate a session to identify systemwide 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 systemwide barriers. | AHCCCS used various Contractor quarterly meetings as opportunities to identify and address a wide array of topics, providing education and the setting to address barriers that may impact the Contractors' abilities to achieve meaningful improvement in various focus areas. AHCCCS also introduced its Back to Basics efforts that included the selection of a child and adolescent preventative care measure PIP with the ability to help Contractors address a notable decline in rates specific to well-child and well-care visits. To help address barriers related to a notable systemwide decline specific to child and adolescent well care and immunization rates, in addition to the Back to Basics PIP discussed previously, AHCCCS also initiated a series of web-based TA and education sessions aimed at providing Contractor QM, QI, and other clinical staff a foundation for the topics found within the "MCH and EPSDT Learning Opportunities" section of the Performance Measures and at addressing barriers which may be impacting the Contractors' abilities to achieve meaningful improvement. |
| No recommendation; however, the AHCCCS QI Team collaborated with the MCH and Executive Management teams to select a child and adolescent preventative care PIP. | During the latter portion of CYE 2018, the AHCCCS QI Team collaborated with the MCH and Executive Management teams to select a child and adolescent preventative care PIP with the ability to help Contractors address a notable decline in rates specific to well-child and well care visits. This methodology has been approved and will soon be distributed to Contractors and posted to the AHCCCS website. The baseline measurement period for this PIP is CYE 2019, with data collection anticipated to start summer 2020; this time frame was intentionally selected to account for the most recent system changes that went into effect October 1, 2018. |

Table 1-8 presents a summary of the follow-up actions per activity that the Contractors reported completing in response to HSAG's recommendations from the SFY 2016–2017 Annual Report.

Note: The text located after each HSAG recommendation box was submitted by each of the Contractors; only light proofing has been conducted.

**Table 1-8—Contractors' Responses to HSAG's Follow-Up Recommendations**

| Care1st |
|---|
| **Performance Measures** |
| **HSAG Recommendation:** Care1st's reported rate for the *Adults' Access to Preventive/Ambulatory Health Services* measure stayed approximately the same for CYE 2016 (73.3 percent) compared to CYE 2015 (73.1 percent) and did not meet the AHCCCS minimum performance standard (MPS) of 75.0 percent. HSAG recommends that Care1st focus efforts on identifying improvement strategies to raise rates for this measure. (This measure has been moved to "Reserve" status by AHCCCS.) |
| Care1st's *Adults' Access to Preventive/Ambulatory Health Services* rate for Acute members showed an overall decline beginning in CYE 2015 and fell below the AHCCCS MPS. <br><br> As a result of these data and trends, Care1st implemented performance improvement activities that included the following: <ul><li>In CYE 2014, Care1st executed value-based agreements with several patient-centered medical homes (PCMHs), with incentives to increase performance measures rates.</li><li>In CYE 2015, Care1st expanded the number of value-based partnerships (VBPs) with primary care incentives. Each year, once the performance reporting is final, Care1st adjusts the primary care physician (PCP) auto-assignment algorithm to direct members to our highest-performing partners.</li><li>Blast faxes to provider offices about preventative visits and access to care were sent.</li><li>Individual education to provider offices on documentation and coding for preventative visits was implemented.</li><li>Medical management department (care coordination) implemented an emergency department (ED) diversion program that included education on preventative visits vs. ED visits.</li><li>Education was provided to adult members on recommended preventative services through the member newsletter.</li><li>Continue to send quarterly gaps-in-care rosters to providers identifying members with missing visits.</li><li>Continue using "wellness messages" identifying member-specific gaps in care allowing for outreach by anyone within Care1st having contact with the member/family.</li><li>Outreach to adults regarding preventive visits and services was expanded. Education was provided to parents about their need for a preventive visit with a PCP when calls were made about EPSDT visits.</li></ul> |

| Care1st |
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| • In CYE 2019, Care1st dedicated a quality improvement full-time equivalent (FTE) to make outreach calls to adults. In addition, the Contractor plans a systemwide initiative to identify members and increase engagement with PCPs.<br>• In CYE 2019, Care1st plans to deploy a new staff of quality practice advisors (QPAs) to work with provider offices to close gaps in screenings and services, as well as correct coding. QPAs will use and distribute a new HEDIS Adult Resource Guide for providers. |
| **HSAG Recommendation:** Care1st's reported rate for the *Cervical Cancer Screening* measure demonstrated a statistically significant increase from CYE 2015 (49.6 percent) to CYE 2016 (51.8 percent). Although there was an increase, the rate was below the AHCCCS MPS of 64.0 percent. HSAG recommends that Care1st focus efforts on identifying improvement strategies to raise rates for this measure. |
| Based on internal monitoring, the *Cervical Cancer Screening* rate for Acute members showed an overall decline in CYE 2014–CYE 2015. Since then, internal monitoring has shown an increase for CYE 2017 (53.21 percent).<br><br>As a result of these data and trends, Care1st implemented performance improvement activities that included the following:<br>• In CYE 2014, Care1st executed value-based agreements with several PCMHs, with incentives to increase performance measure rates.<br>• In CYE 2015, Care1st expanded the number of VBPs with primary care incentives. Each year, once the performance reporting is final, Care1st adjusts the PCP auto-assignment algorithm to direct members to our highest-performing partners.<br>• Education was provided to adult members on recommended preventative services through the member newsletter.<br>• Continue to send quarterly gaps-in-care rosters to providers identifying members with missing visits.<br>• Continue using "wellness messages" identifying member-specific gaps in care allowing for outreach by anyone within Care1st having contact with the member/family.<br>• For CYE18, outreach to adults regarding preventive visits and services was expanded. Calls to adults were increased with follow-up letters for members who continued to be noncompliant with the measure.<br>• In CYE 2019, Care1st dedicated a quality improvement FTE to make outreach calls to adults. In addition, the Contractor plans a systemwide initiative to identify members and increase engagement with PCPs.<br>• In CYE 2019, Care1st plans to deploy a new staff of QPAs to work with provider offices to close gaps in screenings and services, as well as correct coding. QPAs will use and distribute a new HEDIS Adult Resource Guide for providers. |
| **HSAG Recommendation:** Care1st's reported rate for the *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* measure demonstrated a decline from the previous year (CYE 2016 92.6 percent, CYE 2015 94.1 percent) and did not meet the |

| Care1st |
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| AHCCCS MPS of 93.0 percent. HSAG recommends that Care1st focus efforts on identifying improvement strategies to raise rates for this measure. |

Based on internal monitoring, Care1st's *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* rate for Acute members remained at approximately 93 percent or greater (above the MPS) through CYE 2015. The internal rate showed an overall decline beginning in CYE 2015 and fell below the AHCCCS MPS in CYE 2016.

As a result of these data and trends, Care1st implemented performance improvement activities that included the following:

- In CYE 2014, Care1st executed value-based agreements with several PCMHs, with incentives to increase performance measures rates.
- In CYE 2015, Care1st expanded the number of VBPs with primary care incentives. Each year, once the performance reporting is final, Care1st adjusts the PCP auto-assignment algorithm to direct members to our highest-performing partners.
- In CYE 2015, Care1st began running reports twice a year to compare EPSDT tracking forms with claims for these visits, in order to determine whether physician offices are not correctly billing for EPSDT visits performed. The report matches up a claim for a visit with an EPSDT tracking form received from the provider with a date of service seven days before or after the date on the form to determine if a visit was billed. A list of providers who submitted an EPSDT tracking form but did not bill for a visit is forwarded to the Network Management (NM) department. An NM representative reaches out to the physician office to educate about billing for well visits and resubmitting a correctly coded claim. This monitoring and education process includes both acute and DDD claims.
- Blast faxes reminding provider offices about correctly coding visits, including billing for a well visit performed in conjunction with a sick visit, were sent to all PCPs with assigned members < 21 years.
- Continue to send quarterly gaps in care rosters to providers identifying members with missing visits.
- Continue using "wellness messages" identifying member-specific gaps in care, allowing for outreach by anyone within the health plan having contact with the member/family.
- Continue intensive telephone outreach efforts to improve access to PCPs.
- In Q4 of CYE 2017, Care1st implemented a new text messaging program to engage parents of AHCCCS members and remind them when their children are due for well visits and/or dental visits. Care1st was a leader in developing this text messaging approach to parents/guardians and adult Medicaid members that not only educates members of the importance of preventative services but provides regular reminders when visits are not completed. As part of this program, Care1st established a dedicated phone line to link members receiving texts to an EPSDT specialist if they needed help making an appointment or with other issues. The program is based on evidence that shows that interactive and tailored text messages are successful in promoting self-activation among Medicaid members.

| Care1st |
| --- |
| • Care1st has sent more than 90,000 text reminders for medical and/or dental visits to parents/guardians. Overall, the response has been positive, with an opt-out rate of approximately 0.5 percent. Feedback from parents indicates that many appreciate the reminders and others are able to access assistance directly from EPSDT specialists.<br>• Care1st runs semiannual reports to compare EPSDT claims with tracking forms to identify billing issues, educate providers, and encourage them to resubmit claims that were not coded as a preventive visit when EPSDT exams were completed. Care1st has been successful in getting claims resubmitted when an EPSDT Tracking Form indicated a comprehensive well visit in more than 70 percent of cases identified.<br>• An EPSDT Workgroup was convened in February 2018, which included QI, Medical Management, Claims, and Network Management staff to discuss barriers to care and strategies to better close gaps and identify improvements in data upload processes. Additional activities included improved education for providers regarding performing and coding for EPSDT services during a sick visit and scheduling multiple members of a family on the same day for well visits. |
| **HSAG Recommendation:** Care1st's reported rate for the *Chlamydia Screening in Women* measure demonstrated a decline from the previous year (CYE 2016 48.9 percent, CYE 2015 51.2 percent) and did not meet the AHCCCS MPS of 63.0 percent. HSAG recommends that Care1st focus efforts on identifying improvement strategies to raise rates for this measure. |
| Care1st has monitored chlamydia screening rates on a monthly basis for several years, using this and other data from its health information system to identify opportunities for improvement. Based on internal monitoring, the chlamydia screening rate for Acute members showed an increase for CYE 2017 (53.21percent). Rates were lower among 16-to-20-year-olds, at 47.0 percent vs. 54.3 percent for women 21 to 24 years of age. Although there was an increase in this measure, it was still below the AHCCCS MPS. As a result of these data and trends, Care1st implemented performance improvement activities that included the following:<br>• Education was provided to adult members on recommended preventative services through the member newsletter.<br>• Continue to send quarterly gaps-in-care rosters to providers identifying members with missing visits.<br>• Continue using "wellness messages" identifying member-specific gaps in care allowing for outreach by anyone within Care1st having contact with the member/family.<br>• For CYE 2018, outreach to adults regarding preventive visits and services was expanded. Calls to adults were increased with follow-up letters for members that continued to be noncompliant with the measure.<br>• Education on chlamydia screening in teens and young adults was sent to all PCPs serving members younger than 21 years of age in September 2018.<br>• In CYE 2019, Care1st dedicated a quality improvement FTE to make outreach calls to adults. In addition, the Contractor plans a systemwide initiative to identify members and increase engagement with PCPs. |

| Care1st |
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| • In CYE 2019, Care1st plans to deploy a new staff of QPAs to work with provider offices to close gaps in screenings and services, as well as correct coding. QPAs will use and distribute a new HEDIS Adult Resource Guide for providers. |
| **HSAG Recommendation:** Care1st's reported rate for the *Developmental Screening in the First Three Years of Life* measure demonstrated a statistically significant increase from CYE 2015 (17.3 percent) to CYE 2016 (23.6 percent). Although there was an increase, the rate was below the AHCCCS MPS of 55.0 percent. HSAG recommends that Care1st focus efforts on identifying improvement strategies to raise rates for this measure. |
| Based on internal monitoring, the *Developmental Screening in the First Three Years of Life* rate shows an increase for CYE 2018 (29.05 percent). Although there was increase in this measure, it is still below the AHCCCS MPS.<br><br>As a result of these data and trends, Care1st implemented performance improvement activities that included the following:<br><br>• In CYE 2014, Care1st executed value-based agreements with several PCMHs, with incentives to increase performance measure rates.<br>• In CYE 2015, Care1st expanded the number of VBPs with primary care incentives. Each year, once the performance reporting is final, Care1st adjusts the PCP auto-assignment algorithm to direct members to the highest-performing partners.<br>• Send monthly reminders for children due a visit and/or vaccination; send second reminders for children identified as not having a visit/vaccination. Focus is on getting children in for routine visits since providers are completing developmental screenings during the visit.<br>• Continue regular phone outreach to parents/guardians of members younger than 24 months at the following intervals: 6 weeks; 3, 5, 8, and 11 months of age; follow up at 14, 17, and 23 months for members who have not completed visits and/or are behind with required immunizations.<br>• Continue generating "wellness messages" identifying member-specific gaps in care for well-child visits in the first 15 months and children's access to PCPs from 12–24 months; load into managed health care (MHC) information system, allowing for reminders to be given by anyone within the health plan having contact with the parent/guardian.<br>• Send quarterly gaps-in-care rosters to providers identifying members with missing visits.<br>• Continue sending "Practice Pointers" to providers with timely topics related to pediatric health and the EPSDT program.<br>• Review of EPSDT tracking forms for documentation of developmental screenings. When the forms show a lack of documentation of developmental screening, contact provider office and educate about the need to conduct and document screening using the appropriate tool.<br>• Care1st expanded the text messaging program to members 0–15 months to focus on education about developmental milestones and child health, as well as promoting engagement with the child's PCP to complete developmental screenings. |

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| • Care1st is strengthening provider education about the need for a 9-month visit under the AHCCCS EPSDT Periodicity Schedule and the availability of additional reimbursement when a developmental screening is performed using an AHCCCS-approved tool.<br>• In CYE 2019, Care1st plans to deploy a new staff of QPAs to work with provider offices to close gaps in screenings and services, as well as correct coding. QPAs will use and distribute a new HEDIS Adult Resource Guide for providers. |
| **HSAG Recommendation:** Care1st's reported rate for the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure demonstrated a decline from the previous year (CYE 2016 63.7 percent, CYE 2015 66.3 percent) and did not meet the AHCCCS MPS of 65.0 percent. HSAG recommends that Care1st focus efforts on identifying improvement strategies to raise rates for this measure. |
| Based on internal monitoring, Care1st's *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* rate for acute members remained at approximately 67 percent or greater (above the MPS) through CYE 2015. The internal rate showed an overall decline beginning mid-year CYE 2014–CYE 2015 and fell below the AHCCCS MPS in CYE 2016.<br>As a result of these data and trends, Care1st implemented performance improvement activities that included the following:<br>• In CYE 2014, Care1st executed value-based agreements with several PCMHs, with incentives to increase performance measure rates.<br>• In CYE 2015, Care1st expanded the number of VBPs with primary care incentives. Each year, once the performance reporting is final, Care1st adjusts the PCP auto-assignment algorithm to direct members to our highest-performing partners.<br>• In CYE 2015, Care1st began running reports twice a year to compare EPSDT tracking forms with claims for these visits, in order to determine whether physician offices are not correctly billing for EPSDT visits performed. The report matches up a claim for a visit with an EPSDT tracking form received from the provider with a date of service seven days before or after the date on the form to determine if a visit was billed. A list of providers who submitted an EPSDT tracking form but did not bill for a visit is forwarded to the NM. An NM representative reaches out to the physician office to educate about billing for well visits and resubmitting a correctly coded claim. This monitoring and education process includes both acute and DDD claims.<br>• Blast faxes reminding provider offices about correctly coding visits, including billing for a well visit performed in conjunction with a sick visit, were sent to all PCPs with assigned members under 21 years of age.<br>• In Q4 of CYE 2017, Care1st implemented a new text messaging program to engage parents of AHCCCS members and remind them when their children are due for well visits and/or dental visits. Care1st was a leader in developing this text messaging approach to parents and guardians and adult Medicaid members that not only educates members of the importance of preventative services but provides regular reminders when visits are not completed. As part of this program, Care1st established a dedicated phone line to link members receiving texts to an EPSDT specialist if they needed help making an appointment or with other issues. The |

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| program is based on evidence that shows interactive and tailored text messages are successful in promoting self-activation among Medicaid members. |
| • Send monthly reminders for children due a visit or vaccination; send second reminders for children identified as not having a visit and/or vaccination. Focus is on getting children in for routine visits since providers are completing developmental screenings during the visit. |
| • Continue regular phone outreach to parents/guardians of members younger than 24 months at the following intervals: 6 weeks; 3, 5, 8, and 11 months of age; follow up at 14, 17, and 23 months for members who have not completed visits and/or are behind with required immunizations. |
| • Continue generating "wellness messages" identifying member-specific gaps in care for well-child visits in the first 15 months and children's access to PCPs from 12–24 months; load into the MHC information system, allowing for reminders to be given by anyone within the health plan having contact with the parent/guardian. |
| • Send quarterly gaps-in-care rosters to providers identifying members with missing visits. |
| • Care1st has sent more than 90,000 text reminders for medical and/or dental visits to parents/guardians. Overall, the response has been positive, with an opt-out rate of approximately 0.5 percent. Feedback from parents indicates that many appreciate the reminders and others are able to access assistance directly from EPSDT specialists. |
| • Care1st runs semiannual reports to compare EPSDT claims with tracking forms to identify billing issues, educate providers, and encourage them to resubmit claims that were not coded as a preventive visit when EPSDT exams were completed. Care1st has been successful in getting claims resubmitted when an EPSDT Tracking Form indicated a comprehensive well visit in more than 70 percent of cases identified. |
| • In CYE18, education to parents regarding needed preventive visits was expanded. Additional outreach touchpoints were added at 2–3 days, 3–4 weeks, and 6 weeks of life to increase the number of preventive visits and improve compliance. |
| • An EPSDT Workgroup was convened in February 2018, which included QI, Medical Management, Claims, and Network Management staff to discuss barriers to care and strategies to better close gaps and identify improvements in data upload processes. Additional activities included improved education for providers regarding performing and coding for EPSDT services during a sick visit and scheduling multiple members of a family on the same day for well visits. |
| • Care1st is strengthening provider education about the need for a 9-month visit under the AHCCCS EPSDT Periodicity Schedule and the availability of additional reimbursement when a developmental screening is performed using an AHCCCS-approved tool. |

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| Performance Measures |
| **HCA did not document HSAG recommendations but did include information on performance measures.** |

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| HCA is committed to complying with AHCCCS quality management (QM) requirements to improve performance for all AHCCCS performance measures. Monitoring performance measures occurs through data reports, which are stratified by all populations. The results of performance measures monitoring are reviewed at least quarterly by the Quality Management Committee. |
| HCA will deploy performance improvement coordinators (PICs) to partner with HCA-contracted providers and practices to review, troubleshoot, and optimize office workflow, member outreach, and collection of supplemental data. |
| The PIC team will develop a playbook of potential interventions to improve performance on each targeted performance measure. On regularly scheduled visits to provider offices, PICs will conduct a needs assessment including identification of practice-specific areas of opportunity that can be leveraged to improve office efficiency, provider performance, and member care. Once an opportunity has been identified, PICs will select and right-size an intervention from the playbook and apply established principles of process improvement to gain stakeholder buy-in, drive change, and measure the effectiveness of the updated process. |
| HCA will maintain and expand existing partnerships with service delivery partners including mammography centers, eye care centers, transportation vendors, home health agencies, and others to address barriers to care and close care gaps. HCA expects that the deployment of PICs will have tremendous and lasting benefits both to HCA's relationships with providers and the care that HCA and HCA's providers deliver to our members. |
| The PIC team has a high level of oversight from senior and mid-level management. In-depth trainings are provided, and shadowing completes the onboarding process to ensure that messaging is effective and relationship-building with providers is optimized. Weekly meetings occur one-on-one and as a group to monitor progress and ensure that barriers are overcome. A custom application was built to integrate member data from a variety of sources and keep documentation up to date daily on progress toward gap closure. |
| HCA has created 10 full time equivalent (FTE) positions to work on targeted performance measures for Arizona Medicare and Medicaid and has given those individuals specific training on engaging PCPs and parents or guardians to ensure completion of required services. PICs will be assigned to PCP group practices that have a high volume of gaps in care. PICs directly outreach to parents or guardians and PCPs to close gaps in care. Additional phone outreach is targeted at parents or guardians of members who are overdue for vaccines. |
| HCA is implementing and distributing provider report cards and member rosters to share performance rates, targets, and member-level detail about immunization measures with providers themselves. HCA sends provider representatives to provider site locations to help troubleshoot issues and problems. These provider representatives carry and distribute recently updated provider toolkits with resources for providers. |

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| **Performance Improvement Projects** |
| **HCA did not document HSAG recommendations but did include information on performance improvement projects.** |
| HCA has met the MPS for the *E-Prescribing* PIP and attributes this improvement to multiple interventions. <br><br> Educating staff and providers that e-prescribing is a patient safety measure and improves efficiency in clinic operations was the most impactful intervention that has been hardwired into network outreach processes. This has been messaged consistently through the year using several modes of communication which include promotion of webinars, promotion of free continuing medical education (CME), education tied to e-prescribing, face-to-face visits, and written materials. |
| **Consumer Assessment of Healthcare Providers and System** |
| **HSAG Recommendation:** Perform root cause analysis. |
| HCA employs the "Plan, Do, Study, and Act" (PDSA) approach to performance improvement and Lean and Six Sigma's "define, measure, analyze, improve, control" (DMAIC) to manage projects using a team-based approach. Using this philosophy of improvement, HCA proactively works to continually improve outcomes and enhance staff and provider performance. <br><br> In both models, root cause analysis (RCA) is an integral part of the first steps of any performance improvement project. The purpose of this step is to identify, validate, and select root cause for elimination. A large number of potential root causes of the project problem may be identified using RCA. RCA tools like workflow diagrams, Ishikawa diagrams, or 5 Whys exercises may be used to determine root causes. The top potential root causes are selected using multi-voting or other consensus tool for further validation. <br><br> HCA has trained staff in specific quality improvement methods including, among other topics, strategies to integrate QM functions across the organization and best practices in quality improvement. |
| **HSAG Recommendation:** Conduct frequent assessment of targeted interventions. |
| HCA promotes improvement in quality of care and services provided to enrolled members through ongoing monitoring, evaluating, and continuous improvement of the service delivery system and provider network. Through ongoing measurement and intervention, the QM program is designed to achieve and sustain significant improvements in the areas of clinical care and nonclinical care. The goal of continuous improvement is to positively impact health outcomes and member experience while achieving cost containment. HCA implements actions in line with evidenced-based practices to correct deficiencies, administer targeted corrective action plans as needed, and improve the quality of care and services provided to our members. <br><br> HCA addresses findings from internal audits, external audits, and operational reviews— ensuring that corrective actions are incorporated into standard operating procedures throughout |

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| the respective areas of the organization. This is facilitated through ongoing monitoring throughout the year. These results are reported through the HCA QM/PI Committee in coordination with the HCA Compliance Committee. |
| HCA maintains ongoing oversight and monitoring of operational/functional areas, which include formal assessments and evaluations on at least an annual basis. The HCA Compliance team is a significant contributor to these efforts to guarantee full compliance with all policies and procedures in addition to State and federal regulatory standards. Efforts to identify and address areas in need of corrective action or process improvements are addressed, followed by tracking and monitoring of implemented strategies. |
| Program descriptions and outcomes are reported through the Health Choice Quality Management/ Performance Improvement (QM/PI) Committee in coordination with the HCA Compliance Committee. Each of these committees meets, at minimum, on a quarterly basis to encourage interdepartmental collaboration among key stakeholders and the dissemination of best practices within the organization. Further, these committees provide a platform to discuss and develop solutions for vulnerable operational systems, monitoring programs, and/or process improvement activities. |

| **HSAG Recommendation:** Use health information technology. |
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| HCA is restructuring the quality program to improve efficiency and efficacy primarily through adoption of more robust performance monitoring tools; rollout of revised, value-based payment contracts with a focus on incentivizing quality improvement; enhanced contract rates for specific services; expanded health information exchange (HIE) and electronic medical record (EMR) connectivity; enhanced data stewardship; enhanced population targeting; and adoption of additional best practices and evidence-based interventions in performance areas of greatest opportunity. As the most effective and efficient processes and interventions are identified, additional learning-focused infrastructure that leverages a PDSA approach will be built to ensure sustainability and continued improvement over time. |
| Administrative and operational quality management are also included in the QM program scope of work. HCA QM program staff engage all functional areas of the organization in proactive performance improvement activities to ensure the highest quality, most cost-effective administrative processes. A centralized QM/PI email inbox ensures that all staff have open reporting, collaboration, and involvement with continuous quality improvement activities and opportunities. Processes and/or systems are included within the scope, including but not limited to customer service member/provider call metrics, credentialing processes, HIE, data transmission, information systems, workflow, member eligibility, and operational effectiveness. |
| HCA encourages the use of EMR systems across the system of care. To review provider activity and maintain compliance with program audit requirements, HCA conducts provider data validation audits and verifies that services delivered to members are accurately and promptly reported and documented in the medical record. HCA can connect directly to all large provider EMRs to complete reviews. Direct access through the information technology |

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| (IT) infrastructure allows HCA to quickly identify areas where providers may show anomalies in their data and report any incidents to the State, per program requirements.<br><br>HCA is expanding the use of health information technology in the auditing process. In CYE 2018 HCA traced the records retrieval process to identify barriers and diagnose roadblocks to successful sharing of data and retrieval of vital information. Using that information, HCA revised the chase logic to make it more efficient. HCA created a standard operating procedure to ensure that all staff are able to consistently apply that logic. HCA created secure email groups to facilitate fast electronic transfer of records from providers and significantly increased the number of EMR logins that HCA staff have in provider systems to allow for easy remote retrieval of records. HCA also implemented a shared data base to streamline and track records retrieval and enable task sharing with a larger group to eliminate rework and to increase coordination among staff.<br><br>Another way that HCA utilizes health information technologies was noted as an emerging best practice in the EQR annual report last year. HCA implemented the quality gap alert in CareRadius® 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. HCA trained member service representatives and EPSDT teams on the care-gap alert, these staff members are now able to educate members regarding their gaps in care and assist members in scheduling PCP appointments as needed. |

| **HSAG Recommendation:** Share data. |
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| HCA has multiple ways of sharing data with providers, including provider portals where providers upload information to HCA for review, monitoring, or performance.<br><br>HCA maintains active communication with the provider network on a number of issues. The most prominent of these with the greatest focus at this time is the exchange of data related to closing gaps in care as they relate to performance measures. HCA has implemented provider scorecards related to a number of measures and delivers these scorecards to providers as they become available.<br><br>The PIC team utilizes data received from HCA's data vendor to focus direct outreach to members. Gap reports are updated frequently, and new gaps reports are sent to providers as appointments are made to close gaps in care. |

| **HSAG Recommendation:** Facilitate coordinated care. |
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| HCA has multiple care management programs that consist of teams of clinicians that complete outreach to the teams serving a number of populations and subpopulations.<br><br>HCA's care management program promotes and supports "seamless" care coordination across the entire delivery system so that members experience healthcare and their membership with HCA as a single system treating the whole person. Data and support services are shared with providers in order to eliminate blind spots and gaps in medically necessary care. Opportunities for members to engage in their healthcare and improve outcomes and satisfaction are encouraged through HCA's use of condition-specific education, social media, the member portal, telehealth, and mobile applications. |

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| Care managers can assist in coordinating care with and between PCPs, emergency services, hospitals, and specialty providers to ensure that each part of a potentially complicated health system is understood by the member. Care managers complete care plans so that each patient's team can see the whole picture and coordinate care within the team.<br><br>One of the ways that HCA facilitates coordinated care was mentioned as a best practice in the EQR annual report last year. HCA's medical management unit implemented two transition-of-care program innovations identified as best practices 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. |

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| **Operational Reviews (ORs)** |
| **HSAG Recommendation:** Contractors should conduct internal reviews of operational systems to identify barriers that impact compliance with 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 in a timely manner. Contractors should apply lessons learned from improving performance for one category of standards to other categories. 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. |
| HNA's OR conducted for CYE 2017 identified issues in eight of the OR standard areas, including: medical management; delivery systems; grievance system; claims information system; general administration; adult, EPSDT, and maternal child health; quality management; and third-party liability.<br><br>HNA developed corrective action plans which have been approved and closed through AHCCCS. HNA created policies and procedures and continues to review them for ongoing training purposes to ensure full compliance with AHCCCS standards, State rules, and federal regulations.<br><br>HNA performs internal reviews of operational systems on a department level regularly and cross-departmentally on a monthly and/or quarterly basis. The Communication, Access, Respect, and Education (CARE) Task Force is an example of this cross-departmental collaboration to identify and overcome barriers that impact standards and regulations, performance outcomes, policies and procedures, as well as member experience. This cross-departmental representation is measured through the meaningful engagement, collaboration, and problems solved by the following departments: care management, utilization management, quality management; claims; credentialing; contracts; pharmacy, provider network, provider engagement, marketing, operations, individual and family affairs, customer service, grievances and appeals, analytics, and corporate representation. The CARE Task Force was operational |

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| throughout CYE 2018, and implemented an enhanced provider experience and engagement and obtained member feedback on care management support. In December 2017 HNA reported that provider groups were surveyed on whether or not they know that they have a provider engagement specialist (PES) assigned to them; 57.78 percent of those surveyed acknowledged having a PES assigned. Through the efforts of the CARE Task Force, an introductory letter was sent out to every provider providing contact information for their assigned PES and information about the role they fulfill. By June 2018 HNA reported that 63.37 percent of providers acknowledged having a PES assigned. The provider engagement team continues to outreach to providers and provide resources to ensure that providers know who their PES is and how to obtain resolution to any problems that arise. In January 2018 through collaboration with the CARE Task Force, the care management team implemented an after-call survey for members to gauge level of satisfaction. HNA reported that members have expressed high levels of satisfaction, 95–100 percent month over month in 2018. The next step for CYE 2019 is to shift this after-call survey into an automated interactive voice response (IVR) survey. |
| Through monitoring and evaluation efforts as well as principles and tools of continuous quality improvement, lessons learned from successful and unsuccessful interventions are extrapolated and readdressed to ensure sustained, positive impact and ongoing compliance with AHCCCS standards, State rules, and federal regulations. Appropriate processes and control systems have been established and are actively utilized by the HNA claims department to meet applicable compliance standards and regulations. |
| **Performance Measurement** |
| **HSAG Recommendation:** Focus improvement efforts on well-care visits for children and adolescents and on recommended screenings for women. Monitor performance within the access domain as all six measures demonstrated statistically significant declines from CYE 2015 to CYE 2016. |
| HNA relies on the Quality Management/Performance Improvement (QM/PI) Committee as the body that reviews, monitors, evaluates, and develops interventions targeted at performance measures. The QM/PI is structured to ensure that data drill-down is completed with root-cause analysis and PDSA cycles driving intervention development and implementation. Focused interventions on improvement of well-care visits for children and adolescents are performed through the EPSDT team. The EPSDT Subcommittee met quarterly during CYE 2018 and reported on the no-show tracking log. |
| HNA implemented a highly successful intervention in CYE 2018: follow-up on all EPSDT and dental appointment no shows by the EPSDT team and follow-up on all specialist appointment no-shows conducted by the medical management team. PCPs send no-show reports on an ongoing daily or weekly basis; and outreach is done immediately, within 24 to 48 hours. If the EPSDT team is able to make contact with the member, the team attempts to have a conference call by contacting the member's PCP to reschedule appointments and addressing any outstanding concerns that the member or physician may have. Additionally, |

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| during outreach calls, EPSDT team members question family/parent of child to determine what barriers or issues are encountered that prevent completing the appointment. A no-show letter is sent out to every member when a no-show is reported. |
| HNA implemented targeted provider visits conducted by the QI/EPSDT team to provide education and distribute resources to improve performance measures. Education and resources are provided through a number of other modes including Joint Operating Committee (JOC) meetings, provider update calls, newsletters, and provider forums. |
| HNA implemented a new member incentive program in the first quarter of CYE 2019 offering a $25 member gift card per service (not to exceed $75) when members receive a well visit or specific preventative screening. Both well visits and preventative screenings continue to be a focus in CYE 2019. QI has developed a calendar of interventions for these measures in partnership with care management, pharmacy, provider engagement, and the payment innovations teams. These interventions incorporate lessons learned from previous PDSA projects and target both member and provider interventions. |

| Performance Improvement Projects |
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| **HSAG Recommendation:** Continue to monitor and evaluate the effectiveness of interventions for the *E-Prescribing* 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. |
| HNA has continued to show improvement in e-prescribing rates for both indicators tracked by AHCCCS: percentage of AHCCCS-contracted prescribers using e-prescriptions and percentage of prescriptions submitted by AHCCCCS-contracted prescribers electronically. HNA engaged heavily in the *E-Prescribing* PIP and showed ongoing quarterly improvement over remeasurement periods 1 and 2. Interventions in CYE 2018 included targeted ongoing provider education. Beginning in February 2018, HNA actively engaged providers who encountered barriers or issues with e-prescribing through technical assistance support and guidance. |
| The *E-Prescribing* PIP will be closed out in Q1 of CYE 2019, but interventions and processes established throughout the remeasurement periods will continue to be utilized within the pharmacy department. HNA continues monitoring and evaluation efforts to drive identification of provider deficiencies and best practices to ensure that targeted education and interventions are successful. The pharmacy department will also continue to partner with various HNA departments to ensure that messaging and support to AHCCCS-contracted providers are consistent and ongoing. |

| CAHPS |
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| **HSAG Recommendation:** Contractors should conduct root-cause analyses of study indicators identified as areas of low performance. Contractors should frequently measure and monitor targeted interventions. Contractors should enhance and widen use of health information technology. Contractors should pursue joint activities that facilitate coordinated, effective care; |

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| and should combine medical and behavioral health services in primary care clinics. 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. |
| HNA implemented a number of interventions focused on improving CAHPS and overall member satisfaction and experience. HNA created the CARE Task Force Q1 of CYE 2018 to oversee CAHPS initiatives. Part of this includes a CAHPS workplan with numerous domains of interventions including member mailers, CAHPS education, and member surveys. Meetings occur biweekly, and monitoring is tracked in the workplan through a SharePoint site and presented at the biweekly committee meetings. HNA is developing some specific CAHPS interventions including CAHPS education for staff by tailoring it to be meaningful to specific departments; CAHPS Craze Week to engage staff in fun activities and set the tone for member satisfaction, Customer Service IVR Survey; Fluvention; birthday and thank you cards, patient experience toolkit, empathy training, PCP assignment, and others. Health information technology enhancement and growth in users continues to be a targeted focus for HNA. Through the utilization of the Arizona HIE rapid notifications, HNA's medical management team is able to provide quick follow-up to help coordinate needed services and educational materials. Monthly provider calls will be incorporating HNA contracted providers in October 2018. Prior to this time, providers engaged in an HIE breakout session at an August 2018 Integrated Learning Collaborative hosted by Arizona Complete Health. Along with monthly provider calls, provider engagement staff will provide ongoing reminders about the importance of utilizing the HIE at JOC meetings and site visits. HNA has a coordination of care PIP aimed at improving member experience and outcomes. Updates regarding monitoring and evaluation of performance measures and interventions occur on a quarterly basis at the Quality Improvement Committee. |

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| **Performance Measures** |
| **HSAG Recommendation:** 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. |
| • *Adolescent Well-Care Visits (AWC)*—The MCP internal fiscal year-to-date (FYTD) rate of 45.7 percent exceeds the MPS and the CYE 2017 internal rate, demonstrating an |

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improvement in performance. The R12 rate of 47.1 percent exceeds the MPS and the CYE 2017 internal rate. The R12 rate increase from the third to fourth quarter was statistically significant, resulting in two consecutive quarters of statistically significant improvement. The AHCCCS CYE 2017 aggregate rate for *AWC* is 39.2 percent. The goal is considered met based on the comparison of the FYTD rate to the MPS. MCP will continue its current interventions and utilize the PDSA cycle to monitor rates and evaluate any statistically significant changes.

- *Annual Dental Visits—2–20 Years*—The MCP internal FYTD rate of 66.5 percent exceeds the MPS and the CYE 2017 internal rate. The FYTD rate also exceeds the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-7] 90th percentile. The R12 of 66.3 percent rate exceeds the MPS and the CYE 2017 internal rate. The R12 rate also exceeds the HEDIS 90th percentile. The CYE 2017 AHCCCS aggregate rate for this measure is 60.8 percent. The goal is considered met based on the comparison of the reported FYTD rate to the MPS. MCP will continue its current interventions and utilize the PDSA cycle to monitor and evaluate any statistically significant changes.

- *Cervical Cancer Screening*—The MCP internal FYTD rate of 59.4 percent is below the MPS but meets the CYE 2017 internal rate, demonstrating that there has not been a decline in performance. The R12 rate of 59.4 percent is below the MPS but meets the CYE 2017 internal rate. The CYE 2017 AHCCCS aggregate rate for this measure is 50.5 percent. The goal is considered partially met based on the comparison of the reported FYTD rate to the MPS and the CYE 2017 internal rate. MCP understands that for CYE 2019 the MPS for this measure is 53 percent. During the third quarter of CYE 2018, MCP implemented monthly interactive well-woman outreach calls to members who are numerator noncompliant for breast cancer screening (BCS), cervical cancer screening (CCS), and chlamydia screening (CHL). MCP hopes that these interactive calls will improve well-woman screening rates. MCP will continue current interventions and utilize the PDSA cycle to monitor rates and evaluate any statistically significant changes.

- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*—The MCP internal FYTD rate of 95.8 percent exceeds the MPS and exceeds the CYE 2017 internal rate. The R12 rate of 95.7 percent exceeds the MPS and exceeds the CYE 2017 internal rate. The CYE 2017 AHCCCS aggregate rate for this measure is: 93.1 percent. The goal is considered met based on the comparison of the reported FYTD rates to the MPS. MCP understands that for CYE 2019 the MPS for this measure is 95 percent and current MCP performance exceeds that rate. MCP will continue its current interventions and utilize the PDSA cycle to monitor rates and evaluate any statistically significant changes.

- *Chlamydia Screening in Women—Total*—The MCP FYTD rate of 54.7 percent is below the MPS and slightly exceeds the CYE 2017 internal rate. The R12 rate of 53.7 percent meets the CYE 2017 internal rate but does not exceed the MPS. The CYE 2017 AHCCCS aggregate rate for this measure is 48.3 percent. The goal is considered partially met based

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[1-7] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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on the comparison of the FYTD rate to the MPS and the CYE 2017 internal rate. MCP understands that for CYE 2019 the MPS for this measure is 57 percent. During the third quarter of CYE 2018, MCP implemented monthly interactive well-woman outreach calls to members who are numerator noncompliant for BCS, CCS, and CHL screenings. MCP hopes that these interactive calls will improve well-woman screening rates. MCP will continue its current interventions and utilize the PDSA cycle to monitor rates and evaluate any statistically significant changes.

- *Developmental Screening in the First Three Years of Life*—MCP's FYTD rate for the entire 0–3-year-old population of 5.1 percent exceeds the baseline of 4.51 percent. However, this rate falls below the AHCCCS calculated baseline of 25.11 percent. The R12 rate for the entire 0–3-year-old population of 5.3 percent also exceeds the baseline of 4.51 percent. However, this rate falls below the AHCCCS calculated baseline of 25.11 percent. The goal is considered partially met based on the comparison of the FYTD rates to the CYE 2017 internal rates and the AHCCCS baseline rates. The rates for this measure are based on administrative-only (claims) data and only reflect developmental screening claims received from providers. Additionally, MCP value-based providers have added this performance measure to their CYE 2019 reporting and tracking. MCP will continue its current interventions and utilize the PDSA cycle to monitor rates and evaluate any statistically significant changes.

- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*—MCP's FYTD rate of 69.1 percent exceeds the MPS, the CYE 2017 internal rate, and the HEDIS 75th percentile. The R12 rate of 67.6 percent exceeds the MPS and the CYE 2017 internal rate. The CYE 2017 AHCCCS aggregate rate for this measure is 59.5 percent. The goal is considered met based on the comparison of the reported FYTD rates to the MPS. MCP understands that for CYE 2019 the MPS for this measure is 62 percent. MCP will continue to collaborate with two of our value-based providers to coordinate monthly outreach calls to parents and guardians of members 18 months of age who are in need of immunizations and/or well-visits. It is MCP's hope that outreach calls from the members' direct providers will prove effective in increasing the W15 rate. Through enhanced provider education at provider site visits and via provider outreach such as newsletters, MCP will continue working to better educate providers on the AHCCCS periodicity schedule, on accepted well-child visit coding, on combination sick- and well-visit coding, and on MCP's "unlimited" well-child visit policy. MCP will continue its current interventions and utilize the PDSA cycle to monitor rates and evaluate any statistically significant changes. Additionally, MCP has selected this and the W15 measure for its self-selected PIP topic for this population.

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*—MCP's FYTD rate of 64.9 percent is 1.1 percentage points below the MPS but slightly exceeds the CYE 2017 internal rate of 64.07 percent, demonstrating an improvement in performance. The R12 rate of 65.0 percent is 1 percentage point below the MPS but exceeds the CYE 2017 internal rate. The R12 rate demonstrates an improvement in performance. The CYE 2017 AHCCCS aggregate rate for this measure is 60.7 percent. The goal is considered partially met based

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| on the comparison of the reported FYTD rate to the MPS and the CYE 2017 internal rate. The current FYTD rate is within 2 percentage points of the CYE 2017 internal rate. During mid-year CYE 2018, MCP changed its annual W34 Summer Campaign member outreach call campaign to a monthly outreach call format. MCP will continue its monthly outreach calls to members in need of W34 well-child visits. Through enhanced provider education at provider site visits, and via provider outreach such as newsletters, MCP will continue working to better educate providers on the AHCCCS periodicity schedule, on accepted well-child visit coding, on combination sick/well-visit coding, and on MCP's "unlimited" well-child visit policy. During CYE 2019, MCP will administer a provider survey designed to determine what barriers impact the completion of timely well-child visits. MCP will continue its current interventions and utilize the PDSA cycle to monitor rates and evaluate any statistically significant changes. Additionally, MCP has selected this and the W15 measure for its self-selected PIP topic for this population. |

**Performance Improvement Projects**

**HSAG Recommendation Specific to MCP:** MCP should continue to monitor 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 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.

HSAG Recommendation Not Specific to MCP: 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 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.

MCP continued to monitor data related to the *E-Prescribing* PIP and found the implemented interventions to be successful. MCP used the two proportion Z-test for statistical analysis of data calculated both internally and externally by AHCCCS. The comparison of internal data for Remeasurement 1 to Remeasurement 2 demonstrated a statistically significant rate increase. (A data issue prevented MCP from reporting reliable baseline date; thus, MCP was unable to compare internal baseline rates to the remeasurement periods).

The MCP rates for Indicator 1, as calculated by AHCCCS for CYE 2017, represented a 5.4 percentage point improvement over the CYE 2016 rate and a 13.7 percentage point improvement over CYE 2014, which is statistically significant and meets the goal of demonstrating a statistically significant increase in the number of providers submitting electronic prescriptions, followed by sustainment for one year.

The MCP rates for Indicator 2, as calculated by AHCCCS for CYE 2017, represented a 3.5 percentage point improvement over CYE 2016 and a 9.2 percentage point improvement over

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| CYE 2014, which is statistically significant and meets the goal of demonstrating a statistically significant increase in the number of electronic prescriptions submitted, followed by sustainment for one year. |

MCP has achieved the goals of increasing the number of prescribers electronically prescribing prescriptions, of increasing the percentage of prescriptions submitted electronically in order to improve patient safety, and of maintaining that improvement. These improvements are evidenced in both the AHCCCS calculated data and MCP internal calculations.

| CAHPS |
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**HSAG Recommendations:** Perform root cause analyses; conduct frequent assessments of targeted interventions; use health information technology; share data; and facilitate coordinated care.

For the adult survey results, the overall rating for MCP continued to demonstrate year-to-year improvement, up 8.7 percentage points from 2017 and with 2018 rates 11 percentage points higher than the national scoring. The child measure showing the greatest improvement from the MCP 2017 survey to 2018 was the rating of *Specialist Seen Most Often* (up 8.9 percentage points from 2017), which was an area of focus for improvement from the 2017 survey results. The only 2018 rate that did not exceed the 2017 rate was the *Child Rating of All Health Care* rate. The 2018 rate was 0.29 percentage points lower than the 2017 rate, effectively meeting the 2017 rate. The goal is considered met based on the comparison of the 2018 CAHPS survey results to the 2017 CAHPS survey results.

Based on the outcomes, MCP will continue the current interventions. In addition, MCP will focus on removing barriers to care, which is central to improving the healthcare experience of plan members. MCP found that delays experienced by members while waiting for care, tests, or treatment negatively impact the members' experiences with care.

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| Performance Measures |

**HSAG Recommendations:** Focus efforts on the following: well-care visits for children, adolescent well-care visits, increasing screenings for cervical cancer, and increasing screenings for chlamydia in women.

- UFC's performance varied across the areas of quality and access. UFC's results indicated that 10 of the 14 performance measure rates fell below the MPSs for CYE 2016, indicating opportunities for improvement. Furthermore, eight performance measure rates demonstrated statistically significant declines from CYE 2015 to CYE 2016.
- The following are the initiatives that UFC initiated to improve the measures:
- *Well-Child Visits in the First 15 Months of Life* Interventions and Member and Provider Initiatives: Member annual first and third EPSDT reminder card; newborn member reminder postcard, indicating an EPSDT visit is a well child visit; provider mailing listing all members 0–15 months of age to outreach and schedule visits; provider site visits by EPSDT coordinator to review EPSDT requirements and list of members in need of

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services; childhood immunization refrigerator magnet mailed to members at 1 month of age; member letter about blood lead testing. Letter and educational information about sources of lead to the member at 11 months and 23 months; provider mailing listing members in need of a blood lead test; 1-, 2-, 4-, and 6-month EPSDT reminder postcards; 100 percent review of provider-submitted EPSDT forms to ensure provider compliance with the EPSDT Periodicity Schedule; continue partnership with select VBP providers to share information and develop collaborative outreach initiatives to ensure that members are receiving all preventative health services; member handbook indicating that a well-child visit/check is synonymous with EPSDT; reminder calls to the parent/guardian reminding them of the importance of the well-baby visits in accordance with the 0–15-month periodicity schedule; VBP agreements incentivizing providers for meeting the minimum performance standard on the 0–15 measure; provider education forum on EPSDT; choice of $50 gift card to Old Navy, Gap, or Subway for parent of baby member who receives at least six visits before turning 15 months, a well-child member incentive.

- *Well-Child Visits 3–6 Years of Age* Member and Provider Initiatives: member annual first and second EPSDT reminder card; member reminder postcard specific to 3–6-year-olds; provider site visits by EPSDT coordinator to review EPSDT requirements; provide 3–6-year-old gap-in-care lists; outbound member calls: outreach calls to guardians of members to schedule well-child visits and immunizations; Head Start mailing: annual mailing to guardians of 3- and 4-year-olds that includes a list of Head Start facilities; 100 percent review of provider-submitted EPSDT forms to ensure contractor compliance with the AHCCCS EPSDT Periodicity Schedule; Harkins gift card 3–6-year-old Well Child Member Incentive Program; partnership with select VBP providers to ensure that members are receiving all preventative health services; member handbook indicating that a well-child visit/check is synonymous with EPSDT; VBP agreements incentivizing providers for meeting the minimum performance standard on the *Well-Child 3–6* measure; provider forum education on EPSDT.

- *Adolescent Well-Care Visits* Member and Provider Initiatives: member quarterly adolescent reminder card; Harkins gift card incentive for adolescent well-care visits; outbound member calls to guardians of members to schedule well-child visit and immunizations; provider site visits: EPSDT coordinators visit provider sites to review EPSDT requirements and provide a member list of adolescents in need of an EPSDT visit; 100 percent review of provider- submitted EPSDT forms to ensure contractor compliance with the AHCCCS EPSDT Periodicity Schedule; partnership with select VBP providers to ensure that members are receiving all preventative health services; member handbook indicating that a well-child visit/check is synonymous with EPSDT; VBP agreements incentivizing providers for meeting the minimum performance standard on the adolescent well-care measure; provider education.

- *Children's Access to Primary Care Physician* Member and Provider Initiatives: member annual first and second EPSDT reminder card; provider mailing listing children in need of a well-child visit; member annual reminder postcard to schedule a dental visit; member newsletter including articles on the importance of annual well-child visits and

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| immunizations; Harkins gift card 3–6 years and 12–21 years well-child member incentive; 100 percent review of provider-submitted EPSDT forms to ensure contractor compliance with the AHCCCS EPSDT Periodicity Schedule; partnership with select VBP providers to ensure that members are receiving all preventative health services; member handbook indicating that a well-child visit/check is synonymous with EPSDT; VBP agreements incentivizing providers for meeting the minimum performance standard on the adolescent well-care measure. <br><br> • EPSDT Participation Member and Provider Initiatives: member annual first and second EPSDT reminder card; provider mailing listing children in need of well-child visits; member annual reminder postcard to schedule dental visits; member newsletter including articles on the importance of annual well-child visits and immunizations; Harkins gift card 3–6 years and 12–21 years well-child member incentive; 100 percent review of provider-submitted EPSDT forms to ensure contractor compliance with the AHCCCS EPSDT Periodicity Schedule; partnership with select VBP providers to ensure that members are receiving all preventative health services; member handbook indicating that a well-child visit/check is synonymous with EPSDT; VBP agreements incentivizing providers for meeting the minimum performance standard on the adolescent well-care measure. <br><br> • *Cervical Cancer Screening* Member and Provider Initiatives: quarterly gaps-in-care lists to providers; provider site visit education on cervical cancer screening requirements; member newsletter article on cervical cancer screening; provider manual information on cervical screening requirements; VBP collaboration- data sharing on cervical cancer screening performance. <br><br> • Chlamydia Screening Member and Provider Initiatives: quarterly gap-in-care lists to providers; provider site visit education on cervical chlamydia screening requirements; member newsletter article on chlamydia screening; provider manual information on chlamydia screening requirements; VBP collaboration and data sharing on chlamydia screening performance. |
| **Performance Improvement Projects** |
| **HSAG Recommendation:** Continue to monitor outcomes associated with reported interventions for the *E-Prescribing* PIP, and develop more interventions based on outcome data. |
| UFC noted that the Contractor demonstrated "statistically and substantively significant improvement" for both indicators (1 and 2) for the *E-Prescribing* PIP remeasurement period. |
| **CAHPS** |
| **HSAG Recommendations:** Perform root cause analyses; conduct frequent assessments of targeted interventions; use health information technology; share data; and facilitate coordinated care. |
| UFC focused on the following areas: <br><br> • Getting Needed Care: UFC conducted an analysis of the child population and identified the medical groups with a panel size of 50+ UFC members. The QM team is using this data to |

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for conducting site visits; max-packing materials are presented at VBP provider meetings, educating providers on the importance of max-packing. ("Max-packing" is a model designed to maximize each patient's office visit by allowing for as many of the patient's needs to be met during one office visit when feasible. For example, if a patient is scheduled for their annual physical in the fall and a subsequent appointment for a flu vaccination, the current office visit could be used to accomplish both, eliminating the need for a future appointment.)

- Getting Care Quickly: the network development team conducts surveys with PCPs and specialists quarterly for appointment availability and wait times. All results are communicated to the Quality Management Performance Improvement (QMPI) Committee for review and oversight; QM analyzed the no-show logs maintained by Customer Care and found no discernable trends or patterns beyond no-shows being commensurate with the size of the provider practice. Max-packing is included in provider talking points by QM, to be utilized during provider site visits. The quality department and network development teams will continue to educate providers during in-person visits and through newsletters and faxes.

- Coordination of Care: The network development team will work with the quality department to educate providers on promoting effective communication and coordination of care. Education includes quarterly provider newsletters, website posts, and quarterly provider forums. Action plans are tracked and presented in QMPI meetings.

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| Operational Reviews |
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**HSAG Recommendation:** 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.

UHCCP-Acute adopts policies on an as-needed basis and reviews said policies and procedures annually or as often as business or regulatory requirements dictate. UHCCP policies and procedures are instrumental in translating the company's strategies, mission, and values as well as laws and regulations into documented guidelines for management and staff to follow and act upon.

**HSAG Recommendations:** Regular monitoring to 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.

UHCCP-Acute presents new and substantially revised policies and procedures to the Policy Committee. The Policy Committee recommends approval or denial to Contractor management. If approved by Contractor management, the Policy Committee finalizes approval of the policy

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| and procedure. Policies and procedures are reviewed annually or as often as business needs or regulatory requirements dictate. The Policy Committee is comprised of a cross-functional team designated to provide oversight and to ensure that communication to all areas directly and indirectly impacted by these updates is provided and documented. Policies are then converted to PDFs and uploaded to the UHCCP HEART SharePoint, where they can be accessible. |
| **HSAG Recommendations:** Apply lessons learned from improving performance for one category of standards to other categories. Further, Contractors should use opportunities to address and discuss issues identified during ORs. |
| The UHCCP Quality Management Committee is responsible for reviewing the findings from the AHCCCS OR and to oversee the internal corrective actions led by the subject matter experts to address deficiencies. Oversight includes discussion and review of best practices as noted in previous ORs as a means to correct policies, procedures, and practices to address deficient standards. |
| **HSAG Recommendations:** Implement control systems to address specific findings in the CIS standard. |
| UHCCP-Acute had a process in CYE 2017 and carried this over to CYE 2018 that allows for payment of interest on all claims, including overturned claim disputes. Interest paid is reported to providers on the UHCCP provider remit. The response is broken down into two parts: claims and overturned claim disputes. |
| **Performance Measures** |
| **HSAG Recommendation:** Contractors should increase well-care visits for children and adolescents and increase screenings for cervical cancer screening and chlamydia in women. |
| For the well-care visit for children and adolescents, UHCCP-Acute implemented the following:<br><br>• UHCCP-Acute conducted a root cause analysis and identified the following factors negatively impacting well-care visits for children and adolescents: members whose 15-month birthday fell in the subsequent measurement period were not included in the current gaps-in-care reports given to providers; provider difficulty with scheduling the 15-month well-child visit due in part to the painful experience the child had with receiving the series of immunizations at 12 months of age and not wishing to repeat the experience as a subsequent well-child visit; incentivizing providers to close gaps in care; correspondence with the guardians of members less than 24 months of age was infrequent and not personalized; some guardians of healthy children had little interest in scheduling a well-child visit unless there was a corresponding requirement to obtain a well-child visit (for example enrollment in Head Start); some members obtained outpatient services from a provider other than their assigned PCP; providers might be providing developmental screening using a standardized tool recognized by the American Academy of Pediatrics but which may not be captured on UHCCP claims data because the tool was not approved by AHCCCS. |

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| • UHCCP-Acute initiated a series of new actions taken in CYE 2017 and carried over into CYE 2018 in order to improve the number and percentage of children and adolescents obtaining well-care visits: at birth, a personalized letter to the guardian of the newborn that includes a refrigerator magnet outlining the immunization and well-child schedule; at 3 months of age, a live outreach call to the guardian of the member reminding the guardian to schedule a well-child visit; at 4 months of age, an IVR message reminding the guardian of the member to schedule a well-child visit; at 6 months of age, a reminder card to schedule the 6-month well-child visit; at 9 months of age, a live call to the guardian of the member to schedule the 9-month well-child visit; at 11 months of age, IVR call remaining the guardian of the member to schedule the 12-month well-child visit; at 12 months of age, a postcard reminding the guardian of the member to schedule an appointment; at 14 months of age, IVR message to schedule the 15-month well-child visit.<br><br>UHCCP-Acute also implemented the following:<br><br>• A personalized member letter at age 13 months and 14 months to those members who are non-compliant for their immunizations, encouraging the parent of guardian of the member to schedule the 15-month well-child visit and to address the missing immunizations.<br>• Incorporated the member immunization record derived from ASIIS into the live agent outbound call list and eliminated the checking of ASIIS prior to outreach the member.<br>• A monthly provider letter and report that includes a list of 13- and 14-month-olds who are missing immunizations. The report will include the child's immunizations as recorded in ASIIS. The report will be available via the provider portal for UHCCP accountable care organizations.<br>• Provider site visits by the clinical practice consultant (CPC) include a list of all members less than 24 months of age so that the providers are aware of their assigned members not only in the current measurement period but in the subsequent measurement period as well.<br>• Provider financial incentive was expanded to 100 groups that had a sizable Medicaid population under 21 years of age, offering a financial incentive on the group's performance on the three well child measures.<br>• Member incentive for obtaining a well-child visit was offered to guardians of members 3–6 years of age and 12–20 years of age. The incentive was a $25 gift card in CYE 2017. In CYE 2018, the incentive for W34 was increased to $50.<br>• An "EPSDT Toolkit" was developed for the CPCs to use with their providers at the provider site visits. The toolkit outlined several AHCCCS requirements of providers, including information on developmental screening. The toolkit noted the AHCCCS approved tools and the process for billing and outlined the billing process for providing a well-child visit at the time of a sick visit.<br><br>For the cervical cancer screening and chlamydia screening in women, UHCCP-Acute conducted a root cause analysis and decided to implement the following:<br><br>• Expanded the number of CPCs from 7 to 13. Approximately 90 percent of the Medicaid membership is now assigned to groups that were assigned to CPCs. The CPCs review the adult gaps-in-care with their assigned providers. |

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| • A quarterly provider report that is mailed to providers that have fewer than 100 members assigned to their care. The gaps-in-care report includes women missing the cervical cancer screening or chlamydia screening. <br> • Initiated IVR calls to women in need of a cervical cancer screening or chlamydia screening. |

| Performance Improvement Projects |
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| **HSAG Recommendation:** Monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically. |
| During CYE 2017 and into CYE 2018, UHCCP-Acute continued to monitor the performance on the number and percentage of providers who prescribed at least one prescription electronically as well as the number and percentage of all prescriptions prescribed electronically. The results of this ongoing monitoring process resulted in UHCCP-Acute performing well during the second remeasurement period. The e-prescribing rate for providers who prescribed at least one prescription showed a statistically significant increase, from 63.75 percent to 73.73 percent. The percentage of prescriptions prescribed electronically showed a statistically significant increase, from 44.32 percent to 59.38 percent. |

| CAHPS |
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| **HSAG Recommendation:** Perform root cause analyses. |
| UHCCP-Acute performed exceptionally well on both the Adult Medicaid CAHPS scores and Child's <br><br> Medicaid CAHPS scores. However, an area for improvement was the composite measure, Getting Care Quickly. UHCCP-Acute scored a "2 Star" for the adult measure and a "3 Star" for the child measure. <br><br> UHCCP actions to improve upon the CAHPS survey results, follows the "Plan –Do-Study-Act" (PDSA) problem solving methodology. UHCCP conducted a root cause analysis on Getting Care Quickly and determined that the root causes for this level of performance were due to: <br><br> • Lack of provider awareness regarding appointment availability requirements. <br> • Lack of provider training by the provider advocates on appointment availability requirements. <br> • The alignment of members to high versus low value providers. <br> • Frequency of internal monitoring of appointment availability. <br> • Lack of member education on appointment availability. <br> • Lack of member education on the multiple resources available to the member in the event that the assigned PCP in unavailable. <br> • Member education on how to prepare for a visit with the doctor. |
| **HSAG Recommendation:** Conduct frequent assessments of targeted interventions. |
| Consistent with the findings from the root cause analysis, UHCCP-Acute increased the frequency of internal provider monitoring of appointment availability. In addition to |

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| monitoring provider appointment availability, UHCCP-Acute implemented a provider scorecard on the providers' performance on selected HEDIS measures, reflective of member access to care, including: *Children and Adolescent Access to Care; Adolescent Well Care Visits, Well Child six Visits by 15 Months of Age* and *Well Child 3–6 Years of Age*. The providers receive this feedback on a monthly basis from their assigned CPC. |
| **HSAG Recommendation:** Use health information technology. |
| UHCCP-Acute uses ClaimSphere, an NCQA accredited software program, to continuously monitor UHCCP-Acute performance as well as individual provider performance on the AHCCCS contractual performance measures. UHCCP-Acute performance is reflected on the Rolling 12- Month report. This report is generated monthly and calculates annual performance rates on the contractual performance measures. In addition, UHCCP-Acute uses the Patient Care Opportunity Report (PCOR) for provider feedback on performance on contractual measures. The provider report is furnished monthly and is a year-to-date summary report. In addition, the report has a member adherence file listing members assigned to the provider and in need of various access-to-care services. |
| **HSAG Recommendation:** 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. |
| UHCCP's Medical Program has designed health information systems to improve care coordination, providing exchange of physical and behavioral healthcare data to ensure the provision of the full continuum of inpatient and outpatient services. Implementation and ongoing development of electronic health records (EHRs) has improved communication between UHCCP and providers. These data systems function to improve timely, complete, trackable, and cost-effective exchange of information between UHCCP and partners. UHCCP has demonstrated the importance and motivation to lead to improved data exchange through the following activities:<br><br>• Promoting the use of HIE/Health Current among participating providers.<br>• Receiving and utilizing nightly admission, discharge, and transfer (ADT) alert system feed of hospitalization and emergency department utilization through HIE/Health Current to allow appropriate monitoring of clinical utilization.<br>• Tracking medical management clinicians of controlled substance prescriber monitoring program (CSPMP) to monitor and track appropriate opioid utilization.<br>• Evaluating EHR to assess appropriate medical utilization based upon medical necessity criteria for members admitted to EHR participating health systems/facilities.<br>• Exchanging electronic information within Provider Led Integrated Care Coordination (PLICC) program between PCPs and behavioral health providers.<br>• Uploading member records to HealthBI to identify clinical treatment plans, share information, and close gaps in care. |

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| • Exchanging information through the Prior Authorization & Notification (PAAN) information system for timely exchange of prior authorization for elective medical and behavioral health services.<br><br>Data captured through EHR systems enable monitoring, analysis, and evaluation to target specific populations, including members who have chronic and or complex conditions; are at risk or already experiencing poor health outcomes due to their disease burden; and are at high-risk for emergency department visits, inpatient admissions, readmissions within 30 days of discharge for any diagnosis, and overutilization of healthcare services. |

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| **Operational Reviews** |
| **HSAG Recommendation:** To complete the CAPs that remain open, CMDP will need to: complete an upgrade of the information management system and demonstrate 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 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). |
| • CMDP submitted information to AHCCCS for the five CAPs and is including the following updates:<br>• Delivery Systems (DS) 1—CMDP must utilize its provider call tracking/resolution time frames when assessing staffing needs.<br>Supporting documentation was submitted to AHCCCS reflecting staffing needs: provider services productivity review, staffing plan—workload and cost calculation. Documentation was also submitted reflecting resolution time frames: provider call tracking report process, provider request form reports process, corrective action procedure, visual management (huddle boards), and countermeasure template.<br>• DS 3—CMDP must ensure that its provider services reps are trained in provider inquiry handling and tracking including resolution time frames.<br>CMDP re-trained staff and attached training sheets.<br>• DS 7—CMDP must ensure that its policies and procedures address the process for taking systemic action (trending provider inquiries). The Contractor must demonstrate that corrective action is implemented when appropriate.<br>Documentation was submitted reflecting resolution time frames: provider call tracking report process, provider request form reports process. Documentation was submitted reflecting implementation of corrective actions: corrective action procedure, visual management (huddle board), and countermeasures template. |

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| • DS 9—CMDP must ensure it develops, distributes, and maintains a provider manual, and makes its providers and subcontractors aware of its availability. The Contractor's provider manual must include all requirements listed in ACOM 416. All requirements of this Standard must be outlined in policy or procedure.<br>CMDP made updates and revisions to Chapters 1, 5, 8, 9, and 10 of the CMDP Provider Manual for compliance with ACOM 416.<br>• Quality Management (QM) 28—CMDP must have a process for determining best practices related to PIPs and achieving significant improvement. The Contractor must identify opportunities for improvement utilizing their health information system implement Performance Improvement Projects to improve outcomes or results. CMDP developed and implemented a PIP to improve outcomes or results of EPSDT participation.<br>CMDP submitted a copy of the PIP with the 10/31 CAP Matrix update.<br>• Claims and Information Systems (CI)S 2—CMDP must ensure that its remits include the reason(s) for denials and adjustments, a detailed explanation/description of payments less than billed charges, for denials and adjustments.<br>CMDP implemented updated logic for remits including listing all denial reasons/edits and coordination of benefits (COB) field information when applicable. A service ticket remains open for the additional requirement to include the header on every page of the Remittance Advice.<br>• CIS 5—CMDP must ensure that it pays applicable interest on all claims, including overturned claim disputes.<br>Service desk ticket number 72123 represents a request for resources to conduct research toward work efforts to have interest calculated at the claim line-level prior to payment runs; the target date for completion of research/viability assessment was set for November 30, 2018.<br>• Third Party Liability (TPL) 5—CMDP must demonstrate it appropriately files and releases liens on total plan casualty cases that exceed $250.<br>CMDP submitted evidence to support appropriate filing and release of liens on total plan casualty cases exceeding $250 during the month of June 2018. AHCCCS subsequently requested changes to the lien-filing documents. The requested changes were implemented, and new liens were filed. |
| **Performance Measurement** |
| **HSAG Recommendation:** CMDP should focus efforts on increasing screening for chlamydia in women and ensuring that 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. |
| *Chlamydia Screening in Women*:<br>CMDP approaches issues related to sexual health from a trauma-informed perspective which includes the youth's right to privacy and confidentiality. (The CMDP population is children in out-of-home care, some of whom have been the victims of sexual violence.) General education on chlamydia and other sexually transmitted illnesses (STIs) are provided to all youth in |

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| CMDP's care. CMDP, in collaboration with the Adolescent Health Task Force, created the Adolescent Health Toolkit, which includes information on STIs, among other topics. CMDP does not conduct targeted outreach to members regarding STI screening. Education to PCPs includes the need to screen all teens for STIs and promote best practices for adolescent care (which includes screening for STIs, follow-up, counseling, and appropriate treatment). As CMDP focuses on improving the EPSDT rates, an increase in the STI screening rates for all youth is expected. |

Developmental Screening:

CMDP continues to direct its efforts toward *Developmental Screening in the First Three Years of Life* through a PIP and uses the Department of Child Safety (DCS) Management System to track progress. In May 2017, CMDP began its onboarding pilot. The purpose of onboarding is to provide real-time education to new foster caregivers; assist in obtaining appropriate, timely health services for the children; and link foster caregivers with supports available to children and foster families. Since CMDP has realized measured success, the onboarding unit became a part of CMDP's organizational infrastructure. Additional target efforts through this outreach mechanism will be used to increase the number of CMDP children receiving a developmental screening. Although the scope of the intervention is broader than developmental screening, CMDP reasons that improvement in this area may positively impact developmental screening rates.

| Performance Improvement Projects |
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| **HSAG Recommendations:** CMDP continues to monitor outcomes associated with the progress of the PIP interventions to increase providers prescribing electronically and prescriptions sent electronically. |
| CMDP identified 98.8 percent of providers as prescribing at least one prescription electronically. This is an increase percentage change of 38.3 percent.<br>CMDP identified that 64.3 percent of medications were prescribed electronically for this population. This reflects a relative percentage of change increase of 3.9 percent from CYE 2017.<br>CMDP will continue to monitor e-prescribing to maintain or increase percentages. |

| CAHPS |
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| **HSAG Recommendations:** Perform root cause analyses; conduct frequent assessment of targeted interventions; use health information technology; share data; and facilitate coordinated care. |
| • Root Cause Analyses and Targeted Interventions: To measure performance, CMDP uses the DCS Management System. The DCS Management System is an intentional management system focused on outcomes for the children and families that DCS serves. The DCS Management System focuses on setting targets, tracking performance against those targets, identifying gaps between desired and actual performance, closing this gap by conducting problem solving to identify root causes, and implementing countermeasures. |

## CMDP

One key component of the DCS Management System is Visual Performance Management. CMDP uses Visual Performance Management (huddle boards) to measure and display key performance indicators (KPIs) for the areas of people, quality, service level, and cost. The measurements are set against a target so that, at a glance, performance can be easily seen. CMDP conducts weekly reviews of performance at the unit level and also conducts a CMDP-wide huddle every other week. When issues are noted, CMDP uses systematic methods to prevent issues from recurring. Various tools are used to identify root causes and actions put into place with timelines. The results of this structured internal monitoring through visual management (huddle boards) and use of other tools are reported to the chief medical officer (CMO), executive management, DCS leadership, QMPI Committee, and providers, as appropriate.

- Use Health Information Technology (HIT) and Shared Data: CMDP currently utilizes HIT to identify populations for case management. CMDP utilizes the PBM information system and claims information systems to identify children with chronic health conditions for care coordination, for psychotropic medication oversight, and for other health plan initiatives such as e-prescribing. CMDP utilizes the ASIIS system to obtain immunization information and for care coordination. CMDP is exploring additional HIT options to enhance care coordination.

- Facilitate Coordinated Care: Coordinated care occurs through a variety of methods. Two key methods CMDP facilitates related to coordinated care are the onboarding unit (OBU) and enrollment transition information (ETI). The OBU provides support and outreach to foster caregivers and DCS specialists for children upon entry into DCS out of home care; providing information, resources, and support related to needed and timely health services; barrier elimination; and finding, arranging, and assisting caregivers to benefit from medical, social and/or community resources. ETI: When a child transitions to CMDP or from CMDP to another AHCCCS Contractor, CMDP facilitates coordinated care through use of an ETI form to transition to CMDP: CMDP receives medical and treatment plan information on ETI forms from other Contractors. The information is reviewed for open authorizations and significant medical conditions to ensure continued treatment and services coordination and to determine any need for member education. When children and youth return home, are adopted, or reach the age of majority, CMDP sends medical and treatment plan information on ETI forms to the receiving AHCCCS health plan. This includes pertinent medical history and active conditions as well as treatment information. CMDP is housed within DCS. This allows CMDP to access important information about children and youth in care. In mid-2020 DCS is moving to a new information system, Guardian. Guardian is a child-centered, user-friendly technology solution focused on quality data and improved processes to support all DCS work for the safety of Arizona's children. Guardian will include a child's health information, providing DCS specialists (case managers) and CMDP healthcare professionals to better coordinate care for this population of children with special healthcare needs.

In October 2020, behavioral health services will be integrated into CMDP. DCS is exploring an administrative services organization model. This healthcare delivery model

| CMDP |
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| allows CMDP to focus on meeting the healthcare needs of children and their transitions and supporting foster caregivers while garnering an organization to provide provider network, claims system, and other IT efficiencies support. |

## 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 Contractors:

- Validate Contractor PIPs—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—review performed by AHCCCS.

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

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 42 CFR §438.68, CMS will require validation of MCO, PIHP, and PAHP network adequacy as applicable. For the purposes of this report, network validation is not applicable.

### *Optional Activities*

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

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

AHCCCS has numerous sophisticated processes for monitoring both the Contractors and its own performance in meeting all applicable federal and State requirements, its goals and internal objectives, and its policies and procedures. AHCCCS regularly prepares meaningful, detailed, and transparent reports documenting the results of its assessments. AHCCCS is transparent with performance results, posting to its website both provider performance reports and the required quarterly reports it submits to CMS. AHCCCS 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. 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.

## Quality, Access, and Timeliness

CMS has identified the domains of quality, access, and timeliness as keys to evaluating MCO performance. HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs in each of these domains.

- **Quality**, as it pertains to external quality review, means the degree to which an MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement.[2-1]

- **Access**, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network Adequacy Standards) and §438.206 (Availability of Services). Under §438.206, availability of services means that each state must ensure that all services covered under the state's plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that the MCO, PIHP, and PAHP provider networks for services covered in the contract meet the standards developed by the State in accordance with the network adequacy standards (§438.68). Any state that contracts with an MCO, PIHP, or PAHP to deliver Medicaid services is required by §438.68 to develop and enforce network adequacy standards.[2-2]

- **Timeliness**. Federal managed care regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services. HSAG extends the definition of "timeliness" to include other federal managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing expedited member grievances and appeals and providing timely follow-up care. In addition, NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2-3] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.

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[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

[2-2] Ibid.

[2-3] National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.

## 3. Overview of the Arizona Health Care Cost Containment System (AHCCCS)

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 (SB) 1457 into law, ending the enrollment freeze on the KidsCare program. Children who qualify for this program receive care through AHCCCS Contractors.

Effective October 1, 2018, AHCCCS implemented a delivery system reform that allows members to access physical and behavioral healthcare services through a single integrated health plan, AHCCCS Complete Care (ACC). AHCCCS anticipates that with one plan, one provider network, and one payer, healthcare providers will be better able to coordinate care and members will more easily navigate the

system. As a result, AHCCCS expects member health outcomes to improve. Service delivery has been restructured into the three geographical services areas (GSAs): North, Central, and South.

Members continue to have a choice of health plans in their geographic service areas and to have access to a network of providers and the same array of covered services. Regional Behavioral Health Authorities (RBHAs) continue to provide specific crisis services and to serve members with a serious mental illness, children in foster care, and Department of Economic Services/Division of Developmental Disabilities (DDD) eligible members. American Indian members have the choice of enrolling in an ACC managed care plan or the American Indian Health Program (AIHP) and a Tribal RBHA when available. American Indian members have the same access to Indian Health Service providers, Tribal 638 providers, and Urban Indian Health providers. No change occurred for Arizona Long Term Care System (ALTCS) .

Prior to implementation, AHCCCS monitored the ACC plans' readiness activity, including but not limited to the plans' effort in building networks which include those providers that have historically served Arizona's Medicaid population, their efforts to ensure the recruitment of high caliber staff with expertise in the full continuum of services and supports offered by integrated care products, and their adherence to the contractual mandate requiring availability of nurse triage services. ALTCS provides acute care, behavioral health services, long-term care, and case management to AHCCCS members who are elderly, physically disabled, or developmentally disabled and who meet the criteria for institutionalization.

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

Most recently, as part of Governor Ducey's administrative simplification initiative, behavioral health services were integrated at AHCCCS, eliminating the Arizona Division of Behavioral Health Services (DBHS) that historically provided behavioral health services through a contract with AHCCCS and subcontracts with the 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.

In October 2013, children enrolled in the Acute Care Program who had a Children's Rehabilitative Services (CRS) qualifying diagnosis were enrolled into one integrated CRS Contractor, UnitedHealthcare Community Plan (UHCCP). This was done in order to decrease fragmentation and reduce member confusion; ensure optimal access to primary, specialty, and behavioral care; enhance coordination of all service delivery; improve member outcomes and satisfaction; and streamline administration. At the same time, children with CRS qualifying conditions and enrolled in the ALTCS program, other than in DDD, were fully integrated into their ALTCS Contractors' provided services, including all primary, specialty, long-term, and behavioral healthcare related to the members' CRS

conditions. Starting on October 1, 2018, CRS members will need to choose an ACC health plan for all services.

# AHCCCS Waiver Amendment Requests and Legislative Updates

AHCCCS submitted two waiver amendment requests in CYE 2018 that are still pending with CMS.

## AHCCCS Works Waiver Amendment

Pursuant to Arizona Revised Statutes (ARS) 36-2903.09 and taking into consideration over 500 public comments, AHCCCS submitted to CMS a waiver amendment request on December 19, 2017, seeking authority to implement community engagement requirements and a five-year maximum lifetime benefit limit for certain able-bodied AHCCCS members. This waiver amendment, titled "AHCCCS Works," is designed to provide low-income, able-bodied adults with the tools needed to gain and maintain meaningful employment, job training, and education. AHCCCS proposed that able-bodied adults between the ages of 19 and 55 who do not qualify for an exemption will be required to meet the following activities or combination of activities for at least 20 hours per week to qualify for AHCCCS coverage: be employed or actively seek employment, attend school, or partake in an employment support and development program as defined in the waiver request.

AHCCCS sought broad-based stakeholder feedback regarding the AHCCCS Works waiver amendment in accordance with 42 CFR 431.408. In January 2017, over 140 participants attended AHCCCS community forums in Phoenix, Flagstaff, and Tucson and participated in an in-person tribal consultation. In addition, AHCCCS received more than 500 written public comments, including 14 letters from tribal nations and tribal affiliated organizations regarding this issue.

## Prior Quarter Coverage Waiver Amendment

AHCCCS submitted a waiver amendment request on April 6, 2018, to CMS seeking to limit retroactive coverage to the month of application, consistent with Arizona's historical waiver authority prior to January 2014. AHCCCS sought stakeholder feedback regarding the Proposal to Waive Prior Quarter Coverage in accordance with 42 CFR 431.408. AHCCCS conducted public forum meetings in Flagstaff, Phoenix, and Tucson. In addition, the waiver amendment was presented at the State Medicaid Advisory Committee (SMAC) meeting on February 7, 2018, and in a tribal consultation meeting on January 11, 2018.

The following are the legislative bills, provisions of the state fiscal year (SFY) budget package, assigned workgroups, and changes to professional scope of practice and reporting requirements that impacted AHCCCS as written in the 2018 legislative report.

- House Bill (HB) 2228—Exempts American Indians and Alaska natives from the provisions outlined under ARS 36-2903.09 (work requirements, five-year limit, cost sharing).

- HB 2235—Formally recognizes and establishes scope of practice for Dental Health Aide Therapists (DHAT).
- HB 2324—Recognizes community health workers by requiring Arizona Department of Health Services (ADHS) to adopt rules relating to the establishment and administration of a voluntary certification process; including relevant scope of practice, minimum qualifications, and core competencies.
- SB 1296—Requires the State, counties, and municipalities to ensure that communications with persons with disabilities, including online communications and emergency communications, are equally as effective as its communications with persons without disabilities.
- SB 1450—Renames the Human Rights Committees to Independent Oversight Committees and transfers responsibility for these committees to the Arizona Department of Administration (ADOA), from the Department of Economic Security (DES), the Department of Child Safety (DCS), and AHCCCS.

The Opioid Special Session enacted the following provisions effective April 26, 2018:

- The sum of $10 million was appropriated from the state general fund in SFY 2017–2018 to the substance use disorder services fund established by ARS 36-2930.06 for the purpose of providing services for the Non-Title XIX population.
  - Monies are not to be used for those eligible under Title XIX or Title XXI.
  - Contractor payments are to be made in accordance with contracts or, in the absence of a contract, at the capped fee schedule rate established by AHCCCS.
  - The Contractor shall submit expenditure reports monthly for reimbursement of services provided under the agreement.

The SFY 2018–2019 budget package included the following:

- Total of $9,943,700 for behavioral health services in schools.
- Amount of $100,000 for a suicide prevention coordinator to assist school districts and charter schools in suicide prevention efforts.
- Funds to increase inpatient and outpatient hospital rates by 2.5 percent in SFY 2018–2019 based on hospital performance on established quality measures, in addition to rate adjustments that would otherwise be actuarially determined for SFY 2018–2019.
- Monies to increase skilled nursing facility and assisted living facility provider rates by 3 percent in SFY 2018–2019 in addition to rate adjustments that would otherwise be actuarially determined for SFY 2018–2019.
- Amounts of $11 million from the state General Fund and $25,460,100 from developmental disability (DD) Medicaid expenditure authority are appropriated in SFY 2018–2019 to DES for one-time assistance to address DD provider cost increases resulting from the enactment of Proposition 206.
- The sum of $2 million is appropriated from the state General Fund in SFY 2018–2019 to DES for a one-time increase for state-only room and board expenses funded by the DDD.

- The amount of $900,000 in savings is generated by eliminating the AHCCCS Hospital Loan Residency Fund (ARS 36-2921).
- If a behavioral health inpatient facility, as defined in rule by the Director of DHS, and a Contractor or RBHA do not enter into a contract, the reimbursement level for behavioral health services provided on dates of admission on or after July 1, 2018, for that behavioral health inpatient facility is 90 percent of the capped fee-for-services (FFS) schedule. This policy applies retroactively to as well as from and after June 30, 2018.
- Laws 2017, Chapter 309, Section 13, as amended by HB 2659 related to increased disproportionate share hospital (DSH) payments, applies retroactively to as well as from and after June 30, 2017. DSH amount is now $113 million rather than $108 million.
- The amount of $300,000 and 12 FTEs for the American Indian Health Program (AIHP) staffing and a reduction of $545,000 for the AIHP administrative shift.
- Incorporates $2.5 million in savings from ending prior quarter coverage as of July 1, 2018.

Enacted legislation requires the following new reports:

- On or before September 1, 2019, AHCCCS, in consultation with the Arizona Department of Education (ADE), shall report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Director of the Joint Legislative Budget Committee (JLBC) and the Director of the Office of Strategic Planning & Budgeting (OSPB) on the suicide prevention coordinator's accomplishments in SFY 2018–2019.
- On or before January 1, 2019, AHCCCS and ADHS shall jointly report to JLBC how grant monies for states to address the opioid epidemic included in the Consolidated Appropriations Act, 2018 (P.L. 115-141) will supplement the monies appropriated to AHCCCS pursuant to Laws 2018, First Special Session, Chapter 1.
- Effective January 1, 2019, requires ADHS to report "annually" from data gathered from AHCCCS (SB 1394) all of the following:
  - The total number of abortions partially or fully paid for with state monies through AHCCCS.
  - The total amount of state monies used to pay for abortions and expenses incidental to those abortions.
  - The total number of abortions, if any, paid for with state monies and performed out of state.
- On or before December 1, 2018, AHCCCS shall report the current number of behavioral health residential facility beds and supportive housing beds available in this state for adults who have a serious mental illness.

Enacted legislation established the Diabetes Action Plan Team within ADHS.

# AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for State Fiscal Years 2018–2023 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 core values:[3-1]

- 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.
- Core Values:
  - Passion: Good health is a fundamental need of everyone. This belief drives us, inspires and energizes our work.
  - Community: Healthcare is fundamentally local. We consult with, are culturally sensitive to, and respond to the unique needs of each community we serve.
  - Quality: Quality begins as a personal commitment to continual and rigorous improvement, self-examination, and change based on proper data and quality improvement practices.
  - Respect: Each person with whom we interact deserves our respect. We value ideas for change, and we learn from others.
  - Accountability: We are personally responsible for our actions and understand the trust our government has placed on us. We plan and forecast as accurately as possible. Solid performance standards measure the integrity of our work. We tell the truth and keep our promises.
  - Innovation: We embrace change, but accept that not all innovation works as planned. We learn from experience.
  - Teamwork: Our mission requires good communication among interdependent areas inside and outside the agency. Internally, we team up within and across divisions. Externally, we partner with different customers as appropriate.
  - Leadership: We lead primarily in two ways: by setting the standards by which other programs can be judged and by developing and nurturing our own future leaders.

The strategic 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 and AHCCCS fee schedule differentiation for all lines of business.

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[3-1] *AHCCCS Strategic Plan State Fiscal Years 2018-2023* Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_18-23.pdf. Accessed on: October 29, 2018.

- Reduce administrative burden on providers while expanding access to care.
- Successfully implement program integrity strategies.
- Modernize 1115 Waiver to provide new flexibilities to the State.

**2. Pursue continuous quality improvement.**

- Achieve and maintain improvement on quality performance measures.
- Leverage American Indian care coordination initiatives to improve health outcomes.
- Develop comprehensive strategies to curb opioid abuse and dependency.

**3. Reduce fragmentation driving toward an integrated sustainable healthcare system.**

- Establish a system of integrated plans and support provider integration to better serve all AHCCCS members.
- Leverage integrated Health Information Exchange to improve outcomes and reduce costs.
- Improve access for individuals transitioning out of the justice system.

**4. Maintain core organizational capacity, infrastructure, and workforce planning that effectively serves AHCCCS operations.**

- Promote activities that support employee engagement and retention and successful succession planning.
- Strengthen system-wide security and compliance with privacy regulations.
- Continue implementation of the Arizona Management System.

## *Key Accomplishments for AHCCCS*

Following are key accomplishments highlighted by AHCCCS in the AHCCCS Strategic Plan, SFYs 2018–2023:

- AHCCCS successfully defended in court the current statutory structure of the Hospital Assessment funding.
- AHCCCS successfully awarded the ALTCS request for proposal (RFP) and transitioned over 9,000 members on October 1, 2017.
- The ALTCS program began implementing a new eligibility system in November 2017.
- The Office of Human Rights eliminated the waitlist for special assistance services and currently provides assistance to the largest number of individuals ever. The Office of Human Rights has 2,504 individuals identified as requiring special assistance and provides direct advocacy via assignment to 702 members.

- AHCCCS implemented a new assessment policy and streamlined demographic reporting to reduce provider and member administrative burdens.
- AHCCCS received approval from CMS to begin the American Indian Medical Home program and has begun the process of implementation.
- AHCCCS received approval for a $300 million Targeted Investments Program, helping facilitate integration at approximately 500 provider sites across the state.
- AHCCCS established new value-based purchasing (VBP) strategies for nursing facilities (NFs) and providers who utilize e-prescriptions.
- AHCCCS completed a rebase of the All Patient Refined Diagnosis Related Groups (APR-DRG) methodology, better aligning inpatient reimbursement with current data.
- AHCCCS Leadership Academy was established, providing an opportunity for 30 staff to broaden perspective about the Agency's mission, explore key issues within healthcare, better understand the healthcare delivery system, and build personal networks.
- AHCCCS expanded access to Hepatitis C medication while lowering overall drug costs.
- AHCCCS implemented several strategies to combat the opioid epidemic, including implementing seven-day opioid-naïve fills.
- Cross-agency collaboration between AHCCCS, Department of Corrections (DOC), and county justice partners resulted in over six thousand incarcerated individuals becoming eligible for AHCCCS prior to release.
- The number of Health Information Exchange (HIE) providers increased from 250 to 350.
- AHCCCS increased the funding for physicians who are affiliated with graduate medical education by $40 million.
- AHCCCS implemented a new reimbursement methodology for freestanding emergency departments.
- AHCCCS Office of the Inspector General completed a review by CMS; the results were positive.
- AHCCCS transitioned approximately 130,000 acute members as part of the closures of Phoenix Health Plan and Maricopa Health Plan.
- AHCCCS began registering board-certified behavior analyst (BCBA) providers.
- AHCCCS held four quarterly tribal consultations, which saw the largest turnout in AHCCCS history.
- AHCCCS completed a request for information (RFI), held public meetings, and released the largest procurement in the history of Arizona for AHCCCS Complete Care.
- AHCCCS participated in the Repeal and Replace discussions and published timely analysis of proposed legislation.
- For CYE 2018, the overall weighted average capitation rate increase was 2.9 percent, which continues the overall trend for capitation rate growth of below 3 percent for the program.
- AHCCCS continued to have overall employee engagement scores that far exceeded the statewide average.

# 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 §438.340 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 and AHCCCS' Quality Strategy was first established in 2003. Since that time, AHCCCS has revised the Quality Strategy to reflect AHCCCS' innovative approaches to member care and continuous quality improvement efforts. 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 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 draft was completed, submitted to CMS for review and approval, and posted to the AHCCCS website on July 1, 2018.

AHCCCS' Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and results-based performance improvement. AHCCCS designed the Quality Strategy to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. AHCCCS' Quality Strategy identifies and documents issues related to those standards and encourages improvement through incentives or, when necessary, through regulatory action.

The Quality Strategy aligns with AHCCCS' mission and vision and the Strategic Plan, all of which outline overarching goals that provide direction for SFYs 2018–2023. The Quality Strategy outlines AHCCCS' commitment to transparency, stakeholder engagement, and the provision of quality care and services to members. Since 2003, the emphasis of AHCCCS' Quality Strategy has shifted from process measures to more comprehensive outcomes-based measurement and innovative delivery system design. The Quality Strategy provides a framework for improving and/or maintaining members' health status, providing focus on resilience and functional health of members with chronic conditions.

AHCCCS continued to demonstrate innovative and collaborative approaches to managing costs while improving quality of systems, care, and services. The draft July 1, 2018, Quality Strategy, Assessment and Performance Improvement Report (Quality Strategy); the 2018–2023 strategic plan, and the quarterly quality assurance/monitoring activity reports 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, as well as improve member health outcomes.

## Quality Initiative Selection and Initiation

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.

## Systemwide Quality Initiatives/Collaboratives

### 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 Contractors. 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 (SMI) 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 Regional Behavioral Health Authority (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.

On October 1, 2018, AHCCCS offered fully integrated contracts to manage behavioral health and physical health services to children (including children with Children's Rehabilitative Services [CRS] eligible conditions) and adult AHCCCS members not determined to have SMI. AHCCCS also proposed 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.

Contracts awarded to three MCOs throughout Arizona to administer Arizona's integrated long-term care system, were implemented on October 1, 2017. Contracts were awarded based on the bidder's proposed approaches for care and treatment of ALTCS individuals using a fully integrated care perspective at both the systemic and direct care levels (e.g., use of health homes, electronic health records, coordinated case management, collaboration between behavioral and physical health). An additional expectation is centered on their ability to demonstrate a more thorough understanding and use of Arizona's longstanding model of behavioral health service delivery, in conjunction with traditional ALTCS physical healthcare activities. Although Arizona's ALTCS model has historically provided integrated care that included behavioral health treatment, emphasis was added to promote greater use of Arizona's behavioral health model, particularly regarding individuals who have been determined to have a serious mental illness (SMI).

## AHCCCS Complete Care (ACC)

AHCCCS states that that healthcare is most effective and efficient when it treats the patient holistically. Since its inception in 1982 and under the leadership of several directors, AHCCCS has worked to

integrate physical and behavioral healthcare service delivery. AHCCCS has found that evidenced-based studies demonstrate mental health and physical health are dependent on each other and that optimal care includes that link. AHCCCS also stated that studies demonstrate the significant cost-savings resulting from integrating care.

Prior to October 1, 2018, most of the 1.8 million AHCCCS members in Arizona were enrolled in at least two managed care health plans—one for physical healthcare services and a second for behavioral healthcare services.

Throughout 2017 and 2018, AHCCCS has been working to further this strategic goal of healthcare integration. In March 2018, AHCCCS took a large step toward this goal by awarding integrated managed care contracts to seven AHCCCS Complete Care (ACC) health plans. The seven ACC plans throughout the state will manage a network, provide all covered physical and behavioral health services, and be the only Medicaid payer to the ACC providers. The ACC plans will also provide services for members with Children's Rehabilitative Services (CRS) conditions. These CRS members had been restricted to a single plan and now have choice of all ACC health plans offered in their service area.

Success was achieved through a committed team of AHCCCS staff throughout the agency that over the last two years achieved all of the following:

- Obtained stakeholder feedback.
- Conducted community forums.
- Issued and scored a request for proposal.
- Awarded ACC plan contracts without protest.
- Worked with ACC plans to ensure system and plan readiness to serve members.
- Undertook significant information system changes to ensure that members were enrolled correctly for integrated services and ACC plans and that providers had access to information by October 1, 2018.
- Made comprehensive policy and contractual changes as well as provided ongoing communication and education to the community, members, and staff.

The results of the actual October 1 implementation and transition of members to ACC plans have been incredibly successful. From the contract awards that were not protested to health plan and agency system transition on October 1st, the reports have been positive.

With the implementation of AHCCCS Complete Care, more than 1.5 million AHCCCS members now have a single health plan for physical and behavioral healthcare services. A single health plan will be easier for members and providers to navigate, with one network and a single payer. One health plan can streamline care coordination at the health plan and provider levels and work to improve the member's whole health.

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

The 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 preventative 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.

Member 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 preventative 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.

The overarching goal of this initiative is to reduce the prevalence of opioid use disorders and opioid-related overdose deaths. The initiative approach includes developing and supporting state, regional, and local-level 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 receiving combinations of opioids and benzodiazepines.
- Increasing access to and participation and retention in medication-assisted treatment (MAT).
- Reducing the number of opioid-naive members unnecessarily started on opioid treatment.
- Promoting best practices and improving care process models for chronic pain and high-risk members.

The Medication Assisted Treatment – Prescription Drug Opioid Addiction Program (MAT-PDOA) grant, awarded to AHCCCS in September 2016, aims to target states having the highest rates of primary treatment admission for heroin and opioids. The primary goal of AHCCCS' MAT-PDOA program is focused toward engaging individuals diagnosed with opioid use disorder and involved with the criminal justice system. Specifically, intention is to focus on outreaching and screening individuals within four months of their release date to engage them in medication-assisted treatment (MAT) and provide care coordination as they reenter the community. The project also seeks to improve access to MAT services for these individuals by improving infrastructure and collaboration among criminal justice entities and opioid treatment programs (OTPs). Additionally, the project will expand infrastructure and build capacity for State, regional, and local collaborators to implement integrated strength-based treatment

planning, screening, and assessment for co-occurring disorders for the target population by increasing participation in MAT services.

To date the MAT-PDOA program has enrolled 168 participants into the program to receive services. Among those enrolled, program outcomes include reductions in crimes committed, nights spent in jail, and drug-related arrests. The program has also produced an increase in gainful employment as well as increased housing acquirement and treatment retention. MAT-PDOA providers have expanded collaboration and engagement efforts with correctional facilities, re-entry centers, parole and probation departments, and drug courts. The program has also expanded services to the Graham County correctional facilities and drug court to assist an area that has been heavily impacted by the opioid epidemic and which, among other counties, has one of the highest overdose rates.

To expand training and education, AHCCCS will host two free MAT symposiums, in Mohave and Graham County, in efforts to display clinically effective prevention and treatment strategies to best serve those impacted by the opioid epidemic. Topics will also include current State initiatives being implemented to combat this rapidly emerging crisis. The content of the symposiums is designed for MAT providers, substance use disorder treatment providers, physical health providers, harm reduction organizations, justice system partners, and interested community 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 2018, the following efforts supporting this initiative were made:

- Arizona opened five 24/7 centers of excellence (COE) for opioid treatment on demand during year one. The COE is an opioid treatment program in a designated "hotspot" that expanded its hours to be open for intakes around the clock and for warm handoff navigation care post intake. Arizona has also opened two medication units in rural Arizona to make MAT more accessible among those communities.
- AHCCCS launched a concentrated effort through the Opioid State Targeted Response (STR) grant to increase peer support utilization for individuals with opioid use disorder. Through the STR grant, 34 additional peer support navigators have been hired in identified hotspots in Arizona; and efforts to include peer support navigation in centers of excellence, jails, emergency departments, and for first responders at the scene in hotspot areas have increased. Through STR funding, Arizona has launched a real-time auto-dispatch model with Phoenix Fire Department (PFD); when PFD receives an opioid-related call, a peer support staff member from the 24/7 OTP clinic in Phoenix is also dispatched to arrive on the scene to help navigate individuals to resources. Arizona has also launched its first law enforcement "pre-booking" model in Tucson. Peers are called on scene to provide navigation to the 24/7 OTP as a mechanism for an alternative to incarceration.
- A total of 8,798 Naloxone kits were purchased for distribution to law enforcement agencies during the first year of the STR grant.

## Targeted Investments Program

On January 18, 2017, 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 participating 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.

As part of the AHCCCS Targeted Investments Program initiative, use of the Early Childhood Service Intensity Instrument (ECSII), an incentive-based requirement, was adopted by the providers who volunteered to participate in the program for use with children birth to 5 years of age. The ECSII is a screening tool designed to examine risk and protective factors in the environment of infants and toddlers through the use of six major domains: quality of the relationship between child and caregiver; caregiving environment; developmental, emotional, or functional status of the child; and degree of safety within the child's environment. Domain scores are used to help both the formal and informal systems of care that surround the child to coordinate services based on intensity of need.

The ECSII tool was developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and is designed to identify intensity of services needed to improve early intervention outcomes for at-risk infants and toddlers. The tool promotes a collaborative and integrated approach among the various systems working on behalf of the child (behavioral and physical health, educational, foster care system, and State agencies). The ECSII is based on a child-centered, family, and team-driven approach. It is expected to identify the need for behavioral health intervention sooner than what may otherwise be possible, and to thereby improve outcomes.

To satisfy specific requirements for the Targeted Investment Program ECSII, providers were required to document the practice's policies and procedures for use of the ECSII, and to attest that the results of the ECSII were in the electronic medical record, by September 30, 2018. By September 30, 2019, providers will attest that the practice performed the ECSII 85 percent of the time and incorporated service intensity recommendations into the integrated treatment plan.

The following are highlights of the Targeted Investments (TI) program implementation activities conducted by AHCCCS during CYE 2018:

- AHCCCS developed a portal for TI participants and established the reporting system for TI program participants to submit attestations of milestone completion and to upload documents for validation.
- Collaborated with the State health information exchange (HIE) to onboard approximately 40 provider organizations to prepare them to receive admission, discharge, and transfer alerts from the HIE by September 2018.
- Made numerous presentations on the TI program to a range of internal and external stakeholders, explaining the integration and whole person care goals and objectives of the TI program.
- Engaged with TI participants through various means, including electronic and in-person forums for TI participants, surveys to gather feedback from all TI participants, webinars to review the attestation process and the document validation criteria with TI providers, monthly newsletters sent to all participants and including pertinent information such as program updates and upcoming due dates, and the TI webpage that includes resources and communications.
- Developed a peer/family training curriculum to meet a TI milestone for co-located justice clinics that require training of peer/family support staff. The TI program partnered with the Maricopa Integrated Health System to develop the first phase of the peer/family training curriculum, which is being used to train individuals providing peer/family services to the individuals involved in the justice system who are served by the 12 TI co-located justice sites.
- Established an ongoing dialogue between AHCCCS and AHCCCS Contractors to facilitate alignment between the TI program guidance on enhanced provider level integration and the Contractors' provider network initiatives.

## American Indian Health Plan Integration

In addition to the implementation of integrated managed care plans with AHCCCS Complete Care, AHCCCS has worked throughout the last year to integrate physical and behavioral healthcare and services throughout the state for members with CRS conditions who choose to enroll in the American Indian Health Program (AIHP).

Eligible American Indians currently have a choice of using managed care or the AHCCCS fee-for-service program, AIHP.

Prior to October 1, 2018, most members enrolled in AIHP were also enrolled in a RBHA or Tribal Regional Behavioral Health Authority (TRBHA) for behavioral health services.

Effective October 1, 2018, American Indian members have the choice of integrated care: AIHP or an AHCCCS Complete Care (ACC) health plan. AIHP members will also be able to choose care coordination through a TRBHA (when available).

## *Quality Strategy*

During CYE 2018, an internal workgroup was established to lead the most recent overhaul of the AHCCCS Quality Strategy. The Quality Strategy supports the mission and vision of AHCCCS and is aligned with AHCCCS' Strategic Plan, which outlines overarching goals that guide AHCCCS' direction for SFY 2015–2019. The report outlines AHCCCS' commitment to transparency, stakeholder engagement, and ultimately a commitment to the provision of quality care and services to those served through Arizona's Medicaid managed care and fee-for-service system.

## *Arizona Management System (AMS)*

Arizona Governor Doug Ducey has deployed a professional, results-driven management system to transform the way agencies think and do business. AHCCCS has fully embraced this system and is committed to tracking and improving performance daily. Across the agency AHCCCS employees now meet regularly around huddle boards where staff can monitor performance and hold themselves accountable for results. AHCCCS continues to gather data and work toward delivering results for the people of Arizona.

## *Suicide Prevention Plan*

According to officials at the World Health Organization (WHO), more than 800,000 people die by suicide annually; many more make an attempt. Suicide was the second leading cause of death among 15–29-year-olds globally in 2012. It is a global phenomenon in all regions of the world and accounted for 1.4 percent of all deaths worldwide, making it the fifth leading cause of death in 2012.

In Arizona, suicide is a primary public health concern that touches urban and rural communities including people of all ages and backgrounds.

- Among children ages 10–14 in Arizona, suicide is the leading cause of death.
- On average, a suicide occurs every seven hours in Arizona.
- Arizona ranks 12th in the nation for deaths by suicide.
- A total of 1,310 Arizonans died by suicide in 2016—the youngest was 9 years old.
- Among American Indians or Alaskan Natives, the median age of death by suicide is 27 years old (compared to age 51 among Caucasians).

Governor Ducey issued a proclamation declaring September Suicide Prevention Awareness Month in Arizona, encouraging citizens to take part in addressing suicide in communities.

As a member of the Arizona Suicide Prevention Coalition, AHCCCS collaborates with State agencies, organizations, healthcare plans, lawmakers, and other partners to create a community-based plan to end suicide in our state.

## Learning Collaborative

AHCCCS developed a "Learning Collaborative" for clinical staff, where subject matter experts (SMEs) present on issues of topical interest. One such session was a review of the children's system of care. The session reviewed the topic from an historical perspective and considered how it has been modified in response to recent litigation for behavioral health services for children. The session also explored the impact to the new AHCCCS Complete Care plans as outlined in the contract. The audience was provided tools to use in reviewing contractual deliverables associated with behavioral health services for children. As part of its commitment to quality improvement, AHCCCS reviews the feedback provided by the attendees to improve future presentations to ensure that the material is pertinent and germane to the mission of the clinical departments.

## System Improvements

AHCCCS hosts various meetings to continue to direct system improvements:

- Monthly collaborative meetings with Department of Children's Services/Comprehensive Medical and Dental Program (DCS/CMDP) to continue efforts to improve service delivery for children in the foster care system and to ensure availability of medically necessary services.
- Quarterly contractor meetings including DCS/CMDP, to review deliverable submissions and foster care data and to discuss system successes and improvements.
- Quarterly cross-divisional operational team meetings to further enhance service delivery efforts.

Through these meetings, various system improvements have been identified:

- Resource Packet—The frequently asked questions (FAQ) document has been expanded and renamed. It now includes more frequently asked questions, information, and resources for foster, kinship, and adoptive parents related to available physical and behavioral health services.
- Behavioral health and crisis services flyers for foster and kinship that are updated annually.

AHCCCS developed a specific policy (ACOM 449), which outlines specific requirements for behavioral health services for children within custody of the Department of Child Safety and for adopted children.

AHCCCS created a quarterly dashboard to track and trend utilization for children in foster care; this dashboard is posted on the AHCCCS foster care Web page.

## Long-Acting Reversible Contraceptives (LARCs)

AHCCCS implemented the LARC initiative to allow for LARC devices to be reimbursed outside of regular hospital payment. Offering members access to LARC devices in the hospital after delivery is expected to increase utilization of such devices since many members do not attend their six-week post-partum office visits.

## *Summary of Activities Designed to Enhance the Medical Record Review Process*

AHCCCS has initiated a statewide workgroup designed to develop a consistent behavioral health chart review tool. The tool will be designed to:

- Meet the CFR and State statutory requirements.
- Operate according to AHCCCS contractual guidelines.
- Provide consistency across the state with regard to clinical behavioral health practice.
- Allow for consistency of results in chart analysis and review.
- Allow for data comparisons across geographic service areas using consistent measurement of required chart elements.

## Other Systemwide Quality Initiatives/Collaboratives

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

- *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. To further ensure realization of the treatment recommendations within these tools, AHCCCS has begun a statewide Birth to Five initiative to address the unique needs of infants and toddlers. Additionally, AHCCCS is collaborating with CMDP for their Birth to Five learning collaborative.
- 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 Monitoring of Physical Health Providers: Arizona Association of Health Plans (AzAHP), comprised of all AHCCCS Contractors for Medicaid business

except CMDP and the Arizona Department of Economic Security(DES)/Division of Developmental Disabilities (DDD), offers a single point of contact for the Contractors and promotes consistency across the system. AzAHP works closely with AHCCCS discussing Contractor concerns, barriers, and challenges Contractors are asked to undertake. It also provides valuable feedback for consideration as the direct link to the care and services being provided. AHCCCS utilizes the AzAHP to provide stakeholder insight and to collaborate and promote new initiatives. AHCCCS has collaborated with AzAHP to provide consistent monitoring of physical health providers. This collaboration has historically allowed for uniform statewide review of primary care practitioners including internists, family practices, and obstetricians. AHCCCS began discussions with AzAHP regarding capacity to also monitor behavioral health providers throughout Arizona. Utilizing AzAHP as a monitoring agent facilitates consistency in quality monitoring and reduces burden on practitioners because AzAHP serves as the single reviewing entity for multiple MCOs. AHCCCS is currently combining this effort with the development of a consistent tool during meetings conducted with the RBHAs during 2017 and early 2018.

- 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 and Child Health (MCH) Meeting.

- Clinical Integration: The Medical Management (MM) unit, which regularly partners with the Quality Management (QM) and MCH/EPSDT units, added a second 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 the frequency of diabetic screening for individuals with schizophrenia or bipolar disorder.

  – Tracking performance on prenatal and postpartum 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.

- 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.

- Arizona Early Intervention Program: The Arizona Early Intervention Program (AzEIP), Arizona's IDEA Part C program, is administered by the Division of Developmental Disabilities. Maternal and child health (MCH) staff in the Clinical Quality Management unit at AHCCCS work with AzEIP to facilitate early intervention services for children younger than 3 years of age who are enrolled with AHCCCS Contractors. These services are closely monitored to ensure timely access and availability of services to members. AHCCCS and AzEIP continue to collaborate and meet regularly to ensure that members receive care in a timely manner. 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, a teen campaign, addresses teen vaccinations required to maintain health as teens begin to take control of their lives in the realms of college, driving, and even health decisions.

- Health Current: Formerly Arizona Health-e Connection, this non-profit organization is a health information exchange organization (HIO) and is the single statewide Health Information Exchange (HIE). Health Current currently has 500 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 program. AHCCCS members are encouraged to participate in ADHS' Tobacco Education and Prevention Partnership (TEPP) smoking cessation support programs such as "ASHLine" and/or counseling in addition to seeking assistance from their PCPs. Additional efforts have been focused on the integrated SMI population in connecting members to smoking cessation and nicotine replacement programs.

- Medicare and Medicaid Alignment for Duals: Arizona leads the nation with the highest percentage of dual-eligible members aligned in the same plan for Medicaid and Medicare outside the demonstration authority. Arizona has over 64,000 members enrolled in the same plan for Medicare and Medicaid. AHCCCS conducted a study to determine the impact on plan alignment related to dual-eligible members. The study compared national data for dual-eligible members enrolled in traditional Medicare fee-for-service to data for aligned dual-eligible members served by one of the AHCCCS health plans. The study found that the aligned AHCCCS dual-eligible members exhibited a 31 percent lower rate of hospitalization, a 43 percent lower rate of days spent in a hospital, a 9 percent lower rate of ED use, and a 21 percent lower readmissions rate.

- 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 CMDP, RBHAs, or 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.

- 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. AHCCCS offers formal meetings as well as informal workshops, and lunch-hour trainings to ensure that staff had ample 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.

  Quality Management (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 (GMH/SA)
  - 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
  - AHCCCS Waiver process
  - Meeting the needs of members with developmental disabilities and behavioral health challenges
  - Coordination of benefits (e.g., AHCCCS, Medicare, commercial coverage)

## Acute Care Quality Initiatives/Collaboratives

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

- 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 also provide monthly data sharing regarding AHCCCS members receiving immunizations and ongoing collaboration regarding Stage 1 and Stage 2 meaningful use (MU) public health requirements.

- 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 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.

The following are the best practices as reported by the Contractors to AHCCCS.

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

- 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. 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 referring 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).

  Assessment is followed by advising the member of services and assistance available; getting her agreement if help in obtaining services is needed; and providing assistance, including helping her arrange doctor appointments through three-way calls with a provider office and working with Care1st's Customer Service Department to arrange for medically necessary transportation when needed. Care1st also addresses external factors that can support optimal health and quality of life by linking members to community resources such as nutrition assistance and food banks and employment and legal assistance. This process aligns with the U.S. Public Health Service's five "A's" of promoting healthy behaviors: assess, advise, agree, assist, and arrange. Care1st continues the process from the third trimester into the postpartum period.

  If a baby is suspected of or diagnosed as having a potential Children's Rehabilitative Services (CRS) condition prior to birth, an alert is placed on the case rather than waiting until the problem presents itself after the child is born. This ensures that the concurrent review nurse (CRN) who will see the mother before post-delivery discharge is in the loop and that the care coordinator and CRS member advocate are prepared to proactively assist the family. A positive birth outcome does not end at delivery or in the immediate postpartum period; therefore, EPSDT specialists outreach frequently based on the AHCCCS EPSDT Periodicity Schedule during the baby's first two years, using the high-touch, tailored approach. Regular phone outreach to parents and guardians of members is conducted by an EPSDT care gap coordinator assigned to the member at the following intervals: 6 weeks; and 3, 5, 8, and 14 months. An immunization specialist takes over follow-up with the parent

or guardian until the member has completed all recommended immunizations or until 24 months. These processes have been in place since CYE 2017.

- 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.

- Pacify Mobile Application: Care1st is the first Arizona Contractor to use Pacify, an innovative application for smartphone that allows members in the late stages of pregnancy or up to one year after baby's birth to call a certified lactation consultant, registered dietitian, or registered nurse for help and advice at any time of the day or night, seven days a week. Pacify is an evidenced-based approach to improving health outcomes for new moms and babies: The U.S. Preventive Services Task Force recommends providing interventions during pregnancy and after birth to support breastfeeding, including professional support through home visits and telephone contact. The American Academy of Family Physicians also recommends providing interventions during pregnancy and after birth to support breastfeeding, and the National Association of Pediatric Nurse Practitioners endorses the optimization of infant breastfeeding and breastfeeding promotion as part of pediatric care. The Pacify app facilitates a "virtual visit" with a lactation consultant or dietitian by video call at the touch of one button on the app, while the connection to a registered nurse is voice only. A standard practice among these healthcare professionals is to refer callers back to their Care1st PCPs or children's pediatricians for follow-up, to ensure continuity of care. Push notifications sent to the members' phones also provide important health education and reminders, such as reminders for well-baby visits, and are tailored to each member's delivery date or baby's date of birth.

- P360 Program: In CYE 2018, Care1st implemented a multifunctional process that brings together department staff from Quality Improvement, Network Management, and value-based partnerships, along with the Arizona senior medical director and the WellCare senior QI project manager, who lead the P360 initiative to review performance by its largest value-based provider groups. At these twice-monthly meetings, key performance measure rates and other grouped metrics are reviewed, as are the current number of care gaps needing closure in order to meet performance thresholds. Group-specific challenges or barriers to improvement are discussed with the input from frontline staff members who interface with these provider group directors and managers, and interventions to address those challenges and barriers are developed. For example, during CYE 2018, Care1st performed analysis and implemented interventions focused on recommendations for improved

provider education on coding EPSDT services with sick visits and scheduling of family well visits on the same day.

When groups achieve high levels of performance or demonstrate significant improvement in their performance measure rates, a representative of the P360 team reaches out to identify any best practices that may be shared with similar provider types. A valuable tool used in evaluating provider practices and opportunities has been a WellCare proprietary document entitled, "Qualities of a Highly Engaged Physician Practice," which lists 10 best practices for engaging with patients and eight best practices for engaging with the Contractor. These best practices were identified by WellCare based on evidence, and the document is shared with provider groups. The P360 collaborative process allows the Contractor to support its provider groups in the most effective way—making them partners rather than customers, and ensures a consistent approach to interfacing and messaging across departments. This approach is based on the tenet that when payers focus on strengthening patient engagement and improving care coordination accountable care organizations and other providers with alternative payment models are likely to generate savings and greater patient satisfaction.

## Health Choice Arizona (HCA)

- Quality Management Performance Improvement Coordinator (PIC) program: The HCA system of care has been utilizing the PIC program to work alongside providers to improve quality outcomes. The program promotes partnerships by acting as a liaison to the plan, the member, and the provider. The goals of the program are to:
  - Support HCA's practices in addressing quality gaps in care by promoting continuity and coordination of care. The PICs collaborate with practice staff using various tactics to promote delivery of high-quality care, including on-site pre-visit and post-visit planning, measure training, and documentation guidelines. PICs ensure that providers receive member-level gap in care rosters either by in-person delivery, email, or self-directed pulls from the provider portal.
  - Monitor and report in real time gaps in member care and to coordinate visits. The PIC program eliminates barriers to accessing care or keeping appointments and works to ultimately benefit the member and practitioner.
  - Perform direct member outreach to inform members of recommended preventative screenings due, and offer to connect the member to his or her primary care provider to schedule an appointment.
  - Provide education and ongoing oversight activities such as monitoring targeted metrics, developing quality improvement plans, distributing tools and resources to efficiently and effectively reduce errors, promoting safe and best practices, and gathering the necessary real-time data to allow all stakeholders to make informed decisions.
  - Ensure internal coordination of programs in which the member is enrolled.
- Improving Timeliness of Prenatal and Postpartum Care Visits: HCA conducts outreach to newly identified pregnant members who do not have a Total Obstetric (OB) notification on file to educate them about the importance of early entry into prenatal care through review of the active care roster

daily. HCA has assigned designated maternal child health (MCH) coordinators to review the active care roster, contact the member, assist with identifying an OB provider, and schedule appointments as well as requesting Total OB authorization from the OB provider to help identify high-risk conditions timely so that a referral to high-risk OB care manager can be accomplished. When HCA is notified that a member is pregnant, each member receives a Stork Packet with educational material about the importance of prenatal care, HIV/AIDS testing, postpartum depression, how to get behavioral health services, and information on community resources such as WIC.

The MCH team reviews the inpatient census daily to identify members who have been admitted as inpatients or for observation. The MCH coordinators outreach to the hospital to verify status of inpatient admission or observation stay. This information is noted and sent to the appropriate OB care manager. The care manager reviews to ensure that a Total OB package is on file to identify if the member is connected with outpatient OB care. Any member who has been hospitalized but has not established outpatient care with a provider is sent to high-risk OB care management for outreach. HCA ensures that all referrals experience an attempted outreach within 14 days of receipt of referral. A maternal health manager has been hired and is working with the team to provide consistency and follow-up. In addition, HCA is planning to move the review of the active care roster from paraprofessional staff to clinicians to allow for comprehensive assessment and enrollment for high-risk versus routine OB care management.

To assist with the timeliness of prenatal care and the postpartum care rate, the OB care managers covering high-risk members and the OB Transition of Care (TOC) team outreach to members post-delivery to educate them on the importance of postpartum follow-up and to assist with scheduling appointments as appropriate. Members who have delivered receive a postpartum packet containing important information on postpartum depression, family planning services, importance of attending a postpartum follow-up appointment, and community resources. Those same OB care managers follow members eight weeks post-delivery to assist with any postpartum needs. HCA staff members educate both members and providers on the importance of postpartum care. HCA clinical teams work with the Provider Relations department to educate the provider network on how to properly bill for rendered services and about the importance of talking to members early in their pregnancy about postpartum care and signs of possible postpartum depression. The OB care managers complete postpartum depression screenings on all members enrolled in care management during the postpartum period. HCA posted a new community resource for a neonatal abstinence syndrome (NAS) support group to its member portal. HCA has had challenges reaching its member population though the care team makes multiple attempts. HCA is implementing use of the HIE for more current demographic member information and is performing outreach to providers for this information. HCA plans to research a diaper incentive program for members who follow through with prenatal care through postpartum. HCA is also working with Marketing to update mailers and website information to motivate members to follow up with their OB providers after delivery.

- Transition of Care (TOC) program: HCA's TOC team conducts post-discharge follow-up calls on all members within three business days to assess a member's well-being and to ensure that the discharge plan is implemented. HCA uses the following models to engage members in post-discharge follow-up:

- Reach In: HCA has discharge planners and TOC coordinators who call members while they are still inpatient. They conduct telephonic outreach post discharge for 30 days to ensure that the members' discharge needs are addressed, so as to decrease readmission.
- Telephonic: HCA uses care coordinators to conduct telephonic outreach post discharge to all HCA discharges. Telephonic outreach is conducted for 30 days post discharge to ensure that member discharge needs are met, so as to decrease readmission.
- Health Buddy System: HCA has implemented a "Health Buddy" system for members in the serious mental illness (SMI) population. The purpose of this program is to help improve member health outcomes and reduce hospital readmissions within 30 days by following up on received care and ensuring that members' needs are met. Specialized member services representatives, health buddies, call members following any discharge from an acute or behavioral healthcare facility.

HCA's TOC program includes collaborative efforts with the concurrent review team, hospital discharge planners, integrated health homes, and ancillary vendors to ensure care coordination. The TOC team works with the member's PCP to improve access to care and quality outcomes and provides medical management support for continuity of care through the member's transition cycle. The TOC team also provides assistance with scheduling follow-up appointments with the member's medical home provider and other appropriate providers. After 30 days, if members are assessed as needing further assistance with care coordination, a referral is made to the appropriate care management department for further case management activities and planning.

HCA medical management specialists ensure that inpatient hospitals involve the behavioral health member, guardian, or designated representative in the discharge planning process so that the member understands the written discharge plan as well as instructions and recommendations provided by the facility; and is provided resources, referrals, and possible interventions to meet assessed and anticipated needs after discharge. Beginning at the concurrent review, the medical management specialist works closely with the hospital discharge planner and, if applicable, the assigned behavioral health home to ensure that discharge needs are met. Inpatient hospitals are required to send HCA a signed copy of the member's discharge orders within one business day to help facilitate post-discharge coordination and outreach. For members in the HCA care management program, the medical management specialist will notify the member's assigned integrated care manager via CareRadius to ensure coordination with the member's PCP and family members as well as to assist with any prescription medications, medical equipment, appliances, medical supplies, referrals, or therapies that may be needed.

HCA's multi-disciplinary team recognizes discharge planning as a critical component of the utilization process and engages the Child and Family Team/Adult Recovery Team in assessing the member's potential discharge needs and preferences, as per the member's individual recovery plan or individual service plan.

# Health Net Access (HNA)

- Improved Member Outreach: HNA implemented a program to more effectively increase outreach to members using the interactive voice response (IVR) vendor, Eliza. Eliza provided nationwide data, indicating that this method of outreach has a higher impact on more members related to receiving preventative care, acquiring accurate updates on preferred PCPs, and engaging members in care. The IVR contains options that include warm transferring the member to Customer Service or a follow-up call or referral to care management. Eliza was implemented in stages, beginning in April 2018 and completed in July 2018. Programs will run for a full year prior to completing evaluations.

- Improved Provider Education: HNA provided consistent provider education throughout 2016 and 2017; however, providers continued to have many of the same questions specific to performance measures and preventative care. HNA wanted a method to provide information in a more effective and concise manner, so HNA developed the Health Spark Reference Guide, which included easy-to-understand measure summaries, tips on improving the measures at the provider level, and information on Contractor interventions. Health Spark is intended to be a living document, incorporating best practices and effective interventions. HNA distributed Health Spark at targeted technical assistance sessions and provider forums and posted the document on the website. Providers changed the types of questions they were asking from "how is a measure calculated" to "how to execute effective interventions." This is HCA's intended outcome of the document and distribution method, anticipating that effective education will lead to action and an improvement in the health of members.

- EPSDT Follow-Up: HNA's goal with EPSDT follow-up was to improve the comprehensiveness of well visits and completion of all screenings on the EPSDT form through follow-up and education with physicians. HNA's EPSDT team reviews each AHCCCS EPSDT form received from a physician. If all screenings are not completed, HNA generates a letter educating the physician on the need to complete all necessary screenings. If a developmental screening is indicated as completed, the EPSDT team confirms that a claim was received and billed to meet the screening measure. If this is not the case, the team generates a letter to educate the physician on the measure. When a trend is found with a physician or group, contact is made by phone or on-site visit to discuss EPSDT, physician practices, and improvement processes. In addition, claims for EPSDT visits wherein an AHCCCS EPSDT form was not submitted receive follow-up by phone or an on-site visit from the EPSDT team to educate physicians on the forms. In addition, the EPSDT team sends providers a list of their assigned members in need of immunizations and well visits quarterly.

# Mercy Care Plan (MCP)

- Trauma-Focused Cognitive Behavioral Therapy Certification: MCP established a goal to increase provider staff members' and stakeholders' knowledge and abilities to provide trauma-informed responses and strategies in response to children's emotional needs through the use of evidence-based practices. This goal was accomplished through trainings provided through the Mercy 360 Academy on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is an evidence-based treatment for children and adolescents impacted by trauma as well as for their parents and

caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple, and complex trauma experiences. The training program offered was the official TF-CBT National Therapist Certification Program, in which clinicians become certified in the TF-CBT treatment model. Overall, over the past two years MCP trained over 190 staff on trauma-informed responses and strategies through the Mercy 360 Academy.

- High Needs, High Costs (HNHC) Program: MCP identified members who met any of the following criteria:
  – Four or more emergency department (ED) visits in six months
  – Four or more inpatient admissions in six months
  – Three or more readmissions in six months
  – $50,000 or more in total costs in six months

  All members were enrolled in Intensive Case Management (ICM), and MCP case managers accomplished the following:
  – Outreached members who choose to participate in case management
  – Performed triage and outreach
  – Conducted face-to-face visits at least every two months
  – Conducted telephonic outreach at least twice monthly
  – Educated and offered Naloxone kits to members identified having opioid-related concerns
  – Staffed quarterly with the RBHA or every two months with DDD and the RBHA

- Exclusive Prescriber Program (EPP): The purpose of MCP's prescription restriction program is to detect and prevent continued misuse of the pharmacy benefit by restricting members to only one provider or provider office for a defined period. The goals are both to make sure members are getting access to safe and clinically appropriate treatment services and to manage risky and potentially dangerous utilization patterns.

  The process for the EPP is as follows:
  – Confirm with the provider who will be prescribing controlled substances: the PCP, behavioral health, or pain management specialist.
  – Request medical records.
  – Perform an after review of the medical information, including a staffing with the medical director to determine who to enroll in the EPP.
  – Restrict approved members to the PCP, behavioral health, or pain management specialist.
  – Enroll the member into the support coordination level of care management.
  – Review all members annually or upon request of the member and or the prescribing physician.

  The EPP case management program does the following:
  – Identifies barriers to treatment.
  – Coordinates behavioral health and substance abuse treatment.

–   Coordinates care and shares data with the restricted provider(s).

–   Facilitates discharge planning with both medical and behavioral health providers as requested.

–   Educates on high-risk behaviors with the aim of modifying risk factors.

–   Screens members to identify gaps in medically necessary services.

–   Monitors progress and tracks outcomes.

–   Evaluates for more intensive care management needs and assigns management accordingly.

The graduation criteria for the member includes: appropriate use of emergency department (ED) or urgent care facilities, absence of poisoning and/or overdose, no apparent psychoactive substance abuse, and having obtained controlled substances consistently from one medical provider and/or one behavioral health provider. These criteria must be sustained over a six-month period.

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

•   Affiliated Practice Dental Hygienist (APDH): APDHs are direct-access providers established to address members' unmet oral healthcare needs in Arizona. However, due to the inability of APDHs to be credentialed or contracted with Medicaid plans, the model has been highly underutilized. Through an agreement with an affiliated practice dentist, APDHs can provide preventative and therapeutic dental hygiene services as determined 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.

UHCCP-Acute' s initiative integrates medical and dental services to concurrently close preventative medical and dental gaps in care. The APDH at the San Luis Walk-In Clinic (SLWIC) provides dental hygiene services in a medical primary care setting. As the medical provider completes a member's EPSDT visit, the APDH provides an oral screening, education, fluoride varnish, and referral to a dentist.

This innovative initiative utilizes a mid-level dental provider to integrate medical and dental care. The integration raises awareness of the systemic link between poor oral health and medical conditions (i.e. diabetes, cardiovascular disease, pre-term labor, low birth weight). The targeted pilot population has higher risk for and prevalence of dental disease, and low attendance of dental visits. The initiative reinforces the importance of oral health and captures services provided by APDHs to count toward the annual dental visits (ADV) HEDIS measure.

The health plan dental clinical practice consultant (CPC) engages medical and dental offices in developing integrated APDH models. Currently, UHCCP-Acute is working with several community partners throughout Arizona to implement twenty-one APDH models. The dental CPC connects community partners, assists in determining strategies for delivery of dental services, provides resources, and guides medical and dental practices in establishing the APDH provider for reimbursement. As outlined in the UHCCP-Acute business agreements, medical and dental offices coordinate patient care and referral.

The Institute of Medicaid Innovation awarded UHCCP-Acute the "2017 Medicaid Best Practice Award" for bringing dental care to the primary care setting.

- Childhood Immunization by 2 Years of Age: UHCCP-Acute recognizes that childhood immunizations for members under 2 years of age are critical to preventing known diseases and preventing disease transmission. As a result of the availability of vaccinations, most vaccine-preventable diseases which posed health threats for centuries have experienced dramatic declines in mortality and morbidity.

  The UHCCP-Acute CDC Task Force on Community Prevention Services identified three categories for interventions to overcome vaccine noncompliance: increasing community demand for vaccination, enhancing access to vaccination services, and provider-based interventions.

  Based on literature review of best practices that focus on increasing communication between doctor and member, UHCCP-Acute implemented the following member and provider interventions in CYE 2018:

  1. Member-based

    – Newborn: mailer to guardian encouraging well-child visits and presenting the immunization schedule.
    – 6 Months Old: reminder letter to obtain immunizations and information about developmental milestone.
    – 9 Months Old: live call to guardian of member encouraging well-child visit and to address missing immunizations based upon data obtained from ASIIS.
    – Personalized member letter at age 13 months and 14 months to those members noncompliant for their immunizations, encouraging the member to schedule the 15-month well-child visit and to address the missing immunizations.
    – Personalized member letter at age 17 months and 21 months to those members noncompliant for their immunizations based upon data obtained from ASIIS.
    – Transportation services to and from a visit with the doctor.

  2. Provider-based

    – Value-based contracts: financial incentive for providers improved performance on the percentage of members 15 months of age who received six well-child visits.
    – Clinical Practice Consultants: assignment of over 400 provider groups to meet with monthly to review assigned members under 24 months of age who are missing immunizations.
    – Provider education on the best practice of providing EPSDT-related services at a sick visit, if appropriate, and the corresponding billing practice.
    – Provider feedback using a monthly letter to members assigned to their care and who are missing one or more shots.

- Well Child—Six Visits by 15 Months of Age: Based on literature review of best practices, UHCCP-Acute implemented the following member and provider interventions in CYE 2018:

  1. Member-based

- Newborn: mailer to guardian encouraging well-child visits and presenting the immunization schedule.
- 1 Month Old: live call to the guardian of the member encouraging well-child visits and assisting with scheduling appointments.
- 3 Months Old: live calls to the guardian of the member encouraging well-child visits and assisting with scheduling appointments.
- 4 Months Old: IVR reminder calls to schedule appointments.
- 6 Months Old: reminder letter to obtain immunizations and information about developmental milestones.
- 9 Months Old: live calls to the guardian of the member encouraging well-child visits and assisting with scheduling appointments.
- 9 Months Old: letters to the guardian of the member about developmental milestones and scheduling appointments with the PCP in order to conduct developmental screenings.
- 11 Months Old: IVR reminder calls to schedule a well-child appointment.
- 12 Months Old: immunization reminder postcard.
- 14 Months Old: IVR reminder calls to schedule a well-child appointment.

2. Provider-based

- Value-based contracts: financial incentive for providers' improved performance on the percentage of members 15 months of age who receive six well-child visits.
- Clinical Practice Consultants: assignment of over 400 provider groups to meet with monthly to review the assigned members under 15 months of age in need of well-child visits.
- Reports and scorecards: provider feedback on year-to-date performance of members under 15 months of age receiving well-child visits, including a list of members in need of well-child visits.
- Provider education: best practices to increase the percentage of well-child visits.

## University Family Care (UFC)

- Diabetes: A1c Testing: In CYE 2018, UFC worked to get the A1c testing to the MPS of 77 percent. The strategies included coordinating with Sonora Quest to track and monitor A1c tests and values and to conduct outreach to those members without a test on record or those with A1c values greater than 9 percent. UFC care managers assist members with high A1c levels (greater than 9 percent), by following up with providers and caregivers so that interventions can be done quickly to lower the A1c levels. When members' A1c is out of control and they have only received one A1c test, the care managers work to have the test done more often to ensure that the interventions are working and that members are gaining control of their A1cs. This intervention continues until the A1c levels are in appropriate range.
- Annual Dental Visits—2 through 20 years: UFC Quality Department calls and reminds parents of the importance of attending to their children's dental needs, sends out reminder flyers, and ensures that all dental referrals are completed. In addition, UFC partnered with the dental vendor

(DentaQuest), who agreed to reach out to all high-volume providers, send them lists of children with no dental visit within the year, and request that they reach out and encourage these parents to get their children in for appointments. Additionally, the dental performance measure was included in the alternative payment model for all major providers.

- Breast Cancer Screening: UFC reinforces national and widespread positive messages regarding breast cancer awareness and recognition of cancer survivors with regular mailings to all members regarding the importance of mammography. Additionally, UFC had a breast cancer member gift card campaign that appeared to have improved the measures at least slightly for this population. Going forward, UFC is planning a mobile mammography clinic to further positively impact the results of this measure.

## Comprehensive Medical and Dental Program (CMDP)

- Adolescent Health Taskforce Initiative: The Adolescent Health Taskforce is a collaborative team established to invent 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 taskforce consists of members from the Department of Child Safety (DCS), CMDP, and the Arizona Department of Health Services (DHS). The taskforce's project, "The Talk" toolkit, reviews topics such as puberty, sexually transmitted diseases, pregnancy prevention, sexual violence awareness, healthy relationships, human trafficking, and healthy lifestyles. The toolkit is used by DCS specialists and caregivers as a guide to review with out-of-home foster care youth.

- Onboarding of New Members (Children into Care): CMDP aims to use this practice to provide customer service to the caregiver to assist with timely preventative medical and dental appointments for children in care. The service provided includes support in meeting the information and resource needs so that caregivers can navigate the health and DCS systems for optimal advocacy and engagement in the services required of DCS membership. During the caregiver outreach calls, CMDP staff assist with PCP and primary dental provider (PDP) searches. Appointments with those providers can be set up through the CMDP staff. As a result, the rate of preventative care visits being accessed increased.

- PCP Psychotropic Oversight Initiative: CMDP found that PCPs may treat CMDP youth for uncomplicated attention deficient hyperactivity disorder (ADHD), depression, or anxiety disorders. It is essential for PCPs to be aware that all CMDP youth have experienced trauma which may result in severe behavioral symptoms. At times, behaviors that develop as a result of underlying trauma can cause diagnostic confusion and lead to inaccurate diagnoses including ADHD, depression, and/or anxiety disorders. Inaccurate diagnoses may result in unnecessary treatment and poor outcomes. For youth with a history of trauma, comprehensive treatment is essential and usually requires psychosocial interventions. CMPD considers it a best practice for children under 6 years of age to have psychosocial interventions employed prior to the initiation of medication. CMDP requires a provider to submit a prior authorization request to the pharmacy benefits manager for all members under the age of 6 years. This practice allows for early and consistent care coordination among the providers, the child's custodial agency representative (DCS specialist), and the RBHA.

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.

## Conducting the Review

For the CYE 2016 OR review cycle (which includes CYE 2016, CYE 2017, and CYE 2018 activities), AHCCCS conducted the OR with 11 standards for one Contractor during CYE 2018. The updates on CAPs issued during CYE 2016 and CYE 2017 are included for five Contractors with outstanding CAPs as of the CYE 2017 Annual Report. AHCCCS continues to review documentation related to open CAPs for UFC and HNA as of the CYE 2018 Annual Report; therefore, a formal response will occur outside of the review cycle. Additionally, no information for CMDP's CAP updates was available at the time of this report and is therefore not included. Details regarding the standards reviewed for each Contractor are included in the findings.

For details on the review objectives, methodologies for conducting the review and scoring, and criteria for requiring Contractors to submit corrective action plans, please see Appendix A, Validation of Organizational Assessment and Structure Performance Methodology.

### *Standards*

The CYE 2016 OR review cycle, conducted in CYE 2018, 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

## Contractor-Specific Results

### University Family Care (UFC)

AHCCCS conducted an on-site review of UFC from October 23, 2017, through October 25, 2017. A copy of the draft version of the report was provided to the Contractor on December 6, 2017. UFC 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 cycle, 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 presents compliance results for the 11 standards reviewed for the UFC OR.

**Table 6-1—Standard Areas and Compliance Scores for UFC**

| Standard Area (Number of Elements Scored) | Standard Area Score/Maximum Possible Score | Standard Area Percentage Score | Number of Required Corrective Actions |
|---|---|---|---|
| **Corporate Compliance (5)** | 500/500 | 100% | 0 |
| **Claims and Information Systems (12)** | 1,145/1,200 | 95% | 2 |
| **Delivery Systems (9)** | 668/900 | 74% | 5 |
| **General Administration (3)** | 300/300 | 100% | 0 |
| **Grievance Systems (17)** | 1,700/1,700 | 100% | 0 |

| Standard Area (Number of Elements Scored) | Standard Area Score/Maximum Possible Score | Standard Area Percentage Score | Number of Required Corrective Actions |
|---|---|---|---|
| Adult, EPSDT, and Maternal Child Health (15) | 1,109/1,500 | 74% | 11 |
| Medical Management (25) | 2,356/2,500 | 94% | 3 |
| Member Information (9) | 867/900 | 96% | 1 |
| Quality Management (27) | 2,581/2,700 | 96% | 5 |
| Reinsurance (4) | 400/400 | 100% | 0 |
| Third-Party Liability (7) | 700/700 | 100% | 0 |

## Strengths for UFC

For this OR, AHCCCS reviewed a total of 11 standards. For eight of those, UFC achieved either full compliance or compliance. UFC was fully compliant, with 100 percent scores, for five of the 11 standards reviewed (CC, GA, GS, RI, and TPL).

UFC demonstrated full compliance for the CC standard, which included the requirement that UFC audit its providers for accuracy either through UFC's claims payment system or any other data analytics system and identify billing inconsistencies and potential instances of fraud, waste, or abuse. Additionally, UFC demonstrated that UFC (and its subcontractors) have a process for identifying and reporting all suspected fraud, waste, and abuse to the AHCCCS Office of Inspector General (OIG) following the established mechanisms.

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

Full compliance was demonstrated for the RI standard, in which UFC identified a process for advising AHCCCS of reinsurance overpayments against associated reinsurance encounters within 30 days of identification. Additionally, the process includes open or closed contract years and open or closed reinsurance cases. UFC reports known changes in health insurance information to the AHCCCS contracted vendor no later than 10 days from the date of discovery, which complied with the TPL standard.

## Opportunities for Improvement for UFC

The results of the OR demonstrated opportunities for improvement as UFC was less than compliant in three of the 11 standards reviewed. Scores for the DS, MCH, and MM standards ranged from 74 percent to 94 percent. Altogether, UFC received 27 required corrective actions in six standards.

UFC received one of the lowest standard area scores, 74 percent, for the DS standard. During the interview UFC stated that monthly monitoring was occurring; however, more frequent monitoring of providers who appear on AHCCCS' 1800 Report or who have exceeded their contracted capacity did not occur. AHCCCS also noted that no documentation was present in which UFC notifies subcontractors when modifications are made to AHCCCS guidelines, policies, or manuals. Further, UFC's documentation did not demonstrate compliance with the requirement that the Contractor not prohibit or otherwise restrict a provider from advising or advocating on behalf of a member who is his or her patient. UFC did not demonstrate implementation of corrective action when appropriate, that the provider manual contains all requirements listed in the AHCCCS Contractors Operations Manual (ACOM) 416, or that UFC ensures that its providers and subcontractors are informed of the availability of the provider manual.

AHCCCS identified several deficiencies when reviewing the MCH standard, which also had one of the lowest standard area scores (74 percent). UFC did not adequately demonstrate compliance with the following requirements:

- Monitor the maternity care program outreach activities for effectiveness; have an ongoing process to coordinate referrals of high-risk members to appropriate service providers to ensure that services are received, which includes revising the plan of care as appropriate.

- Monitor provider compliance of perinatal and postpartum depression screenings being conducted at least once during the pregnancy and then again at the postpartum visit, with appropriate counseling and referrals made if a positive screening is obtained.

- Identify postpartum depression, refer members to the appropriate healthcare providers and ensure that the member is connected to care; ensure that both male and female members who wish to use family planning services understand what coverage is available and how to access services; monitor, track, and evaluate provider compliance with providing EPSDT/well-child services to all eligible members according to the most current periodicity schedule.

- Intervene when necessary to improve the rate of use of the AHCCCS-approved EPSDT tracking forms; monitor providers to determine if oral health and dental services are provided according to the AHCCCS Dental Periodicity Schedule; monitor, track, and evaluate primary care provider (PCP) fluoride varnish applications for children under 2 years of age.

- Assign members to a dental home by 1 year of age or upon assignment to the Contractor, including monitoring interventions of the dental home to ensure that members receive care; include a process and monitor the reassigning of members when a PCP is no longer participating in ASIIS and the VFC program.

- Assist members in navigating the healthcare system to ensure that members receive appropriate services as well as community-based resources that support optimal health outcomes.

- Ensure that medical necessity for commercial oral nutritional supplements is determined on an individual basis by the member's PCP or attending physician using the criteria specified in the AHCCCS Medical Policy Manual (AMPM) and monitoring and implementing referrals for underweight and overweight members.

- Educate members identified as having CRS-eligible conditions on the benefits of enrollment in the CRS program, including ensuring that members are aware of the option to opt out of the CRS program.
- Inform all PCPs and obstetrician/gynecologist (OB/GYN) providers of the availability of women's preventative care services or inform members about women's preventative health services.

For the MM standard (scored at 94 percent), AHCCCS identified that five maternity case files reviewed did not receive post-discharge follow-up calls. Additionally, UFC did not adequately demonstrate that UFC has policies and procedures related to assisting homeless clinics with obtaining prior authorization and referrals to specialists. AHCCCS also noted that UFC's policies did not indicate that payment shall not be denied in the event that the Contractor's representative instructs an enrollee to seek emergency services or if an emergency room provider, hospital, or fiscal agent has notified the Contractor within 10 calendar days of presentation for emergency services.

Although the CIS, MI, and QM standards received scores that complied with the "at or above 95 percent" threshold established by AHCCCS, several opportunities for improvement were identified. For the CIS standard, for which UFC received a score of 95 percent, AHCCCS found that an incorrect calculation of interest was applied to claims and that one claim was denied due to the provider not being registered with AHCCCS. UFC received a standard area score of 96 percent for the MI standard. AHCCCS noted that the time frame between the termination notice and the date that the member letters were sent was outside of the required 15-day notification time period. AHCCCS found that for the QM standard, which AHCCCS scored at 96 percent, UFC did not have a process to monitor that initial credentialing applicants have a minimum of five years' work history for the purpose of consideration during the credentialing process. Additionally, AHCCCS noted that UFC did not provide evidence for implementing corrective actions or for notifying AHCCCS when a health information system inaccuracy or issue exists; nor did UFC demonstrate a process to determine best practices related to PIPs.

## Corrective Action Plans for UFC

In the report generated from UFC's OR, AHCCCS included requirements that UFC develop CAPs for issues that AHCCCS identified. UFC submitted the first CAP submission to AHCCCS on January 17,2018. On February 14, 2018, AHCCCS accepted all CAPs that UFC had proposed. AHCCCS required that UFC submit to AHCCCS on August 14, 2018, an update for the open CAPs. With few exceptions, AHCCCS expected all CAP steps to be completed within six months. (AHCCCS' response to UFC's six-month CAP update was not available at the time of this report and is therefore not included.)

AHCCCS identified deficiencies in the DS standard, requiring UFC to submit five related CAPs. Following is a list of the required actions and CAPs that UFC submitted for approval to AHCCCS.

- UFC must develop a process for monitoring appointment standards more frequently for providers who appear on the 1800 report or who have exceeded their contracted capacity. UFC proposed a CAP to do the following: create a cross-functional workgroup to review the current appointment availability (AA) process; send a fax blast to contracted providers, including the requirements for

AA standards; conduct a secret shopper AA survey; and issue a corrective action plan for providers who fail the secret shopper AA survey. AHCCCS accepted the CAP. However, to close the CAP UFC must provide documentation demonstrating compliance with each proposed corrective action.

- UFC must notify its subcontractors when modifications are made to AHCCCS guidelines, policies, and manuals. UFC proposed a CAP to implement a process to notify subcontractors when modifications are made to AHCCCS guidelines, policies, and manuals and to update the related internal policy to include the notification process. The subcontractor account managers will review and document that the information was received. AHCCCS accepted the CAP. However, to close this CAP UFC must provide documentation demonstrating compliance with each proposed corrective action.

- UFC must ensure that providers have mechanisms to advise or advocate on behalf of the member regarding: the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; any information the member needs in order to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; and the member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions. UFC proposed a CAP to revise the provider manual to: include information for providers on their responsibilities to advise or advocate on behalf of the member, update the provider in-service training packets to include the applicable AHCCCS requirement, and include a reminder in the quarterly provider newsletter. AHCCS accepted the CAP. However, to close the CAP UFC must provide documentation demonstrating compliance with each proposed corrective action.

- UFC must ensure that corrective action, as the result of a provider call, is implemented when appropriate. UFC proposed a CAP to: modify the process for documenting and reviewing provider calls and update the policy to reflect the process change as well as to follow up on noncompliance during a phone call (including issuing corrective action plans if applicable, which will be documented in the customer relationship management (CRM) system. AHCCS accepted the CAP. However, to close this CAP UFC must provide documentation demonstrating compliance with each proposed corrective action.

- UFC must ensure that its provider manual contains all provisions as required by ACOM 416. The Contractor must ensure that its subcontractors are also informed of the availability of its provider manual. UFC proposed a CAP to: update the internal policy, submit a validated crosswalk with the ACOM 416 identifying the requirements in the provider manual, and notify all providers and subcontractors and providers of the changes (upon AHCCCS approval of the changes). AHCCCS accepted the CAP. However, to close the CAP UFC must provide documentation demonstrating compliance with each proposed corrective action.

AHCCCS identified several deficiencies in the MCH standard, requiring UFC to submit 11 CAPs related to this standard. Following is a list of the required actions and the CAPs that UFC submitted for approval to AHCCCS.

- UFC must develop and implement a written process to monitor the maternity care program outreach activities for effectiveness. UFC must develop and implement a written process to coordinate referrals of high-risk members to appropriate service providers to ensure that services are received

and which includes revising the plan of care as appropriate. UFC proposed a CAP to develop a report of additional key delivery outcome indicators and monitor the new indicators, establish a desktop process outlining changes in types of outreach activities resulting from report evaluations, develop a tool to document high-risk members receiving referrals to appropriate service providers and a traceable workflow in acuity, follow up on referrals, train staff on new processes, and revise the applicable policy. AHCCCS accepted the CAP. However, to close the CAP UFC will need to provide a copy of the following: the new report, desktop procedures for reviewing workgroup data and conducting follow-up on member referrals, workflow changes, training materials, the monitoring tool, draft policy revisions, and work toward the creation of a training call script.

- UFC must develop and implement a written process to monitor provider compliance of perinatal and postpartum depression screenings being conducted at least once during the pregnancy and then again at the postpartum visit, with appropriate counseling and referrals made if a positive screening is obtained. UFC proposed a CAP to add components to the established tool that audits providers for documentation of the screening results in order to identify if positive screenings are made. Additionally, UFC will revise the applicable policy, communicate the requirement to providers through fax blasts, and incorporate the information into the new provider orientation materials and provider forums. AHCCCS accepted this CAP. However, to the close the CAP UFC will need to provide a copy of the following: proposed edits to the audit tool, policy revisions, the provider fax document, and provider outreach or presentation to providers outlining the new components.

- UFC must implement a written process to identify postpartum depression, refer members to the appropriate healthcare providers and ensure that members are connected to care. UFC proposed a CAP to revise applicable policies, determine and implement health plan documentation program changes, develop a tool to document high-risk members identified with possible postpartum depression and a traceable workflow, train staff on new processes, update the desktop processes to identify and document members who require referrals, and develop a tool for a monthly documentation review process. AHCCCS accepted the CAP. However, to close the CAP UFC will need to provide a copy of the following: draft policy revisions, workflow changes, training materials, revised desktop procedures, and the monitoring tool.

- UFC must develop and implement a written process and materials to ensure that practitioners and members (both male and female) understand what coverage is available for family planning services and how to access those services. UFC proposed a CAP to revise the applicable policies as well as to provide clarification to members and providers (in the member newsletter and flyer, member handbook, and provider manual) that family planning services are available to both male and female members, what family planning services are covered, how to access services, and how to obtain health plan assistance with family planning services. Additionally, UFC will incorporate the information into the new provider orientation materials and provider forums. AHCCCS accepted this CAP. However, to the close the CAP UFC will need to provide a copy of the policy revisions and the member newsletter and flyer.

- UFC must develop and implement a written process which monitors, tracks, and evaluates provider compliance with providing EPSDT and well-child services to all eligible members according to the most current periodicity schedule. The Contractor shall develop and implement a written process that implements interventions when necessary to improve the rate of use of the AHCCCS-approved EPSDT tracking forms. UFC proposed a CAP to update EPSDT desktop procedures, send quarterly

fax blasts to providers, incorporate the information into the provider site visit materials, develop a desktop procedure for reconciling the EPSDT forms with the claims, and train staff on the new procedures. AHCCCS accepted the CAP. However, to close the CAP UFC will need to provide a copy of the following: new and revised desktop procedures, the provider fax document, site visit material revisions, and training materials.

- UFC must develop and implement a written process to monitor providers to determine if oral health and dental services are provided according to the AHCCCS Dental Periodicity Schedule. UFC must develop and implement a written process which monitors, tracks, and evaluates PCP fluoride varnish applications for children under 2 years of age. UFC must develop and implement a written process to assign members to a dental home by 1 year of age or upon assignment to the Contractor, including monitoring interventions of the dental home to ensure that members receive care. UFC proposed a CAP to revise the established tool that audits providers on oral health checks, dental screenings, and fluoride varnish questions; and which aligns with ages and the periodicity schedule. Additionally, UFC will have its subcontractor auto-assign members to a dental home or dentist by 1 year of age or upon assignment to UFC and provide various monitoring reports. UFC will also develop an internal report to monitor, track, and evaluate PCP fluoride varnish applications for children under two years of age, develop desktop procedures related to coordination of care and monitoring of interventions implemented for its subcontractor, train staff on the changes, and attend quarterly joint operations committee meetings with its subcontractors. AHCCCS accepted the CAP. However, to close the CAP UFC will need to provide a copy of the following: proposed edits to the audit tool, the subcontractor reports, newly developed desktop procedures, training materials, and recent minutes from the committee meetings.

- UFC must develop and implement a written process to monitor the reassigning of members when a PCP is no longer participating in ASIIS and the VFC program, with emphasis for both urban and rural members. UFC proposed a CAP to revise the applicable policy, revise the EPSDT desktop procedures to include missing elements, and add a new process to make high blood lead calls to members to discuss the need for follow-up testing and PCP appointments, develop a process to assist members in receiving the appropriate services and community-based resources, and train staff on the changes. AHCCCS accepted the CAP. However, to close the CAP UFC will need to provide a copy of the following: script revisions, desktop procedure and form revisions, and training materials.

- UFC must develop and implement a written process which assists members in navigating the healthcare system to ensure that members receive appropriate services as well as community-based resources that support optimal health outcomes. UFC proposed a CAP to revise the scripts, revise the EPSDT desktop procedures to include missing elements, add a new process to make high blood lead calls to members to discuss the need for follow-up testing and PCP appointments, develop a process to assist members in receiving the appropriate services and community-based resources, and train staff on the changes. AHCCCS accepted the CAP. However, to close the CAP UFC will need to provide a copy of the following: script revisions, desktop procedure and form revisions, and training materials.

- UFC must develop and implement a written process which 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 criteria specified in the AMPM. The Contractor must develop and implement a written process for monitoring and implementing referrals for underweight and

overweight members. UFC proposed a CAP to train staff regarding the requirement that vision and prescriptive lenses are a covered EPSDT service; revise the member handbook to clearly specify that no copayment or other charge is required for EPSDT screening and resultant services; and revise the EPSDT tracking form's desktop to detail the procedures for addressing received EPSDT forms which identify members with failure to thrive, low body mass index (BMI), and/or underweight or overweight diagnoses, including appropriate follow-up and referrals to pediatric case management as appropriate. Additionally, UFC plans to develop and implement a written process which details how UFC will ensure that medical necessity for commercial oral nutritional supplements is determined on an individual basis by the member's PCP or attending physician using the criteria specified in the AMPM; and staff will be trained on all process changes. AHCCCS accepted the CAP. However, to close the CAP UFC will need to provide copies of the draft desktop procedures and processes revisions as well as the materials used to train staff.

- UFC must develop and implement a written process for the following: educating members who are identified as having a CRS-eligible condition, educating members on the benefits of enrollment in the CRS program, and ensuring that members are aware of the option to opt out of the CRS program. UFC proposed a CAP to revise desktop procedures to include specific language requiring MCH staff to educate members, parents, and guardians on CRS enrollment benefits and the option to opt out of the CRS program (including related financial responsibility when opting out) when a CRS-eligible condition is present. UFC plans to train staff on the changes, develop a review tool, and implement a monthly documentation review process. AHCCCS accepted the CAP. However, to close the CAP UFC will need to provide a copy of the following: revised desktop procedures, monitoring tool, and training materials.

- UFC must develop and implement a written process and materials to inform all PCPs and OB/GYN providers and members (annually and within 30 days of enrollment with the Contractor for newly enrolled members) about all women's preventative health services and of the requirements and availability of all women's preventative care services, detailing the covered services included as part of the well-woman preventative care visit. UFC proposed a CAP to revise all applicable policies, to provide clarification to members and providers (in the member newsletter, member handbook, and the provider manual), and to ensure that a detailed list of covered services available as part of the well women's preventative care visit is included. AHCCCS accepted the CAP. However, to the close the CAP UFC will need to provide a copy of the policy revisions and the member newsletter and flyer.

AHCCCS identified deficiencies in the MM standard, requiring UFC to submit three CAPs related to this standard. Following is a list of the required actions and the CAPs that UFC submitted for approval to AHCCCS.

- UFC must conduct follow-up calls within seven days of discharge to all members. UFC proposed a CAP to review and revise current desktop processes related to post-discharge member outreach calls, train staff on the process changes, and develop a tool and monthly review process. AHCCCS accepted the CAP. However, to close the CAP UFC must submit the revised desktop processes, training material provided to staff, and the tool that will be used to review the documentation process.

- UFC must have policies and procedures stating that only members who request a homeless clinic as a PCP may be assigned to a homeless clinic and that the Contractor must assist homeless clinics with administrative issues such as obtaining prior authorization and resolving claims issues. UFC proposed a CAP to revise the associated policy to include additional verbiage stating that only members who request a homeless clinic as a PCP may be assigned to the homeless clinic. AHCCCS accepted the CAP. However, to close the CAP the updated policy should be submitted with the proposed changes.

- UFC must have in its policies and procedures that payment will not be denied for the treatment of emergency services when a representative of the Contractor instructs the enrollee to seek emergency services and in the event that the emergency room provider, hospital, or fiscal agent has notified the Contractor within 10 calendar days of presentation for emergency services. UFC proposed a CAP to revise the associated policy to include language clarifying when emergency services are not denied. AHCCCS accepted the CAP. However, to close the CAP the updated policy should be submitted with the proposed changes.

Although the Contractor scored at or above the 95 percent compliance threshold in the CIS, MI, and QM standards, AHCCCS required a CAP to address deficiencies identified during the OR.

AHCCCS identified deficiencies in the MI standard, requiring UFC to submit one CAP related to this standard. Following is a list of the required actions and the CAPs that UFC submitted for approval to AHCCCS.

- UFC must ensure that UFC provides written notice about termination of contracted providers, within 15 days after the receipt or issuance of the termination notice, to each member who received their primary care from, or was seen regularly by the terminated provider. UFC proposed a CAP to send to contracted providers every quarter a fax blast containing reminders on the requirement and to update the procedures for processing termination notifications. AHCCCS accepted the CAP. However, to close the CAP UFC must submit documentation of the training and new and uprated protocols as well as examples of timely termination notification to members.

AHCCCS identified deficiencies in the QM standard, requiring UFC to submit five related CAPs. Following is a list of the required actions and the CAPs that UFC submitted for approval to AHCCCS.

- UFC must develop a process and provide documentation which demonstrates that UFC is monitoring grievances; utilization management; performance improvement; results of medical record review; and all quality of care issues, including trend data for the purpose of consideration during the re-credentialing process. UFC proposed a CAP to revise the re-credentialing process and to train staff on the updated process. AHCCCS accepted the CAP. However, to close the CAP UFC must provide the revised policy, the QM form, and a copy of the training materials.

- UFC must include information that captures performance improvement (PI) monitoring and activities in its policies and procedures as delineated in the Contractor's policy. UFC proposed a CAP to implement a tracking log to track health information system inaccuracies or errors, update the applicable policy, update the notification (both internally and externally), review processes, and train staff on the changes. AHCCCS accepted the CAP. However, to close this CAP UFC must

provide documentation that aligns with AHCCCS requirements and supports the implementation of those items outlined in the proposed CAP.

- UFC must develop and employ a process for implementing corrective actions and notifying AHCCCS in event of a health information system inaccuracy or issue. UFC proposed a CAP to: develop a process and desktop for identifying best practices related to PIPs, update the applicable policy, discuss the issue during the Quality Management/Performance Improvement (QMPI) Committee meetings, and retrain staff on the changes. AHCCCS accepted the CAP. However, to close this CAP UFC must provide documentation that aligns with AHCCCS requirements and supports the implementation of those items outlined in the proposed CAP.

- UFC must develop and implement a process for determining best practices related to PIPs. After a review of the appropriate national standards and evidence-based guidelines, UFC proposed updating policy QM 6010, Collection Analysis and Reporting of Quality Indicators and Performance Measures Data (QM 6010) to describe the process to identify best practices. In addition, UFC will discuss best practices related to PIPs in the QAPI Committee, develop a desktop procedure for identifying best practices, and train staff members on the process.

- UFC must develop and implement a process to ensure interrater reliability (IRR). In addition, AHCCCS required UFC to develop and implement a process for determining best practices related to performance measures and achieving the MPS. For the IRR process, UFC proposed to implement an IRR process to ensure that clinical data are applied in a consistent manner, create a desktop procedure for IRR audits, include the IRR process in the quality management work plan, present the results of IRR activity to the QMPI Committee, and update QM 6010 regarding the IRR process. For determining best practices related to performance measures and achieving the MPS, after a review of the appropriate national standards and evidence-based guidelines, UFC will include this process in the quality management work plan, discuss it in the QMPI Committee annually, create a desktop procure for the process, and update QM 6010 with the process.

AHCCCS identified deficiencies in the CIS standard, requiring UFC to submit two related CAPs. Following is a list of the required actions and the CAPs that UFC submitted for approval to AHCCCS.

- UFC must ensure that it pays applicable interest on all claims, including overturned claim disputes. UFC proposed a CAP to correct date description fields that are populated into the UFC systems, validate that interest was paid correctly on claims processed after the OR, monitor that the newly populated check date field and the interest rate calculation programming correctly calculate interest, and train staff on the newly populated date field. AHCCCS accepted the CAP. However, to close the CAP UFC must provide documentation showing interest appropriately applied on claims for hospital, non-hospital and overturned claim disputes as well as for completed training.

- UFC must ensure that all claims are correctly matched against AHCCCS registration data. UFC proposed a CAP to re-train staff on how to identify AHCCCS registration status and select the correct denial reason. AHCCCS accepted the CAP.

## Recommendations for UFC

Based on the CAPs that UFC developed to address actions required by AHCCCS, HSAG recommends that UFC consider the following recommendations:

- Continue to conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations.
- Pay particular attention to the DS and MCH standard areas as the Contractor scored 74 percent on each.
- Continue to regularly monitor and ensure that updates are made to contracts with providers, and continue to ensure communication to all providers directly and indirectly impacted by these updates. Additionally, UFC should continue to assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes.

# Outstanding CAPs From Plans With ORs in CYE 2016 and CYE 2017

Discussion follows related to the outstanding CAPs for Contractors for which ORs were conducted in CYE 2016 and CYE 2017.

With few exceptions, AHCCCS expects all CAP steps to be completed within six months. The following are the CAP summaries for Care1st, HCA, HNA, MCP, and UHCCP-Acute.

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

### Corrective Action Plans

On October 6, 2017, AHCCCS accepted and/or closed all CAPs that Care1st submitted, except one CAP for the CC standard (CC element 4). On October 31, 2017, Care1st submitted the six-month update to its CYE 2016 OR CAPs, which described how Care1st has contracted with an entity for fraud, waste, and abuse (FWA) analysis services and training. Additionally, Care1st submitted a draft policy regarding FWA. On November 15, 2017, AHCCCS closed the CAP.

## Health Choice Arizona (HCA)

### Corrective Action Plans

HCA submitted a second CAP on September 29, 2017, for the issues identified during the OR conducted in April 2017, and AHCCCS accepted the CAP submission. In order to close the CAPs, HCA needed to demonstrate progress on the six-month CAP update. On May 31, 2018, AHCCCS informed HCA that two CAPs remained open (for DS element 2 and MCH element 2). AHCCCS determined that the six-month CAP update submitted thereafter demonstrated that the Contractor made appropriate changes to its policies and processes for both CAPs. AHCCCS closed the remaining open CAPs on July 5, 2018.

## Health Net Access (HNA)

### Corrective Action Plans

On September 27, 2017, AHCCCS accepted and closed two CAPs and accepted all remaining CAPs except one. HNA submitted a second response for the CAP that remained open; and on November 8, 2017, AHCCCS accepted the CAP resubmission and closed three CAPs. To close the three CAPs, HNA updated the provider manual to contain all requirements listed in ACOM 416 and notified providers of the update. HNA explained that since the Contractor had been moved under its parent company, policies and procedures were not retrievable; however, HNA submitted an example report to AHCCCS to satisfy this requirement. HNA also submitted an updated well woman's outreach letter to satisfy the

requirement of notifying providers and members of the availability of women's preventative health services.

In order to close the CAPs that remained open, HNA needed to demonstrate progress in the six-month CAP update. On June 1, 2018, AHCCCS informed HNA that one CAP remained open (for the CIS standard). To close the CAPs, HNA provided the following: a sample remit from Envolve Vision that included reason codes for all adjustments on the remit, the required claims dispute, and corrected claim language; results of an audit of overturned claim disputes, along with supporting documentation; details of the workflows and documentation regarding the processing of provider registration files received from AHCCCS; and hospital Notice of Decision templates for hospital disputes with the applicable Arizona Administrative Code (AAC) citations. HNA also conducted staff training on timeliness requirements for claims disputes and on resolution time frames being monitored by HNA executive management for compliance. Additionally, HNA completed SMI decertification training and provided sufficient supporting documentation. HNA modified its Medical Home and Quality of Care Resolution policies, retrained staff on the updated policies, and provided sufficient supporting documentation.

Additionally, HNA provided results of an audit of interest payments, along with supporting documentation; however, in order to close the CAP for the CIS standard, AHCCCS required that HNA provide an update.

## Mercy Care Plan (MCP)

### Corrective Action Plans

MCP submitted a six-month CAP update for the CIS standard, which included the implementation status of a system enhancement that would ensure that the claims processing system calculates the interest appropriately. On September 28, 2018, AHCCCS closed the CAP that MCP submitted.

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

### Corrective Action Plans

On June 22, 2017, AHCCCS accepted all CAPs that UHCCP-Acute submitted and closed two of those CAPs. UHCCP-Acute submitted the six-month update on November 14, 2017, in which UHCCP-Acute demonstrated that all subcontractors were notified of availability of the provider manual and provided evidence of provider re-education regarding timely inpatient and medical necessity reviews. AHCCCS closed the remaining open CAPs on December 8, 2017.

## Strengths

As of the CYE 2018 Annual Report, all CAPs were closed for the Acute Contractors, except those for CMDP, UFC, and HNA. (A formal response from AHCCCS will occur outside of the review cycle for CMDP, as well as UFC, and HNA.)

## Overall Opportunities for Improvement and Recommendations

Please see the Executive Summary for the overall recommendations for all Contractors over the 2016 three-year review cycle.

## Methodology

The following section presents the results for the mandatory performance measure activity conducted during the CYE 2017 reporting period. To evaluate performance levels and to provide an objective, comparative review of the Contractors' performance, AHCCCS required its Contractors to report CYE 2017 data (i.e., October 1, 2016–September 30, 2017). HSAG calculated results on AHCCCS' behalf for a variety of performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS, CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), and CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). AHCCCS approved the CYE 2017 rates for inclusion in this report.

For a detailed explanation of the methodology, please see Appendix B, "Conducting the Review," of this report.

## Required Performance Measures

The performance measures selected by AHCCCS for CYE 2017 were grouped into the following domains of care: Access to Care, Pediatric Health, Preventive Screening, and Utilization. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages the Contractors and AHCCCS to consider the measures as a whole rather than in isolation and to develop strategic changes required to improve overall performance.

Table 7-1 displays the CYE 2017 performance measures presented within this report; the associated measure specifications used to calculate each measure rate; and the established MPS, if applicable, for the Acute Care Contractors, CMDP, and the KidsCare Contractors. Of note, CMDP serves children in foster care in Arizona and the KidsCare Contractors serve children under age 19 in Arizona; therefore, these Contractors were only required to report a subset of the following performance measures for inclusion in this report, which are noted (*†* and *††*) in Table 7-1. An MPS had not yet been established for all reported performance measure rates.

**Table 7-1—CYE 2017 Performance Measures for Acute Care Contractors, CMDP, and KidsCare Contractors**

| Performance Measure | Measure Specification | MPS |
|---|---|---|
| **Access to Care** | | |
| *Annual Dental Visits—2–20 Years†* | HEDIS | 60.0% |
| *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months†* | Child Core Set | 93.0% |
| *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years†* | Child Core Set | 84.0% |

| Performance Measure | Measure Specification | MPS |
|---|---|---|
| *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years†* | Child Core Set | 83.0% |
| *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years†* | Child Core Set | 82.0% |
| **Pediatric Health** | | |
| *Adolescent Well-Care Visits†* | Child Core Set | 41.0% |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk††* | Child Core Set | — |
| *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* | Child Core Set | 65.0% |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life†* | Child Core Set | 66.0% |
| **Preventive Screening** | | |
| *Breast Cancer Screening* | Adult Core Set | 50.0% |
| *Cervical Cancer Screening* | Adult Core Set | 64.0% |
| *Chlamydia Screening in Women—Total* | Adult Core Set and Child Core Set | 63.0% |
| **Utilization** | | |
| *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total\** | HEDIS | 55.0 |
| *Inpatient Utilization—General Hospital/Acute Care—Days per 1,000 Member Months (Total Inpatient)—Total* | HEDIS | — |
| *Plan All-Cause Readmissions—Total\** | Adult Core Set | 11.0% |

*† Indicates that CMDP and the KidsCare Contractors were required to report the performance measure for inclusion in this report.*
*†† Indicates that CMDP was required to report the performance measure for inclusion in this report, while the KidsCare Contractors were not required to report the performance measure.*
*— Indicates that an MPS had not yet been established by AHCCCS.*
*\* A lower rate indicates better performance for this measure; therefore, rates must fall at or below the established MPS in order to exceed the CYE 2017 MPS.*

## Performance Measure Results—Acute Care Contractors

Table 7-2 presents the CYE 2017 performance measure rates with an MPS for each Acute Care Contractor and the statewide aggregate. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the CYE 2017 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (\*). For these measures, rates that fall at or below the established MPS are shaded green.

**Table 7-2—CYE 2017 Performance Measure Results—Acute Care Contractors**

| Performance Measure | Care1st | HCA | HNA | MCP | UFC | UHCCP-Acute | Aggregate |
|---|---|---|---|---|---|---|---|
| **Access to Care** | | | | | | | |
| *Annual Dental Visits* | | | | | | | |
| 2–20 Years | 61.6% | 56.8% | 41.5% | 63.8% | 56.1% | 61.2% | 60.8% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | | | |
| 12–24 Months | 91.7% | 91.1% | 91.8% | 93.9% | 92.5% | 93.3% | 93.1% |
| 25 Months–6 Years | 83.3% | 79.4% | 77.9% | 84.8% | 81.5% | 82.7% | 82.9% |
| 7–11 Years | 89.1% | 86.3% | 81.4% | 90.8% | 87.2% | 88.7% | 89.0% |
| 12–19 Years | 85.6% | 83.4% | 78.7% | 87.7% | 86.1% | 86.6% | 86.4% |
| **Pediatric Health** | | | | | | | |
| *Adolescent Well-Care Visits* | | | | | | | |
| *Adolescent Well-Care Visits* | 42.1% | 34.5% | 30.9% | 41.0% | 38.3% | 38.2% | 39.2% |
| *Well-Child Visits in the First 15 Months of Life* | | | | | | | |
| *Six or More Well-Child Visits* | 65.8% | 56.9% | 57.5% | 63.2% | 60.1% | 59.1% | 59.5% |
| *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* | 64.2% | 56.4% | 55.3% | 62.1% | 59.0% | 60.4% | 60.7% |
| **Preventive Screening** | | | | | | | |
| *Breast Cancer Screening* | | | | | | | |
| *Breast Cancer Screening* | 52.0% | 49.0% | 50.0% | 58.1% | 55.5% | 56.6% | 54.4% |
| *Cervical Cancer Screening* | | | | | | | |
| *Cervical Cancer Screening* | 52.3% | 44.0% | 47.7% | 55.2% | 53.4% | 48.1% | 50.5% |
| *Chlamydia Screening in Women* | | | | | | | |
| *Total* | 51.2% | 46.3% | 48.5% | 46.8% | 51.3% | 49.4% | 48.3% |
| **Utilization** | | | | | | | |
| *Ambulatory Care (per 1,000 Member Months)* | | | | | | | |
| ED Visits—Total* | 50.9 | 56.2 | 52.7 | 56.9 | 50.2 | 51.7 | 53.4 |
| *Plan All-Cause Readmissions* | | | | | | | |
| *Total** | 14.0% | 11.2% | 10.5% | 12.8% | 10.1% | 11.3% | 12.0% |

*\* For this indicator, a lower rate indicates better performance.*

[green cell] Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

Table 7-3 presents a comparison of the Acute Care Contractors' CYE 2016 to CYE 2017 rates. Performance measure rates were compared to determine if there was a significant difference between CYE 2016 and CYE 2017 using a Chi-square test of proportions. In cases where the cell size was less than five (i.e., fewer than five people were either numerator positive or numerator negative for either reporting year), a Fisher's exact test was used in place of a Chi-square test. The results of the statistical tests were considered significant when the *p* value was ≤0.05. A green upward arrow (↑) indicates a

significant improvement in performance, a red downward arrow (↓) indicates a significant decline in performance, and a dash (—) indicates that the change in performance was not significant.

For some measures, significance testing was not performed, either because comparison to the prior year was not appropriate due to technical specification changes (i.e., *Breast Cancer Screening*), CYE 2017 was the first year that the measure was required to be reported (i.e., *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk*), or the measure data were not appropriate for statistical testing (i.e., *Ambulatory Care* and *Inpatient Utilization*).

**Table 7-3—Trend Analysis From CYE 2016 to CYE 2017—Acute Care Contractors**

| Performance Measure | Care1st | HCA | HNA | MCP | UFC | UHCCP-Acute | Aggregate |
|---|---|---|---|---|---|---|---|
| **Access to Care** | | | | | | | |
| *Annual Dental Visits* | | | | | | | |
| 2–20 Years | ↓ | ↓ | — | ↑ | ↑ | — | ↑ |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | | | |
| 12–24 Months | — | — | ↑ | ↑ | ↑ | ↑ | ↑ |
| 25 Months–6 Years | ↓ | ↓ | — | ↓ | ↓ | ↓ | ↓ |
| 7–11 Years | ↓ | ↓ | — | ↓ | ↓ | ↓ | ↓ |
| 12–19 Years | ↓ | ↓ | — | ↓ | ↓ | ↓ | ↓ |
| **Pediatric Health** | | | | | | | |
| *Adolescent Well-Care Visits* | | | | | | | |
| Adolescent Well-Care Visits | — | — | ↑ | — | — | ↑ | — |
| *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* | | | | | | | |
| Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life | ↓ | — | ↑ | — | — | ↑ | — |
| **Preventive Screening** | | | | | | | |
| *Cervical Cancer Screening* | | | | | | | |
| Cervical Cancer Screening | — | — | ↑ | ↓ | — | — | — |
| *Chlamydia Screening in Women* | | | | | | | |
| Total | — | ↓ | — | — | — | ↑ | ↑ |
| **Utilization** | | | | | | | |
| *Plan All-Cause Readmissions* | | | | | | | |
| Total | ↓ | — | — | — | — | ↓ | ↓ |

↑   *Indicates a significant improvement in the Contractor's rate from CYE 2016 to CYE 2017.*

↓   *Indicates a significant decline in the Contractor's rate from CYE 2016 to CYE 2017.*

—   *Indicates no significant difference in the Contractor's rate from CYE 2016 to CYE 2017.*

## Strengths and Opportunities for Improvement

The following CYE 2017 performance measure rates were determined to be high performers for the Acute Care Contractors (i.e., the performance for at least four of the six Contractors met or exceeded the MPS):

- *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- *Breast Cancer Screening*
- *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*

Although the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* performance measure rates are considered to be high performers, the rates for all six Contractors and the Acute Care aggregate declined from CYE 2016 to CYE 2017, with the declines for the Acute Care aggregate and five Contractors considered significant. Despite the high performance for these indicators, the Contractors should assess the cause of this decline to ensure that performance stays above the MPS in future years.

Care1st and MCP demonstrated strength for CYE 2017, with seven of 13 (53.8 percent) performance measure rates for both Contractors meeting or exceeding the MPS. Of note, Care1st and MCP were the only Acute Care Contractors to meet or exceed the MPS for any performance measure rate in the Pediatric Health domain (both Care1st and MCP met or exceeded the MPS for *Adolescent Well-Care Visits* and Care1st also exceeded the MPS for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*). MCP was also the only Contractor to meet or exceed the MPS for all five performance measures within the Access to Care domain. Additionally, UHCCP-Acute exceeded six of 13 (46.2 percent) MPS, including four of five (80.0 percent) performance measure rates within the Access to Care domain.

The following CYE 2017 performance measure rates were determined to be low performers for the Acute Care Contractors (i.e., the performance for at least four of the six Contractors fell below the MPS):

- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
- *Adolescent Well-Care Visits*
- *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*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *Plan All-Cause Readmissions—Total*

Despite only two Acute Care Contractors exceeding the MPS for the *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* performance measure rate, four Contractors and the Acute Care aggregate demonstrated significant improvement from CYE 2016 to CYE 2017.

Conversely, no Acute Care Contractors met the MPS for the following three performance measure rates: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Cervical Cancer Screening*; and *Chlamydia Screening in Women*. Well-child visits are recommended annually for children from 3 to 6 years of age. These well-child visits are an opportunity for PCPs to track physical development (e.g., height, weight, vision, hearing), mental and emotional development (e.g., autism screening, attention deficit hyperactivity disorder), administer necessary vaccinations to prevent illness, and provide anticipatory guidance to caregivers.[7-1] This allows PCPs to identify potential issues such as diabetes or high blood pressure and implement interventions at an early age, including counseling for nutrition and physical activity. AHCCCS and the Acute Care Contractors should focus efforts on identifying the factors contributing to low rates for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and implement improvement strategies to increase well-child visits for members 3 to 6 years of age.

For the *Cervical Cancer Screening* and *Chlamydia Screening in Women* performance measures, all six Contractors fell below the MPS by at least 8 percentage points. The Pap test has been instrumental in preventing cervical cancer mortality in women, with cervical cancer deaths declining by 74 percent since the introduction of the test in the United States. Contractors should work with providers to increase cervical cancer screenings, especially for women who have not been screened within the last five years, as 50 to 64 percent of cervical cancer cases occur among these women.[7-2] Chlamydia is the most common sexually transmitted disease (STD) in the United States, with Arizona reporting 571.3 cases per 100,000 people in 2017; and rates have been on the rise, both within the state and nationally. Women are more likely to be infected with chlamydia and are often asymptomatic. Left untreated, chlamydia is associated with pelvic inflammatory disease (PID), which can cause infertility and chronic pain. Additionally, screening programs in young women have been linked to a reduction in PID rates.[7-3] AHCCCS and Acute Care Contractors should focus efforts on identifying the factors contributing to low rates for these measures and implement improvement strategies to increase screenings for cervical cancer and chlamydia in women.

Additionally, HCA and HNA demonstrated the most opportunities for improvement with meeting or exceeding only two of 13 (15.4 percent) and three of 13 (23.1 percent) MPS for CYE 2017, respectively. Additionally, HCA demonstrated significant declines in performance for five of 11 (45.5 percent) measure rates that were compared to the prior year.

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[7-1] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: Apr. 2, 2019.
[7-2] Centers for Disease Control and Prevention. *Module 2: Cervical Cancer*. Available at: https://www.cdc.gov/cancer/knowledge/provider-education/cervical/rationale.htm. Accessed on: Apr. 2, 2019.
[7-3] Centers for Disease Control and Prevention. *Chlamydia*. Available at: https://www.cdc.gov/std/stats17/chlamydia.htm. Accessed on: Apr. 2, 2019.

# Performance Measure Results—CMDP

Table 7-4 presents the CYE 2016 and CYE 2017 performance measure results for CMDP. The table displays the following information: CYE 2016 performance, where available; CYE 2017 performance; the relative percentage change between CYE 2016 and CYE 2017 rates, where available; the significance of the relative percentage change, where available; and the CYE 2017 aggregate for the Acute Care Contractors for comparison. Performance measure rate cells shaded green indicate that CMDP met or exceeded the CYE 2017 MPS established by AHCCCS.

**Table 7-4—CYE 2016 and CYE 2017 Performance Measure Results—CMDP**

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | Acute Care Aggregate |
|---|---|---|---|---|---|
| **Access to Care** | | | | | |
| *Annual Dental Visits* | | | | | |
| 2–20 Years | 68.0% | 73.8% | 8.5% | **P<0.001** | 60.8% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | |
| *12–24 Months* | 98.3% | 97.9% | -0.4% | P=0.562 | 93.1% |
| *25 Months–6 Years* | 93.2% | 91.8% | -1.5% | P=0.053 | 82.9% |
| *7–11 Years* | 96.0% | 96.8% | 0.8% | P=0.299 | 89.0% |
| *12–19 Years* | 95.9% | 97.1% | 1.3% | P=0.111 | 86.4% |
| **Pediatric Health** | | | | | |
| *Adolescent Well-Care Visits* | | | | | |
| *Adolescent Well-Care Visits* | 68.3% | 72.3% | 5.9% | **P=0.002** | 39.2% |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk[2]* | | | | | |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | — | 27.1% | — | — | 23.8% |
| *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* | 70.7% | 74.5% | 5.4% | **P=0.006** | 60.7% |

[1] *Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 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] *An MPS had not yet been established for this measure.*

— *Indicates that CMDP was not required to report the measure for the CYE 2016 reporting period, or that a comparison of performance between CYE 2016 and CYE 2017 was not possible.*

☐ *Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.*

## Strengths and Opportunities for Improvement

CMDP demonstrated overall strength for CYE 2017, exceeding the MPS for all seven performance measure rates with an established MPS. Of note, three performance measure rates (*Annual Dental Visits*; *Adolescent Well-Care Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) demonstrated significant improvements from CYE 2016 to CYE 2017. Additionally, CMDP's performance for all eight performance measures exceeded the Acute Care aggregate.

# Performance Measure Results—KidsCare

The six Acute Care Contractors provide services to eligible children under age 19 enrolled in the KidsCare program (i.e., Arizona's CHIP). Enrollment in the KidsCare program resumed July 26, 2016, for coverage that began September 1, 2016. As a result, CYE 2017 was the first year of reporting these performance measure rates for the KidsCare program. Table 7-5 presents the CYE 2017 performance measure rates with an MPS for the six Acute Care Contractors serving the KidsCare program and the statewide KidsCare aggregate. Of note, the KidsCare aggregate rates include all members who met the enrollment criteria for the KidsCare program regardless of Contractor; therefore, members enrolled in United Healthcare Community Plan-Children's Rehabilitative Services (UHCCP-CRS) were included in the KidsCare aggregate rate calculations in addition to those members enrolled in the six Acute KidsCare Contractors. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the CYE 2017 MPS established by AHCCCS. As CYE 2017 was the first year reporting performance measure results for the KidsCare Contractors, no historical data were available.

**Table 7-5—CYE 2017 Performance Measure Results—KidsCare Contractors**

| Performance Measure | Care1st | HCA | HNA | MCP | UFC | UHCCP | Aggregate |
|---|---|---|---|---|---|---|---|
| **Access to Care** | | | | | | | |
| *Annual Dental Visits* | | | | | | | |
| *2–20 Years* | 74.2% | 73.0% | 57.8% | 78.9% | 64.4% | 72.6% | 74.3% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | | | |
| *12–24 Months* | NA | NA | NA | NA | NA | NA | 97.4% |
| *25 Months–6 Years* | 92.7% | 93.1% | 95.2% | 94.2% | 93.5% | 88.7% | 92.3% |
| *7–11 Years* | NA | NA | NA | NA | NA | NA | 100.0% |
| *12–19 Years* | NA | NA | NA | 97.4% | NA | 98.2% | 95.1% |
| **Pediatric Health** | | | | | | | |
| *Adolescent Well-Care Visits* | | | | | | | |
| *Adolescent Well-Care Visits* | 64.1% | 59.8% | 48.6% | 61.5% | 62.5% | 59.2% | 61.1% |
| *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* | 85.0% | 68.5% | 76.5% | 80.0% | 81.1% | 74.0% | 75.8% |

*NA indicates that the rate was withheld because the denominator was less than 30.*

▢ *Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.*

## Strengths and Opportunities for Improvement

The KidsCare aggregate demonstrated overall strength for the first year of reporting, as all seven performance measure rates exceeded the established MPS. Of note, four performance measure rates (*Annual Dental Visits*, *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*, and *Adolescent Well-Care Visits*) exceeded the MPS by at least 13 percentage points. Additionally, only one of the KidsCare Contractors' reportable performance measure rates (*Annual Dental Visits* for HNA) fell below the MPS for CYE 2017.

One of the three 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, performed 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. The QAPI program must focus on clinical and nonclinical areas and include PIPs designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. These PIPs must include the following:

- 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

In the AHCCCS Medical Policy Manual, 980—Performance Improvement Projects, AHCCCS mandates that Contractors participate in PIPs selected by AHCCCS. In addition, with AHCCCS approval, Contractors may select and design additional PIPs specific to needs and data identified through internal surveillance of trends. Mandated PIP topics are selected through AHCCCS' analysis of internal and external data and trends that may include Contractor input. AHCCCS considers topics such as comprehensive aspects of enrollee needs, care, and services for a broad spectrum of members or for a focused subset of the population, including those members with special healthcare needs or receiving Long Term Services and Supports (LTSS).

AHCCCS may mandate that a PIP be conducted by a Contractor or group of Contractors, according to standardized methodology developed by AHCCCS.

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).

AHCCCS implemented the *E-Prescribing* PIP because research suggested that an opportunity existed to improve preventable errors experienced 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. 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 that members may encounter, especially for those taking multiple medications.

The purpose of the *E-Prescribing* PIP is to increase the number of providers ordering prescriptions electronically 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.

This annual report will include CYE 2014 recalculated baseline measurement data; CYE 2016 Remeasurement 1 data; CYE 2017 Remeasurement 2 data; relative percentage change from Remeasurement 1 to Remeasurement 2; overall relative percentage changes from baseline data; statistical significance data; qualitative analyses, including limitations and lessons learned identified by the Contractor; and interventions.

# Contractor-Specific Results

AHCCCS provided HSAG with its Contractors' CYE 2017 *E-Prescribing* PIP information including qualitative analysis, with limitations and lessons learned; and interventions for six Acute Care Contractors and CMDP (total of seven Contractors). The Acute Care and CMDP Contractors for which data were provided were Care1st, HCA, HNA, MCP, UFC, UHCCP, , and CMDP.

This section includes Contractors' PIP Remeasurement 2 results as calculated by AHCCCS, along with specific activities conducted during Remeasurement 2, from October 1, 2016, through September 30, 2017.

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

### Findings

Table 8-1 presents the baseline, Remeasurement 1, and Remeasurement 2 results for the *E-Prescribing* PIP for Care1st's members. The table also presents relative percentage changes from Remeasurement 1 to Remeasurement 2 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 Remeasurement 1 to Remeasurement 2 | 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% | 62.47% | 10.13% | **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% | 54.18% | 11.04% | **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 2, 62.47 percent of Care1st providers prescribed at least one prescription electronically and 54.18 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. Care1st's Remeasurement 2 rate for Indicator 1 demonstrated a relative percentage change from Remeasurement 1 of 10.13 percent and for Indicator 2 demonstrated a relative percentage change from Remeasurement 1 of 11.04 percent. Care1st demonstrated statistically significant and substantively large improvements in the performance of the indicators for this PIP.

Table 8-2 presents the overall relative percentage change from baseline and statistically significant performance for Indicator 1 and Indicator 2.

**Table 8-2—Care1st *E-Prescribing* PIP**

| PIP Measure | Baseline Period Oct. 1, 2013, Through Sept. 30, 2014 | Overall Relative Percentage Change From Baseline | Overall Statistical Significance |
|---|---|---|---|
| Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically | 48.80% | 28.02% | **P<.001** |
| Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically | 41.23% | 31.42% | **P<.001** |

Care1st demonstrated a significant improvement in both indicators; however, the overall relative percentage change for Indicator 2 at 31.42 percent was slightly above the change for Indicator 1 of 28.02 percent.

Care1st submitted the following qualitative analysis:

Limitations:

Prior to implementation of the PIP, Care1st identified as a potential limitation the effect that the Medicare Improvements for Patients and Providers Act (MIPPA) and implementation of meaningful use (MU) measures had on the number of e-prescribers and on prescriptions generated electronically. Care1st reported that these existing initiatives combined may make it difficult to continue to achieve significant improvement.

Care1st reported that an intervention proposed at baseline to explore funding sources to assist selected providers with technical upgrades and other fees in order to have e-Rx functionality was not implemented. The funding intervention was discussed by Arizona Alliance of Health Plan's (AzAHP's) e-prescribing workgroup (workgroup) as a strategy to be used if needed; however, it was not implemented because other interventions that required less resources were demonstrating ability to drive improvement. In addition, the array of electronic health records systems and the fact that providers most likely to need financial assistance were not contracted with all participating plans would have complicated the ability to identify and fund technical improvements.

Care1st conducted a barrier analysis that included a systematic literature review which established that the primary barriers to greater use of e-prescribing were the cost of implementing an e-prescribing system, e-prescribing system errors, and privacy and legal issues.

In addition, Care1st participated in the workgroup, which is a group of Contractor representatives who collaborate to increase the rate of e-prescribing. As part of this work, Contractors surveyed providers to identify major barriers to e-prescribing. As a result of the survey, Care1st identified the following barriers:

- Members and/or physicians prefer hard-copy prescriptions.
- Technical problems exist with the e-prescribing transmission.
- Members have a belief that controlled substances cannot be electronically transmitted.
- Electronic medical records (EMRs) used by providers do not support electronic prescribing of controlled substances (EPCS).
- EPCS is more time consuming.
- Inconsistent messaging and provider information overload are factors against e-prescribing.

Care1st found that similar barriers identified consistently across Contractors reflected the major issues identified in the literature review conducted.

Care1st also found that the following were barriers to e-prescribing:

- Provider staff turnover or lack of interest
- Lack of detailed actionable information by the Contractor and/or provider group
- Provider complacency about adopting or improving processes

Lessons learned:

- Care1st identified that provider reluctance to use EPCS, even though sending prescriptions for controlled substances electronically is much more secure than paper prescriptions, was one continuing barrier to improvement.
- Care1st established that approximately 95 percent of pharmacies in Arizona were EPCS-enabled. Review and discussion of internal e-prescribing monitoring indicated that urgent care providers, who often wrote prescriptions for pain control medications, were more likely to use written prescriptions for patients. Care1st plans to explore targeting urgent care providers, along with other prescribers of controlled substances.
- Care1st internal data showed that the current overall rate of prescriptions for AHCCCS members sent electronically is 54.7 percent. However, the rate for e-prescribing of non-controlled substances is higher, at 62.5 percent. Care1st concluded that increasing provider understanding of EPCS represented an opportunity for improvement. Care1st plans to address this barrier through consistent and sustained provider education focusing on EPCS in CYE 2018.
- Care1st noted that opportunities to increase e-prescribing exist within certain provider specialties. For example, prescribing data demonstrated a high proportion of general dentists and emergency physicians with no or extremely low rates of e-prescribing.

- Care1st concluded that providers were reluctant to use EPCS, even though sending prescriptions for controlled substances electronically is much more secure than paper prescriptions, which can be tampered with, lost, or stolen. Consequently, Care1st adopted a particular focus on educating providers to improve EPCS, and will continue to maintain that effort.

- Care1st concluded that evidence demonstrated that financial incentives can drive providers' adoption and use of health information technology such as e-prescribing. In addition to continued member and provider education regarding the benefits of e-prescribing, Care1st noted that one intervention proposed at baseline, to explore funding sources to assist selected providers with technical upgrades and other fees in order to have e-prescribing functionality, was not implemented. This intervention was discussed by the workgroup as a strategy; however, it did not move forward as other interventions that required less resources demonstrated ability to drive improvement. In addition, the array of electronic health record systems and the fact that the providers most likely to need financial assistance were not contracted with all participating Contractors would have complicated the group's ability to identify and fund technical improvements. However, as part of its collaborative efforts with other organizations, Care1st did find that the Arizona Board of Pharmacy had some funding available for limited electronic functionality. This did not address the seed funding needed to institute e-prescribing; however, Care1st made providers aware of available external funding assistance opportunities such as funding from the Board of Pharmacy.

- When Care1st analyzed the baseline data, the Contractor found that e-prescribing rates for members ages 65 and older were higher than for members from birth through 64 years for both Acute and the Department of Developmental Disabilities (DDD) providers. Consequently, Care1st was able to rule out the hypothesis that a higher percentage of older patients were opting out of e-prescribing.

Care1st stated in the report submitted to AHCCCS that their interventions reflected an analysis of quantitative and qualitative data and that the interventions were evidence-based. In addition, the interventions were developed in a collaborative manner with other Contractors and organizations in order to drive systemwide change and employ frequent and consistent messaging and education to reinforce provider and member understanding of e-prescribing. Care1st reported the following interventions to improve both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically:

- Educate providers about the benefits of e-prescribing, how to get started, and solutions to barriers—including clarifying that EPCS is legal in Arizona and the specific requirements for EPCS.

- Incorporate incentives into value-based purchasing (VBP) agreements to encourage providers—particularly physicians, physician assistants, and nurse practitioners—to improve rates of e-prescribing.

- Educate members, via repeated communications in member newsletter articles, about the benefits of sending prescriptions electronically to pharmacies.

- Engage providers to educate members about the benefits of sending prescriptions electronically to pharmacies.

- Educate members about the benefits of having their prescriptions sent electronically to related pharmacies.

- Provide targeted education through meetings with high-volume providers, such as patient-centered medical homes (PCMHs) and provider specialties via fax blasts and during provider forums.

## Strengths

Care1st's rates for the percentage of providers using e-prescribing increased in Remeasurement 2 by 10.3 percent and for the percentage of e-prescriptions by 11.04 percent. In addition, Care1st made significant gains since the baseline period, with an overall percentage change of 28.02 for Indicator 1 and 31.42 percent for Indicator 2. Care1st completed a thorough barrier analysis and formulated interventions to address the barriers. Care1st developed strong interventions, including educating prescribers on the advantages of e-prescribing, specifically on how to start the process and the legal implications; provided incentives to encourage e-prescribing; and engaged providers in educating members about the benefits of e-prescribing.

## Opportunities for Improvement and Recommendations

Care1st remains below the AHCCCS aggregate rate for the percentage of providers using e-prescribing (AHCCCS aggregate rate: 73.42 percent) and for the percentage of e-prescriptions (AHCCCS aggregate rate: 55.76 percent). Care1st has already identified that increasing provider education about EPCS would impact one barrier and plans to address this by consistent and sustained provider education. Although this is the last measurement year, HSAG recommends that Care1st continue to monitor outcomes associated with the reported interventions, particularly provider education. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors in the workgroup to improve performance for these indicators.

# Health Choice Arizona (HCA)

## Findings

Table 8-3 presents the baseline and Remeasurement 1 and 2 results for the *E-Prescribing* PIP for HCA's members. The table also presents the relative percentage changes from Remeasurement 1 to Remeasurement 2 and the statistical significance of changes in rates.

**Table 8-3—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 Remeasurement 1 to Remeasurement 2 | 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% | 62.98% | 11.01% | **P<.001** |
| Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically | 43.46% | 45.79% | 51.45% | 12.37% | **P<.001** |

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-3 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 2, 62.98 percent of HCA providers prescribed at least one prescription electronically and 51.45 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. HCA's rate for Remeasurement 2 for Indicator 1 demonstrated a relative percentage change from Remeasurement 1 of 11.01 percent and for Indicator 2 demonstrated a relative percentage change from Remeasurement 1 of 12.37 percent. HCA demonstrated statistically significant improvement for Indicators 1 and 2.

Table 8-4 presents the overall relative percentage change and statistically significant performance for Indicator 1 and Indicator 2.

**Table 8-4—HCA *E-Prescribing* PIP**

| PIP Measure | Baseline Period Oct. 1, 2013, Through Sept. 30, 2014 | Overall Relative Percentage Change From Baseline | Overall Statistical Significance |
|---|---|---|---|
| Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically | 56.69% | 11.09% | **P<.001** |
| Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically | 43.46% | 18.39% | **P<.001** |

HCA demonstrated improvement in both indicators; however, the overall relative percentage change from baseline for Indicator 2 at 18.39 percent represented a significant improvement and was above the change for Indicator 1 of 11.09 percent.

HCA submitted the following qualitative analysis:

Limitations:

HCA identified several barriers to improving the indicator rates:

- Paper charting was used in 10 percent of the clinics assessed during the CY 2017 environmental scan.
- Most network providers were not aware that narcotics could be prescribed electronically.
- Not all e-prescribing practices were either willing or able to purchases additional software necessary for e-prescribing.
- A small number of members still preferred paper prescriptions.

Lessons learned:

- Providing financial incentives through value-based contracting was the most effective way to influence provider prescribing behavior.

- Provider education may be a factor in e-prescribing, even though the increase in e-prescribing rates mirrored HCA's increase in value-based contracts.
- HCA found an increase in rates when the Contractor switched its pharmacy benefits manager from Envision to OptumRx. After meeting with both vendors, HCA concluded that the increase in rates may have been because OptumRx prepared for the transition by an outreach to providers; however, HCA considered that the Envision methodology may have underestimated the rates.

HCA reported that three primary interventions would be the focus for CYE 2017 and that these interventions would be reviewed quarterly:

- Increased education to the network providers
- More training for network representatives who conduct provider outreach, including updated e-prescribing information and Health Current materials to distribute to providers.
- Enhance reports to include details regarding narcotic vs. non-narcotic prescribing patterns for network providers by sending a blast fax to providers to promote an AHCCCS free continuing medical education credit, and a Health Current webinar.

### Strengths

HCA demonstrated improvement in both PIP indicators, with each showing statistically significant improvement. In addition, HCA made gains since the baseline period, with an overall percentage change of 11.09 for Indicator 1 and 18.39 percent for Indicator 2. HCA conducted a barrier analysis and environmental scan to prioritize which interventions would be most successful in increasing both indicator rates. HCA concluded that value-based contracting made the most significant impact on rates. In addition, HCA determined that including e-prescribing messages in all network outreaches is an intervention that will maintain the momentum of rate increases.

### Opportunities for Improvement and Recommendations

HCA remains below the AHCCCS aggregate rate for the percentage of providers using e-prescribing (AHCCCS aggregate rate: 73.42 percent) and for the percentage of e-prescriptions (AHCCCS aggregate rate: 55.76 percent). HCA completed a barrier analysis and concluded that value-based contracting is the most significant intervention to improving the rates. Although this is the last measurement year, HSAG recommends that HCA continue to monitor interventions quarterly to determine which interventions cause the greatest improvement over time.

## Health Net Access (HNA)

### Findings

Table 8-5 presents the baseline, Remeasurement 1, and Remeasurement 2 results for the *E-Prescribing* PIP for HNA's members. The table also presents relative percentage changes from Remeasurement 1 to Remeasurement 2 and statistical significance of changes in rates.

**Table 8-5—HNA *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 Remeasurement 1 to Remeasurement 2 | 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% | 66.56% | 6.42% | **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% | 54.50% | 11.71% | **P<.001** |

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-5 shows that, during the baseline period, 51.37 percent of HNA's providers prescribed at least one prescription electronically and 36.18 percent of the prescriptions were sent by an AHCCCS-contracted provider electronically. For Remeasurement 2, 66.56 percent of HNA's providers prescribed at least one prescription electronically and 54.50 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the Remeasurement 2 period, HNA demonstrated for Indicator 1 a relative percentage change from Remeasurement 1 of 6.42 percent and demonstrated for Indicator 2 a relative percentage change from Remeasurement 1 of 11.71 percent. HNA demonstrated statistically significant improvements in performance for this PIP.

Table 8-6 presents the overall relative percentage change and statistically significant performance for Indicator 1 and Indicator 2.

**Table 8-6—HNA *E-Prescribing* PIP**

| PIP Measure | Baseline Period Oct. 1, 2013, Through Sept. 30, 2014 | Overall Relative Percentage Change From Baseline | Overall Statistical Significance |
|---|---|---|---|
| Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically | 51.37% | 29.57% | **P<.001** |
| Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically | 36.18% | 50.64% | **P<.001** |

HNA demonstrated a significant improvement in both indicators; however, the overall relative percentage change from baseline for Indicator 2 at 50.64 percent was above the change for Indicator 1 of 29.57 percent.

HNA submitted the following qualitative analysis:

Limitations:

HNA reported that the workgroup performed initial surveys which identified that one barrier listed by providers was the number of controlled substances prescribed. Consequently, HNA developed and distributed provider educational material in provider quality of care guides which addressed the fact that controlled substances can be processed electronically.

HNA identified that although e-prescribing is increasing on a national perspective, most prescriptions are still not sent electronically, and adoption of the technology remains limited. Research has shown that barriers to a wider implementation include the following:

- Individual providers' lack of access to the technology
- Complexity of the technology available
- Incomplete patient data and physicians' attitudes
- Provider concern that e-prescribing may diminish clinical independence and authority
- Concerns that workflows and existing processes may require significant change to accommodate the new technology required for e-prescribing
- Effort needed to adapt office systems and manage technical difficulties
- Costs associated with purchase and implementation of a new system
- Insufficient time for providers and staff to learn how to use a new system

- Inability of multiple systems to share information effectively
- Difficulty of distributing provider education materials to all prescribers

Lessons learned:

- Identifying a means of distributing provider education is a vital step to insuring success of the intervention. HNA's quality management staff partnered with the provider relations and pharmacy services staff to distribute materials. As a result of the collaboration, materials were widely distributed to over twelve hundred providers.
- Despite the education provided, a wide difference exists between the proportions of total prescriptions submitted electronically and the controlled substances prescribed using the electronic method. HNA plans to continue education of providers to decrease the difference.

HNA completed the following interventions:

- Provider online news article was developed that detailed the potential benefits of e-prescribing and provided a list of available e-prescribing resources.
- Education provided at a provider forum.
- Provider education materials were developed which included the fact that controlled substances can be processed using e-prescribing.
- Provider quality resource booklet revised to include educational article about e-prescribing.
- Pharmacy update article was directed at providers related to the value of using e-prescribing.
- Monitoring of e-prescribing rates continued and technical assistance was offered to providers who have low rates.

## Strengths

HNA demonstrated a relative percentage change from baseline of 6.42 percent for Indicator 1and 11.71 percent for Indicator 2. In addition, HCA made significant gains since the baseline period, with an overall relative percentage change of 29.57 for Indicator 1 and 50.64 percent for Indicator 2. HNA attributed the rates of improvement to the amount of provider education implemented over the past contract year. The Quality Management department developed and distributed multiple provider educational articles and updates, including the Provider Quality of Care Guide, a provider newsletter, and a pharmacy update. HNA distributed the materials through online updates and news, provider forums, and provider office visits by the provider relations and quality management staff.

## Opportunities for Improvement and Recommendations

HNA remains below the AHCCCS aggregate rate for the percentage of providers using e-prescribing (AHCCCS aggregate rate: 73.42 percent) and for the percentage of e-prescriptions (AHCCCS aggregate rate: 55.76 percent). Although HNA reported barriers to the achievement of rate increases, HNA only reported three interventions for Remeasurement 2. Although this is the last measurement year, HSAG

recommends that HNA prioritize the barriers encountered and develop interventions that address the barriers with the highest priority. In addition, HSAG recommends that HNA continue the collaboration between the provider relations and quality management staff as HNA has identified that multiple provider educational articles and updates, online updates and news, provider forums, and provider office visits have resulted in improvements in the rates for both indicators.

# Mercy Care Plan (MCP)

## Findings

Table 8-7 presents the baseline and Remeasurement 1 and 2 results for the *E-Prescribing* PIP for MCP's members. The table also presents relative percentage changes from Remeasurement 1 to Remeasurement 2 and statistical significance of changes in rates.

**Table 8-7—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 Remeasurement 1 to Remeasurement 2 | 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% | 63.97% | 9.09% | **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% | 49.32% | 7.69% | **P<.001** |

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-7 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 2, 63.97 percent of MCP's providers prescribed at least one prescription electronically and 49.32 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For MCP's Remeasurement 2 period, Indicator 1 demonstrated a relative percentage change from Remeasurement 1 of 9.09 percent and Indicator 2 demonstrated a relative percentage change from Remeasurement 1 of 7.69 percent. MCP demonstrated statistically significant improvements in performance for this PIP.

Table 8-8 presents the overall relative percentage change and statistically significant performance for both Indicator 1 and Indicator 2.

**Table 8-8—MCP *E-Prescribing* PIP**

| PIP Measure | Baseline Period Oct. 1, 2013, Through Sept. 30, 2014 | Overall Relative Percentage Change From Baseline | Overall Statistical Significance |
|---|---|---|---|
| Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically | 50.27% | 27.26% | **P<.001** |
| Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically | 40.10% | 23.01% | **P<.001** |

MCP demonstrated a significant improvement in both indicators; however, the overall relative percentage change from baseline for Indicator 1 at 27.26 percent was above the change for Indicator 2 of 23.01 percent.

MCP submitted the following qualitative analysis:

Limitations:

MCP identified a significant difference in the denominator size for the indicators between the data calculated by AHCCCS and MCP for the baseline and Remeasurement 1. MCP reported a desire to continue collaborative efforts with AHCCCS to identify any discrepancies in processes used to calculate PIP rates.

MCP used a survey of providers conducted by all Contractors in the workgroup to identify the following barriers:

- 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 that it was "illegal" to e-prescribe as an original signature is required on the script.

- One 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 to have a different password and a key tag to facilitate a revolving identification.

MCP reported the following 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.

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

- Cost of implementing an e-prescribing system—per the research, more than 80 percent of primary care providers report a lack of financial support necessary for implementation, training, and information technology (IT) support for installation and maintenance of an e-prescribing system
- E-prescribing system errors—system errors include:
    - System alerts which lack specificity and/or are produced excessively. This may lead to "alert fatigue," in which prescribers tend to stop reading the alerts and just quickly scroll through them. This may cause significant system alerts to be ignored.
    - Hardware problems.
    - Workflow issues.
    - Software problems.

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

– Other problems such as cost, time consumption, and connection issues.
- Privacy and legal issues
  – Potential exists for patient information to be leaked from a web-based EHR system as proper firewalls and intrusion prevention systems are not in place.
  – EPCS has the potential to cause legal issues. Although the Drug Enforcement Agency (DEA) made a final ruling on EPCS in 2010, there are many standards contained in the ruling that may cause legal issues, including the following:
    o Identity proofing
    o Two-factor authentication
    o Digital certificates
    o Monthly logs
    o Third-party software audits
    o Requirement to keep two years of records

In the final PIP report, MCP reported that although the PIP met goals the following barriers and limitations existed:

- A data issue prevented MCP from reporting reliable baseline date.
- The AHCCCS reported CYE 2014 time period for reporting did not include a full contract year.

Lessons learned:

- Implementation of data-driven, provider-specific interventions such as providing prescribers with "report cards" that include their rates for providing electronic prescriptions has proven to be a difficult task.
- An inability to determine the root cause for providers who report that they provide electronic prescriptions at a higher rate than what the data indicate was noted.
- Recognition of a need for identification of the cause for data discrepancies between AHCCCS calculated data and MCP internal data.

MCP reported no new interventions to improve either the rate of providers prescribing prescriptions electronically or the rate of prescriptions sent electronically; however, MCP concluded that, since the number of prescribers electronically prescribing prescriptions and of increasing the percentage of prescriptions are increasing, the interventions are working. MCP continued to track e-prescribing data through the Quality Improvement Committee, Quality Management/Utilization Management Committee, and the Quality Committee of the Board of Directors. MCP reported that the current interventions will be continued, and new interventions may be developed if a new opportunity for improvement is identified or if MCP begins to identify a decline in performance. The current interventions that MCP has had in place are as follows:

- Continue MCP medical director and provider relations staff on-site visits and distribution of EPCS fact sheets.
- Conduct targeted review and outreach to larger practices to show variances across providers.
- Continue to develop member educational materials to communicate the benefits of e-prescribing on the MCP website and/or Facebook posts.
- Provide updated information about each provider's e-prescribing rate to practice representatives, and discuss the results with each practice periodically. MCP made the information specific to individual providers and concentrated on outlier low users.
- Continue to post a provider toolkit on the website to educate providers on the benefits and value of e-prescribing.

## Strengths

MCP was successful in increasing performance rates for Indicator 1 with a rate increase of 9.09 percent and for Indicator 2 with a rate increase of 7.69 percent. In addition, MCP made significant gains since the baseline period, with an overall relative percentage change of 27.26 for Indicator 1 and 23.01 percent for Indicator 2. MCP reported that it used the Plan-Do-Study-Act (PDSA) problem-solving cycle as a tool to increase the performance of the indicators. Using this approach, MCP developed a plan to implement an intervention, tested the effectiveness of the intervention, evaluated the results of the intervention, and determined what changes may needed before implementation. Before the PDSA cycle was initiated, MCP used the FOCUS approach (**F**ind the problem, **O**rganize the team, **C**larify the problem, **U**nderstand the problem, and **S**elect interventions to address the barriers) as well as the "5 Whys" and a fishbone diagram.

## Opportunities for Improvement and Recommendations

MCP remains below the AHCCCS aggregate rate for the percentage of providers using e-prescribing (AHCCCS aggregate rate: 73.42 percent) and for the percentage of e-prescriptions (AHCCCS aggregate rate: 55.76 percent). For Remeasurement 2, MCP reported a barrier analysis that was reported in the Remeasurement 1 reporting period. In addition, the interventions that MCP reported were the same interventions as in Remeasurement 1. Even though this is the last measurement year, to consolidate the gains made by MCP, HSAG recommends that MCP conduct a current barrier analysis to determine what interventions might be prioritized to increase performance in both indicators. MCP identified a data error that prevented accurate and reliable baseline data Consequently, MCP reported that the internal baseline rates to Remeasurement 1 and Remeasurement 2 outcomes were not comparable. However, MCP used the two-proportion Z-test for statistical analysis and compared internal Remeasurement 1 and Remeasurement 2 indicator rates. HSAG recommends that MCP request a meeting with AHCCCS to reconcile the PIP indicator data.

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

### Findings

Table 8-9 presents the baseline, Remeasurement 1, and Remeasurement 2 results for the *E-Prescribing* PIP for UHCCP-Acute members. The table also presents relative percentage changes from Remeasurement 1 to Remeasurement 2 and statistical significance of changes in rates.

**Table 8-9—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 Remeasurement 1 to Remeasurement 2 | 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% | 73.73% | 4.15% | **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% | 59.38% | 11.84% | **P<.001** |

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-9 shows that, during the baseline period, 63.75 percent of UHCCP-Acute 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 2 period, 73.73 percent of UHCCP-Acute providers prescribed at least one prescription electronically and 59.38 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For Remeasurement 2, the UHCCP-Acute Indicator 1 rate demonstrated a relative percentage change from Remeasurement 1 of 4.15 percent and the Indicator 2 rate demonstrated a relative percentage change from Remeasurement 1 of 11.84 percent.

UHCCP-Acute demonstrated statistically significant and substantively large improvements in performance for Indicator 2.

Table 8-10 presents the overall relative percentage change and statistically significant performance for Indicator 1 and Indicator 2.

**Table 8-10—UHCCP-Acute *E-Prescribing* PIP**

| PIP Measure | Baseline Period Oct. 1, 2013, Through Sept. 30, 2014 | Overall Relative Percentage Change From Baseline | Overall Statistical Significance |
|---|---|---|---|
| Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically | 63.75% | 15.65% | **P<.001** |
| Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically | 44.32% | 33.97% | **P<.001** |

UHCCP-Acute demonstrated a significant improvement in both indicators, however, the overall relative percentage change from baseline for Indicator 2 at 33.97 percent was above the change for Indicator 1 of 15.65 percent.

UHCCP-Acute submitted the following qualitative analysis:

Limitations:

UHCCP-Acute identified several limitations regarding the PIP. UHCCP-Acute used paid claims for members for internal monitoring; however, the pharmacy claims system was currently set to pay for all licensed prescribers and did not differentiate between UHCCP contracted and non-contracted prescribers. UHCCP-Acute reported that as some of these providers may not be contracted with AHCCCS, these claims may not have been included in the AHCCCS results. As a result of this issue, UHCCP-Acute concluded that internal monitoring may have yielded a slightly higher rate of change than did the AHCCCS results.

UHCCP-Acute noted that the interventions implemented resulted in increased rates of provider use of e-prescribing and the e-prescribing rate; however, the Contractor reported that other factors could be associated with the increases. UHCCP-Acute stated that all AHCCCS Contractors participated in this PIP. Consequently, many of the prescribing providers contracted with multiple Contractors. UHCCP-Acute hypothesized that e-prescribing education, intervention, and messaging coming repeatedly from

multiple Contractors could attribute to increased provider adoption. In addition, UHCCP-Acute noted that the increase in e-prescribing rates occurred during a time of wider adoption and use of EHRs, which frequently have e-prescribing capabilities. UHCCP-Acute speculated that the increase in e-prescribing rates could have been aided by the increased use of electronic records technology along with increased awareness of the benefits of e-prescribing.

Lessons learned:

UHCCP-Acute concluded that, given the issues presented in the limitations section, the impact of multiple Contractor interventions and technology adoption cannot be easily ascertained.

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

- Presentation of e-prescribing information at provider forums.
- Instituted a new program called PreCheck MyScript that encourages providers to generate prescriptions electronically while giving real-time information regarding medication formulary status, need for prior authorization, and point-of-sale drug utilization information.

## Strengths

UHCCP-Acute achieved a rate increase of 73.73 percent that was slightly above AHCCCS' aggregate rate of 73.42 percent for Indicator 1. UHCCP-Acute' s rate of 59.38 percent surpassed the AHCCCS aggregate rate of 55.76 percent for Indicator 2, Rates for both indicators demonstrated a statistically significant increase. In addition, UHCCP-Acute made gains since the baseline period, with an overall relative percentage change of 15.65 for Indicator 1 and 33.97 percent for Indicator 2. UHCCP-Acute conducted an analysis regarding the increases of the PIP indicators and concluded that, due to interventions from multiple Contractors, the increased rates could not be attributed directly to the interventions the Contractor implemented. UHCCP-Acute has instituted a new technology, PreCheck MyScript, via several electronic health record systems and the UHCCP provider portal. PreCheck MyScript provides real-time information regarding medication formulary status, need for prior authorization, and point-of-sale drug utilization information that may improve both indicator rates in the future.

## Opportunities for Improvement and Recommendations

UHCCP-Acute identified that internal monitoring was performed using all paid claims for acute members; however, the pharmacy claims system was set to pay for all licensed prescribers and to not differentiate between UHCCP contracted and non-contracted prescribers. Therefore, some prescribers may not be contracted with AHCCCS, resulting in a question as to whether the claims were included in the AHCCCS results. UHCCP-Acute reported that internal monitoring may have yielded a slightly higher rate of change than did the AHCCCS results. This is an opportunity for improvement for UHCCP-Acute. Even though this is the last measurement period, HSAG recommends that UHCCP-Acute analyze this situation and develop interventions that alleviate the potential discrepancies between

UHCCP-Acute and AHCCCS data. UHCCP-Acute implemented a program called PreCheck MyScript that encourages providers to generate prescriptions electronically while giving real time information regarding medication formulary status, need for prior authorization, and point of sale drug utilization information. To consolidate gains, HSAG recommends that UHCCP-Acute monitor whether the PreCheck MyScript intervention makes a difference in the rates of improvement.

## University Family Care (UFC)

### Findings

Table 8-11 presents the baseline and Remeasurement 1 and Remeasurement 2 results for the *E-Prescribing* PIP for UFC's members. The table also presents relative percentage changes from Remeasurement 1 to Remeasurement 2 and statistical significance of changes in rates.

**Table 8-11—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 Remeasurement 1 to Remeasurement 2 | 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% | 60.73% | 9.21%% | **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% | 62.96% | 11.03% | **P<.001** |

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-11 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 2 period, 60.73 percent of UFC's providers prescribed at least one prescription electronically and 62.96 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For Remeasurement 2, UFC's Indicator 1 demonstrated a relative percentage change of 9.21 percent from Remeasurement 1 and Indicator 2 demonstrated a relative percentage change from Remeasurement 1 of 11.03 percent. UFC demonstrated statistically significant improvements in performance for this PIP.

Table 8-12 presents the overall relative percentage change and statistically significant performance for Indicator 1 and Indicator 2.

**Table 8-12—UFC *E-Prescribing* PIP**

| PIP Measure | Baseline Period Oct. 1, 2013, Through Sept. 30, 2014 | Overall Relative Percentage Change From Baseline | Overall Statistical Significance |
|---|---|---|---|
| Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically | 48.45% | 25.33% | **P<.001** |
| Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically | 47.34% | 32.99% | **P<.001** |

UFC demonstrated a significant improvement in both indicators; however, the overall relative percentage change from baseline for Indicator 2 at 32.99 percent was above the change for Indicator 1 of 25.33 percent.

UFC submitted the following qualitative analysis:

Limitations:

UFC identified that prescribers in the system are not a stagnant population, but change across time. UFC concluded that inferences about changing actual practices of individual providers across time cannot be made; however, global inferences can be made regarding UFC as a whole.

UFC identified the following barriers:

- Provider practices are slow to adopt e-prescribing and/or e-prescribing of controlled substances.
- Member preferences are for prescription submission by methods other than electronically.
- Confusion exists in the provider community about EPCS, the steps to take in order to become certified to e-prescribe, and the capabilities of pharmacies to accept e-prescriptions.

Lessons learned:

- Education regarding any emerging practice should be provided to the prescribers or providers as early as possible as unanticipated resistance or hesitancy could perhaps be overcome with early exposure to the concepts or anticipated benefits.

- Member education could also be included earlier to perhaps have members asking about these emerging or promising practices before actual inception into the delivery system.

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 with other Contractors.
- Conducted telephonic provider surveys.
- Conducted provider forums.
- Implemented VBP provider arrangements.
- Provided quarterly provider notifications regarding e-prescribing.

Although UFC reported no new interventions for this reporting period, the Contractor concluded that the existing interventions yielded an increase in both the percentage of prescriptions electronically submitted and the percentage of overall prescribers engaging in e-prescribing.

## Strengths

UFC's rate of 60.73 percent for Indicator 1 showed an increase from baseline of 9.21 percent. UFC achieved a rate of 62.96 for Indicator 2, which surpassed the AHCCCS aggregate rate of 55.76. Rates for both indicators demonstrated a statistically significant increase. In addition, UFC made significant gains since the baseline period, with overall relative percentage changes of 25.33 for Indicator 1 and 32.99 percent for Indicator 2. UFC incorporated an e-prescribing measure into its shared savings arrangement with targeted provider groups in CYE 2015. The shared savings arrangement required that providers meet a medical loss ratio threshold as well as the minimum performance standard on the *E-Prescribing* PIP. In order to achieve compliance with the PIP, UFC required the provider to demonstrate a 20 percent increase above baseline in the percentage of prescriptions originating through e-prescribing. UFC identified eight provider groups to participate in the shared savings initiative and tied a financial incentive to each group's performance on the *E-Prescribing* PIP. The financial incentive, coupled with consistent and sustained interventions, accounted for the increase in the performance in both indicators.

## Opportunities for Improvement and Recommendations

UFC remains below the AHCCCS aggregate rate for the percentage of providers using e-prescribing (AHCCCS aggregate rate: 73.42 percent). UFC reported no new interventions for this reporting period but concluded that the interventions in place were effective. Even though this is the last measurement period, since UFC remains below the AHCCCS aggregate rate for Indicator 1, HSAG recommends that UFC conduct another barrier analysis, prioritize the barriers, and develop interventions to increase the rate of Indicator 1 and maintain the momentum of Indicator 2. HSAG recommends that UFC continue to monitor outcomes associated with the reported interventions as well as any new interventions that UFC develops as a result of further barrier prioritization and analysis.

## Comprehensive Medical and Dental Program (CMDP)

### Findings

Table 8-13 presents the baseline and Remeasurement 1 and 2 results for the *E-Prescribing* PIP for CMDP's members. The table also presents relative percentage changes from Remeasurement 1 to Remeasurement 2 and statistical significance of changes in rates.

**Table 8-13—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 Remeasurement 1 to Remeasurement 2 | 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% | 60.53% | 9.44% | **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% | 60.65% | 7.23% | **P<.001** |

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-13 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 2, 60.53 percent of CMDP providers prescribed at least one prescription electronically and 60.65 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For CMDP, for Remeasurement 2, Indicator 1 demonstrated a relative percentage change of 9.44 percent from Remeasurement 1 and Indicator 2 demonstrated a relative percentage change of 7.23 percent from Remeasurement 1. CMDP demonstrated statistically significant improvements in performance for this PIP.

Table 8-14 presents the overall relative percentage change and statistically significant performance for Indicators 1 and Indicator 2.

**Table 8-14—CMDP *E-Prescribing* PIP**

| PIP Measure | Baseline Period Oct. 1, 2013, Through Sept. 30, 2014 | Overall Relative Percentage Change From Baseline | Overall Statistical Significance |
|---|---|---|---|
| Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically | 47.65% | 27.03% | **P<.001** |
| Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically | 46.69% | 29.90% | **P<.001** |

CMDP demonstrated a significant improvement in the overall relative percentage change from baseline for both indicators, however, the change for Indicator 2 at 29.90 percent was slightly above the change for Indicator 1 of 27.03 percent.

CMDP submitted the following qualitative analysis:

Limitations:

- CMDP stated that it was not clear why such a high percentage score was achieved for this PIP, and reported that one attribute may be the push to place a child with a qualified relative or in a licensed placement, which could result in a higher propensity for CMDP's population to utilize providers outside the "normal" AHCCCS/Medicaid provider network.

- Pediatric membership has historically had a small percentage of prescriptions for controlled substances.

- Members are prescribed drugs such as antibiotics and asthma/allergy medications that are less complicated medications, allowing e-prescribing to be implemented more easily.

- CMDP reported that due to the fact that CMDP is part of a State agency, payment of provider incentives is not allowed. ARS 8-512.E. mandates that CMDP shall use (for payment) the AHCCCS rates for services for eligible children. This made it difficult to promote to providers because CMDP could not offer any incentive or VBP for e-prescribing.

Lessons learned:

- In order to see an actual impact of planned interventions, CMDP has found it important to target CMDP credentialed providers. These providers are seeing CMDP more often and are open to additional resources that CMDP can provide.
- CMDP will also continue to partner with AHCCCS to address system issues and prepare for the 2020 plan changes for the CMDP provider network.

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

- Health services and provider services staff met to review the current PIP. CMDP discovered that the previous information was not an accurate representation of the network. CMDP staff reviewed available data and found a more accurate way to track provider improvement within CMDP.
- Provider services staff incorporated e-prescribing protocols as a formal item to be addressed as part of provider education during on-site visits.
- CMDP supported and continues to support efforts of the workgroup to encourage e-prescribing.
- CMDP distributed e-prescribing information to providers through the provider newsletter, educational site visits, and email blasts.
- CMDP will track all communication with providers and will continue to monitor the data.

## Strengths

CMDP's rate of 60.53 percent for Indicator 1 showed an increase from baseline of 9.44 percent. CMDP achieved a rate of 60.65 for Indicator 2, which surpassed the AHCCCS aggregate rate of 55.76. In addition, CMDP made gains since the baseline period, with an overall relative percentage change of 27.03 for Indicator 1 and 29.90 percent for Indicator 2. Rates for both indicators demonstrated a statistically significant increase. Two of CMDP's departments (Health and Provider Services) met to discuss opportunities to improve the PIP and through collaboration discovered a more accurate way to track provider improvement. CMDP completed an analysis of reasons for its performance in increasing both indicator rates and concluded that distributing e-prescribing information to providers through the provider newsletter, educational site visits, and email blasts will be continued. CMDP plans to track all communication with providers and will continue to monitor the data.

## Opportunities for Improvement and Recommendations

CMDP remains below the AHCCCS aggregate rate for the percentage of providers using e-prescribing (AHCCCS aggregate rate: 73.42 percent). CMDP reported that it was unclear why CMDP scored such a high percentage (60.65 percent) over the AHCCCS aggregate rate of 55.76 percent for Indicator 2. Although this is the last measurement period, HSAG recommends that CMDP conduct a thorough barrier analysis, determine reasons for rate increases, and prioritize new interventions. HSAG recommends that CMDP continue to monitor the outcomes associated with the reported interventions to consolidate gains made for this PIP.

# 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 of AHCCCS-contracted providers who prescribed at least one prescription electronically. The figure presents baseline and Remeasurement 2 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**
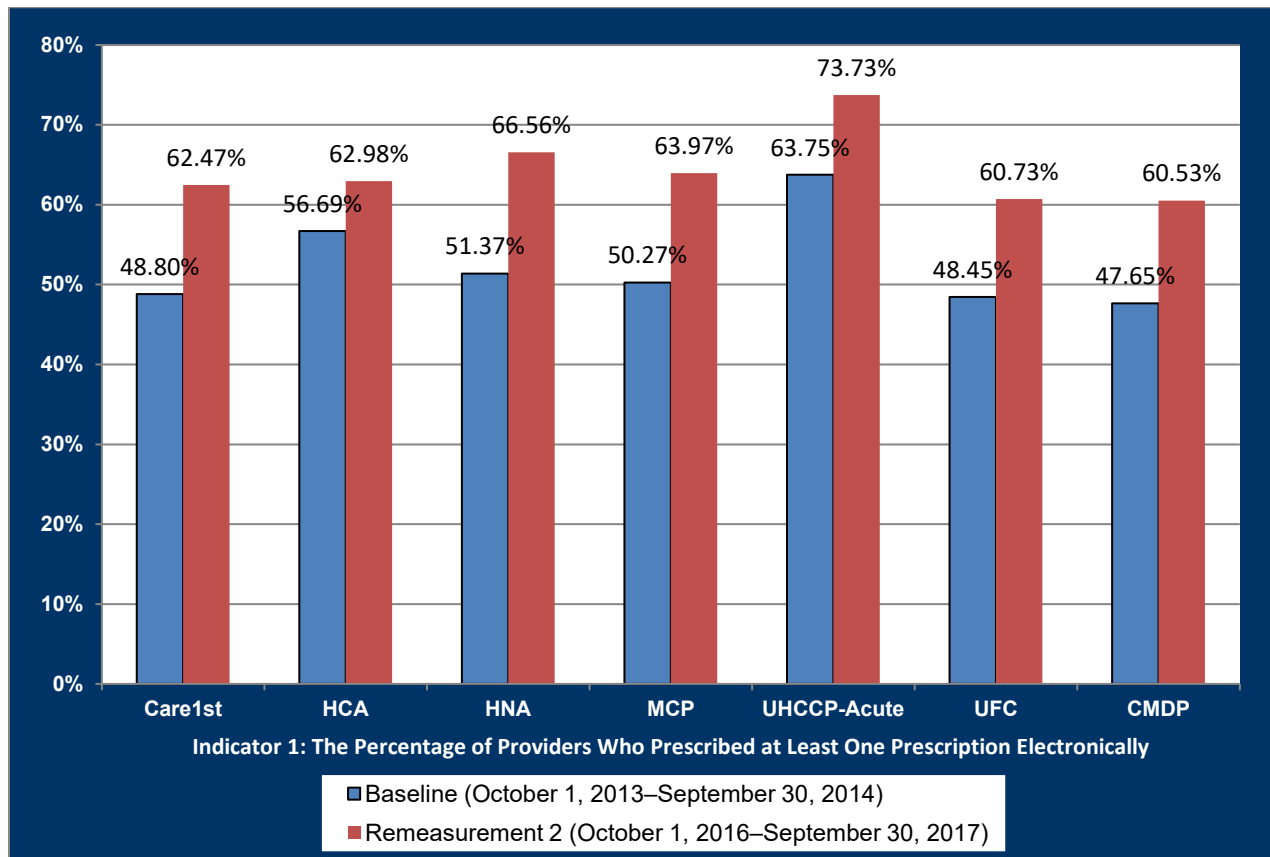


Figure 8-1 shows that each Contractor exceeded the respective baseline rate by a statistically significant amount at Remeasurement 2 for Indicator 1: The percentage of providers who prescribed at least one prescription electronically. UHCCP-Acute's rate of 73.73 percent was the highest percentage of providers who prescribed at least one prescription electronically of any of the Contractors and surpassed the AHCCCS aggregate rate of 73.42 percent. CMDP's rate of 60.53 percent was the lowest percentage of any of the Contractors. These findings indicate that all Contractors have improved and need to continue barrier analysis and prioritized interventions in order to consolidate the gains made for this PIP.

Figure 8-2 presents seven Acute Care and CMDP Contractors' comparison rates for the *E-Prescribing* PIP Indicator 2: the percentage of prescriptions sent electronically. The figure presents baseline and Remeasurement 2 rates for each Acute Care and CMDP Contractor tasked with completing this PIP.

**Figure 8-2—Performance Improvement Projects—*E-Prescribing:* Indicator 2: The Percentage of Prescriptions Sent Electronically—All Acute Care and CMDP Contractors**
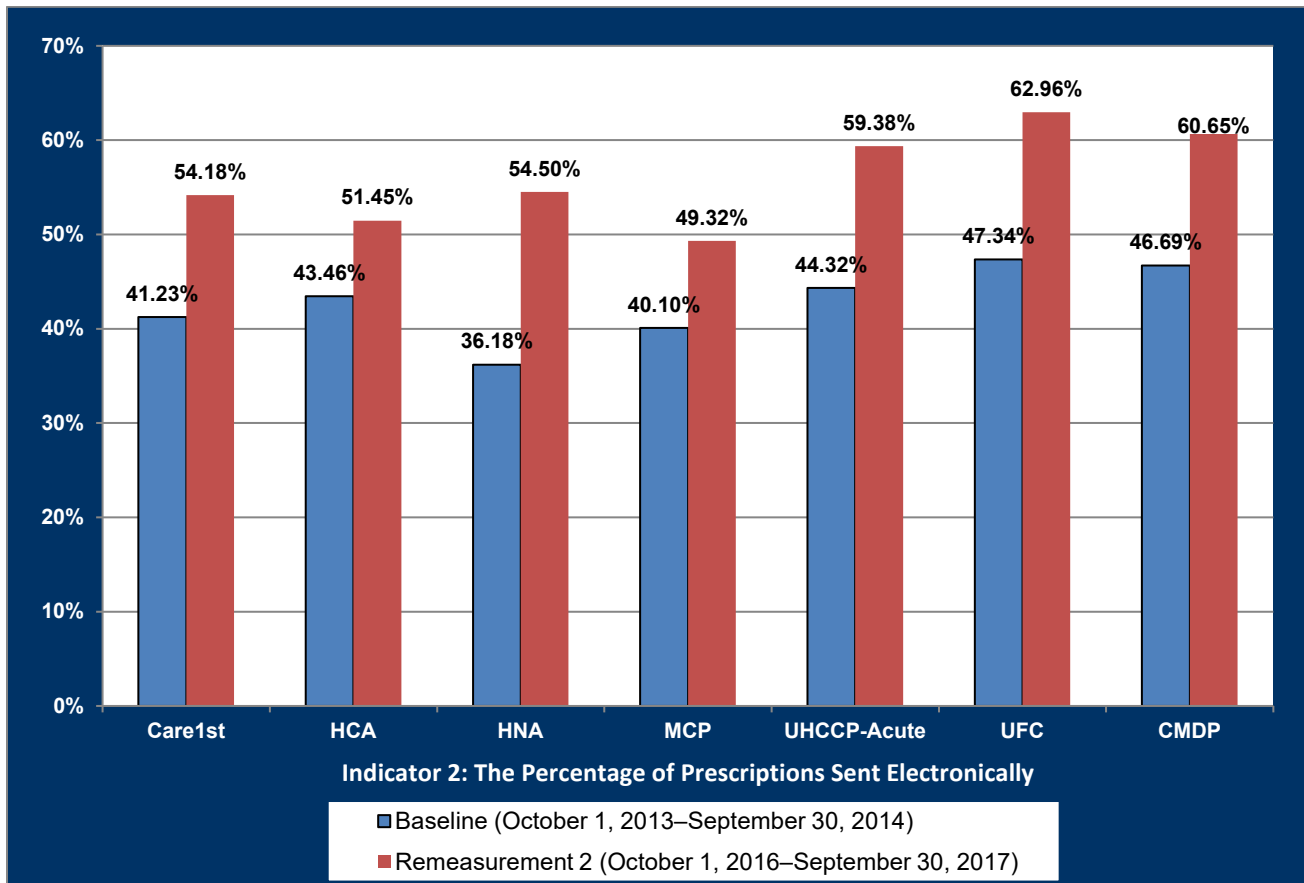


Figure 8-2 shows that each Contractor exceeded the respective baseline rate by a statistically significant amount at the second remeasurement for Indicator 2: the percentage of prescriptions sent electronically. UFC's rate of 62.96 percent was the highest percentage prescriptions sent electronically of any of the Contractors and surpassed the AHCCCS aggregate rate of 55.76 percent. MCP's rate of 49.32 percent was the lowest percentage of any of the Contractors. Three contractors (UHCCP-Acute, UFC, and CMDP) exceeded the AHCCCS aggregate rate of 55.76 percent. These findings indicate that all Contractors have improved and need to continue barrier analysis and prioritized interventions in order to consolidate the gains made for this PIP.

## Strengths

Figure 8-1 and Figure 8-2 demonstrate the strength of the Acute and CMDP Contractors' *E-Prescribing* PIP. All Contractors demonstrated increases in the performance of the indicators against baseline. In

addition, for Indicator 1, one Contractor exceeded the AHCCCS aggregate rate of 73.42 percent, and for Indicator 2, three Contractors exceeded the AHCCCS aggregate rate of 55.76 percent. Contractors continued to participate in the e-prescribing workgroup formed by AHCCCS. All Contractors attributed progress in the workgroup and the survey that was completed as factors in improving the rates of Indicator 1 and Indicator 2. 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. The survey results identified barriers to e-prescribing that assisted the Contractors in formulating interventions. All Contractors provided education to providers, while several targeted high-volume prescribers and provided incentives to encourage e-prescribing. One Contractor conducted targeted review and outreach to larger practices to show variances across providers. Many Contractors provided information about the benefits of e-prescribing to providers in provider newsletters, on educational site visits, in email blasts, and at provider forums.

### Opportunities for Improvement and Recommendations

The AHCCCS Quality Improvement (QI) Team implemented multiple process improvement efforts during CYE 2018, which included:

- Updated the PIP policy in the AHCCCS Medical Policy Manual.
- Implemented a revised PIP reporting template structure that better captured the evolution and progress of the Contractor throughout the PIP cycle.
- Created an AHCCCS PIP-Specific Review Checklist that will be used for future AHCCCS PIP submission reviews to:
  – Align coordinator reviews to enhance interrater reliability.
  – Provide more feedback to the Contractors to enhance the quality and comprehensiveness of the reports submitted.
  – Change the formatting to allow AHCCCS to provide item-specific feedback and associated updates, if resubmission is required.

HSAG noted that all Contractors used the new reporting template for the PIP submission. Based on the submitted results from the Contractors and the information submitted to HSAG from AHCCCS regarding the *E-Prescribing* PIP, as well as the fact that this is the last remeasurement period for this PIP, HSAG offers the following recommendations related to PIP rates:

- AHCCCS may want to review and compare the data for these indicators with the Contractors' data as several Contractors reported issues with data as a barrier to improvement. Even though this PIP been completed, the data issue seemed to remain unresolved.
- AHCCCS has made significant progress in making PIP process improvements in the past year, including the development of a new reporting template. Contractors submitted comprehensive reports using the new template; however, some Contractors did not include current barrier analysis or interventions. AHCCCS may want to consider offering and facilitating training opportunities to enhance the Contractors' ability to use the quality improvement tools, such as root cause analyses,

key driver diagrams, process mapping, and failure modes and effects analysis (FMEA) to assist the Contractors to improve not only the *E-Prescribing* PIP, but subsequent PIPs.

- AHCCCS may want to use the quarterly meetings with Contractors as opportunities to identify and address systemwide barriers which may be impacting the ability to achieve meaningful improvement related to the PIP process.

- AHCCCS should consider continuing the collaboration among Contractors in a workgroup to improve new PIP study indicator rates, as many of the Contractors reported the workgroup helped performance for the *E-Prescribing* PIP.

- Although this is the last measurement year, 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.

- AHCCCS should consider requiring for the Contractors new PIPs which pertain to aspects of the Arizona Complete Care activities.

## Appendix A. Validation of Organizational Assessment and Structure Performance Methodology

## 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.[A-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

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[A-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: February 14, 2019.

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.

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.

## 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.

## 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.

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.

In accordance with 42 CFR §438.240(b), AHCCCS requires Contractors to have a Quality Management/Performance Improvement (QM/PI) 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 4§38.358(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 2018 annual report.

## Conducting the Review

HSAG calculates and reports rates on AHCCCS' behalf for a variety of Contractor-specific and statewide aggregate performance measures to address different quality initiatives. HSAG calculated the measure rates for CYE 2017.

Using the results and statistical analysis of Contractors' performance measure 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 2017.

### 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.

### Methodology for Conducting the Review

For the CYE 2017 review period (i.e., measurement year ending September 30, 2017), 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 a statewide aggregate.
- Compared Contractor performance rates with minimum performance standards (MPS) defined by AHCCCS' contract, if available.

CAPs, key components of the AHCCCS Quality Strategy, are used as foundational elements to improve performance measure rates that fall below the contractual MPS. During CYE 2018, AHCCCS required Contractors to propose and implement CAPs for CYE 2016 contractually required performance measures that did not meet the MPS. The Contractors then submitted CAP proposals. Once a CAP proposal was approved by AHCCCS and implemented, the Contractors were required to provide CAP updates as required by AHCCCS.

HSAG calculated results on AHCCCS' behalf for a variety of performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS, CMS Adult Core Set, and CMS Child Core Set. 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). The administrative methodology used for data collection in the current measurement did not differ from the methodology used for the previous measurement period. NCQA and CMS update their respective methodologies annually to add new codes to better identify the eligible populations and/or services being measured or to delete codes retired from standardized coding sets used by providers.

HSAG analyzed Contractor-specific and statewide aggregate performance results for each measure to determine if performance rates met or exceeded each corresponding AHCCCS MPS. 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 significant.

Using the performance rates that HSAG calculated on AHCCCS' behalf, 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 recommendations to improve Contractor performance rates.

## Performance Measure Results—Acute Care Contractors

The following tables include performance measure results for the Acute Care Contractors. The tables display the following information: CYE 2016 performance, where available; CYE 2017 performance; the relative percentage change between CYE 2016 and CYE 2017 rates, where available; the significance of the relative percentage change, where available; and the AHCCCS MPS, where available. Performance measure rate cells shaded green indicate that performance met or exceeded the CYE 2017 MPS established by AHCCCS. Of note, measures for which lower rates suggest better

performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

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

**Table B-1—CYE 2016 and CYE 2017 Performance Measure Results—Care1st**

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Access to Care** | | | | | |
| ***Annual Dental Visits*** | | | | | |
| *2–20 Years* | 62.8% | 61.6% | -1.9% | **P=0.001** | 60.0% |
| ***Children and Adolescents' Access to Primary Care Practitioners*** | | | | | |
| *12–24 Months* | 92.6% | 91.7% | -1.0% | P=0.183 | 93.0% |
| *25 Months–6 Years* | 85.9% | 83.3% | -3.0% | **P<0.001** | 84.0% |
| *7–11 Years* | 90.4% | 89.1% | -1.4% | **P=0.004** | 83.0% |
| *12–19 Years* | 87.3% | 85.6% | -1.9% | **P=0.001** | 82.0% |
| **Pediatric Health** | | | | | |
| ***Adolescent Well-Care Visits*** | | | | | |
| *Adolescent Well-Care Visits* | 42.5% | 42.1% | -0.9% | P=0.478 | 41.0% |
| ***Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk*** | | | | | |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | — | 25.9% | — | — | — |
| ***Well-Child Visits in the First 15 Months of Life*** | | | | | |
| *Six or More Well-Child Visits* | 63.7% | 65.8% | 3.3% | P=0.116 | 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* | 66.9% | 64.2% | -4.0% | **P<0.001** | 66.0% |
| **Preventive Screening** | | | | | |
| ***Breast Cancer Screening[2]*** | | | | | |
| *Breast Cancer Screening* | — | 52.0% | — | — | 50.0% |
| ***Cervical Cancer Screening*** | | | | | |
| *Cervical Cancer Screening* | 51.8% | 52.3% | 1.0% | P=0.311 | 64.0% |
| ***Chlamydia Screening in Women*** | | | | | |
| *Total* | 48.9% | 51.2% | 4.7% | P=0.064 | 63.0% |
| **Utilization** | | | | | |
| ***Ambulatory Care (per 1,000 Member Months)*** | | | | | |

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| *ED Visits—Total** | 54.8 | 50.9 | -7.0% | — | 55.0 |
| *Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total* | | | | | |
| *Days per 1,000 Member Months (Total Inpatient)—Total* | 29.7 | 27.4 | -7.6% | — | — |
| ***Plan All-Cause Readmissions*** | | | | | |
| *Total** | 11.8% | 14.0% | 18.6% | **P=0.020** | 11.0% |

\* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 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] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the Contractors were not required to report the measure for the CYE 2016 reporting period, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.

☐ Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

## Health Choice Arizona (HCA)

**Table B-2—CYE 2016 and CYE 2017 Performance Measure Results—HCA**

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Access to Care** | | | | | |
| *Annual Dental Visits* | | | | | |
| *2–20 Years* | 57.6% | 56.8% | -1.4% | **P=0.001** | 60.0% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | |
| *12–24 Months* | 90.2% | 91.1% | 1.0% | P=0.107 | 93.0% |
| *25 Months–6 Years* | 82.3% | 79.4% | -3.5% | **P<0.001** | 84.0% |
| *7–11 Years* | 88.6% | 86.3% | -2.6% | **P<0.001** | 83.0% |
| *12–19 Years* | 85.7% | 83.4% | -2.7% | **P<0.001** | 82.0% |
| **Pediatric Health** | | | | | |
| *Adolescent Well-Care Visits* | | | | | |
| *Adolescent Well-Care Visits* | 34.8% | 34.5% | -0.9% | P=0.260 | 41.0% |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | | | | | |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | — | 22.4% | — | — | — |

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| *Well-Child Visits in the First 15 Months of Life* | | | | | |
| *Six or More Well-Child Visits* | 57.2% | 56.9% | -0.5% | P=0.778 | 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* | 56.2% | 56.4% | 0.4% | P=0.589 | 66.0% |
| **Preventive Screening** | | | | | |
| *Breast Cancer Screening[2]* | | | | | |
| *Breast Cancer Screening* | — | 49.0% | — | — | 50.0% |
| *Cervical Cancer Screening* | | | | | |
| *Cervical Cancer Screening* | 44.5% | 44.0% | -1.1% | P=0.140 | 64.0% |
| *Chlamydia Screening in Women* | | | | | |
| *Total* | 48.6% | 46.3% | -4.7% | **P=0.004** | 63.0% |
| **Utilization** | | | | | |
| *Ambulatory Care (per 1,000 Member Months)* | | | | | |
| *ED Visits—Total\** | 58.4 | 56.2 | -3.7% | — | 55.0 |
| *Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total* | | | | | |
| *Days per 1,000 Member Months (Total Inpatient)—Total* | 28.5 | 26.9 | -5.8% | — | — |
| *Plan All-Cause Readmissions* | | | | | |
| *Total\** | 11.5% | 11.2% | -2.6% | P=0.629 | 11.0% |

*\* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
*[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 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] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.*
*— Indicates that the Contractors were not required to report the measure for the CYE 2016 reporting period, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.*

  ▢  *Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.*

## Health Net Access (HNA)

**Table B-3—CYE 2016 and CYE 2017 Performance Measure Results—HNA**

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Access to Care** | | | | | |
| *Annual Dental Visits* | | | | | |
| *2–20 Years* | 40.4% | 41.5% | 2.7% | P=0.070 | 60.0% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | |
| *12–24 Months* | 88.2% | 91.8% | 4.1% | **P=0.001** | 93.0% |
| *25 Months–6 Years* | 79.3% | 77.9% | -1.8% | P=0.085 | 84.0% |
| *7–11 Years* | 83.0% | 81.4% | -1.9% | P=0.113 | 83.0% |
| *12–19 Years* | 78.0% | 78.7% | 0.9% | P=0.452 | 82.0% |
| **Pediatric Health** | | | | | |
| *Adolescent Well-Care Visits* | | | | | |
| *Adolescent Well-Care Visits* | 29.0% | 30.9% | 6.6% | **P=0.017** | 41.0% |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | | | | | |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | — | 21.1% | — | — | — |
| *Well-Child Visits in the First 15 Months of Life* | | | | | |
| *Six or More Well-Child Visits* | 51.3% | 57.5% | 12.1% | **P=0.001** | 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% | 55.3% | 9.1% | **P<0.001** | 66.0% |
| **Preventive Screening** | | | | | |
| *Breast Cancer Screening[2]* | | | | | |
| *Breast Cancer Screening* | — | 50.0% | — | — | 50.0% |
| *Cervical Cancer Screening* | | | | | |
| *Cervical Cancer Screening* | 45.0% | 47.7% | 6.0% | **P<0.001** | 64.0% |
| *Chlamydia Screening in Women* | | | | | |
| *Total* | 46.8% | 48.5% | 3.6% | P=0.318 | 63.0% |
| **Utilization** | | | | | |
| *Ambulatory Care (per 1,000 Member Months)* | | | | | |
| *ED Visits—Total\** | 51.0 | 52.7 | 3.3% | — | 55.0 |

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| *Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total* | | | | | |
| *Days per 1,000 Member Months (Total Inpatient)—Total* | 27.2 | 32.1 | 18.0% | — | — |
| *Plan All-Cause Readmissions* | | | | | |
| *Total** | 12.6% | 10.5% | -16.7% | P=0.052 | 11.0% |

*\* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
*[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 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] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.*
*— Indicates that the Contractors were not required to report the measure for the CYE 2016 reporting period, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.*

Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

## Mercy Care Plan (MCP)

**Table B-4—CYE 2016 and CYE 2017 Performance Measure Results—MCP**

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Access to Care** | | | | | |
| *Annual Dental Visits* | | | | | |
| *2–20 Years* | 56.2% | 63.8% | 13.5% | **P<0.001** | 60.0% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | |
| *12–24 Months* | 93.0% | 93.9% | 1.0% | **P=0.007** | 93.0% |
| *25 Months–6 Years* | 87.4% | 84.8% | -3.0% | **P<0.001** | 84.0% |
| *7–11 Years* | 92.2% | 90.8% | -1.5% | **P<0.001** | 83.0% |
| *12–19 Years* | 89.3% | 87.7% | -1.8% | **P<0.001** | 82.0% |
| **Pediatric Health** | | | | | |
| *Adolescent Well-Care Visits* | | | | | |
| *Adolescent Well-Care Visits* | 41.2% | 41.0% | -0.5% | P=0.332 | 41.0% |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | | | | | |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | — | 22.5% | — | — | — |

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **_Well-Child Visits in the First 15 Months of Life_** | | | | | |
| *Six or More Well-Child Visits* | 63.0% | 63.2% | 0.3% | P=0.760 | 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* | 62.6% | 62.1% | -0.8% | P=0.172 | 66.0% |
| **Preventive Screening** | | | | | |
| **_Breast Cancer Screening[2]_** | | | | | |
| *Breast Cancer Screening* | — | 58.1% | — | — | 50.0% |
| **_Cervical Cancer Screening_** | | | | | |
| *Cervical Cancer Screening* | 56.8% | 55.2% | -2.8% | **P<0.001** | 64.0% |
| **_Chlamydia Screening in Women_** | | | | | |
| *Total* | 46.0% | 46.8% | 1.7% | P=0.231 | 63.0% |
| **Utilization** | | | | | |
| **_Ambulatory Care (per 1,000 Member Months)_** | | | | | |
| *ED Visits—Total\** | 59.8 | 56.9 | -4.9% | — | 55.0 |
| **_Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total_** | | | | | |
| *Days per 1,000 Member Months (Total Inpatient)—Total* | 30.9 | 30.3 | -1.8% | — | — |
| **_Plan All-Cause Readmissions_** | | | | | |
| *Total\** | 12.4% | 12.8% | 3.2% | P=0.454 | 11.0% |

*\* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
*[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 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] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.*
*— Indicates that the Contractors were not required to report the measure for the CYE 2016 reporting period, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.*

    *Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.*

# University Family Care (UFC)

**Table B-5—CYE 2016 and CYE 2017 Performance Measure Results—UFC**

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Access to Care** | | | | | |
| *Annual Dental Visits* | | | | | |
| *2–20 Years* | 54.6% | 56.1% | 2.7% | **P<0.001** | 60.0% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | |
| *12–24 Months* | 90.5% | 92.5% | 2.2% | **P=0.003** | 93.0% |
| *25 Months–6 Years* | 83.1% | 81.5% | -1.9% | **P=0.001** | 84.0% |
| *7–11 Years* | 88.7% | 87.2% | -1.7% | **P=0.001** | 83.0% |
| *12–19 Years* | 88.0% | 86.1% | -2.2% | **P<0.001** | 82.0% |
| **Pediatric Health** | | | | | |
| *Adolescent Well-Care Visits* | | | | | |
| *Adolescent Well-Care Visits* | 37.6% | 38.3% | 1.9% | P=0.101 | 41.0% |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | | | | | |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | — | 23.5% | — | — | — |
| *Well-Child Visits in the First 15 Months of Life* | | | | | |
| *Six or More Well-Child Visits* | 55.0% | 60.1% | 9.3% | **P<0.001** | 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* | 58.8% | 59.0% | 0.3% | P=0.738 | 66.0% |
| **Preventive Screening** | | | | | |
| *Breast Cancer Screening[2]* | | | | | |
| *Breast Cancer Screening* | — | 55.5% | — | — | 50.0% |
| *Cervical Cancer Screening* | | | | | |
| *Cervical Cancer Screening* | 53.1% | 53.4% | 0.6% | P=0.470 | 64.0% |
| *Chlamydia Screening in Women* | | | | | |
| *Total* | 49.7% | 51.3% | 3.2% | P=0.104 | 63.0% |
| **Utilization** | | | | | |
| *Ambulatory Care (per 1,000 Member Months)* | | | | | |
| *ED Visits—Total** | 52.0 | 50.2 | -3.5% | — | 55.0 |

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| *Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total* | | | | | |
| *Days per 1,000 Member Months (Total Inpatient)—Total* | 24.8 | 24.1 | -3.1% | — | — |
| *Plan All-Cause Readmissions* | | | | | |
| *Total** | 9.8% | 10.1% | 3.1% | P=0.695 | 11.0% |

* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 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] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the Contractors were not required to report the measure for the CYE 2016 reporting period, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.

Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.

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

**Table B-6—CYE 2016 and CYE 2017 Performance Measure Results—UHCCP-Acute**

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Access to Care** | | | | | |
| *Annual Dental Visits* | | | | | |
| *2–20 Years* | 61.3% | 61.2% | -0.2% | P=0.733 | 60.0% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | |
| *12–24 Months* | 92.0% | 93.3% | 1.4% | **P=0.001** | 93.0% |
| *25 Months–6 Years* | 84.9% | 82.7% | -2.6% | **P<0.001** | 84.0% |
| *7–11 Years* | 90.7% | 88.7% | -2.2% | **P<0.001** | 83.0% |
| *12–19 Years* | 88.4% | 86.6% | -2.0% | **P<0.001** | 82.0% |
| **Pediatric Health** | | | | | |
| *Adolescent Well-Care Visits* | | | | | |
| *Adolescent Well-Care Visits* | 36.8% | 38.2% | 3.8% | **P<0.001** | 41.0% |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | | | | | |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | — | 25.3% | — | — | — |

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| ***Well-Child Visits in the First 15 Months of Life*** | | | | | |
| *Six or More Well-Child Visits* | 54.6% | 59.1% | 8.2% | **P<0.001** | 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* | 59.0% | 60.4% | 2.4% | **P<0.001** | 66.0% |
| **Preventive Screening** | | | | | |
| ***Breast Cancer Screening[2]*** | | | | | |
| *Breast Cancer Screening* | — | 56.6% | — | — | 50.0% |
| ***Cervical Cancer Screening*** | | | | | |
| *Cervical Cancer Screening* | 48.3% | 48.1% | -0.4% | P=0.430 | 64.0% |
| ***Chlamydia Screening in Women*** | | | | | |
| *Total* | 47.0% | 49.4% | 5.1% | **P<0.001** | 63.0% |
| **Utilization** | | | | | |
| ***Ambulatory Care (per 1,000 Member Months)*** | | | | | |
| *ED Visits—Total\** | 55.4 | 51.7 | -6.7% | — | 55.0 |
| ***Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total*** | | | | | |
| *Days per 1,000 Member Months (Total Inpatient)—Total* | 26.1 | 24.2 | -7.3% | — | — |
| ***Plan All-Cause Readmissions*** | | | | | |
| *Total\** | 9.3% | 11.3% | 21.5% | **P<0.001** | 11.0% |

*\* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
*[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 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] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.*
*— Indicates that the Contractors were not required to report the measure for the CYE 2016 reporting period, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.*

    *Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.*

## Acute Care Aggregate

**Table B-7—CYE 2016 and CYE 2017 Performance Measure Results—Acute Care Contractors**

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| **Access to Care** | | | | | |
| *Annual Dental Visits* | | | | | |
| *2–20 Years* | 58.6% | 60.8% | 3.8% | **P<0.001** | 60.0% |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | | | |
| *12–24 Months* | 92.1% | 93.1% | 1.1% | **P<0.001** | 93.0% |
| *25 Months–6 Years* | 85.4% | 82.9% | -2.9% | **P<0.001** | 84.0% |
| *7–11 Years* | 90.6% | 89.0% | -1.8% | **P<0.001** | 83.0% |
| *12–19 Years* | 88.0% | 86.4% | -1.8% | **P<0.001** | 82.0% |
| **Pediatric Health** | | | | | |
| *Adolescent Well-Care Visits* | | | | | |
| *Adolescent Well-Care Visits* | 39.2% | 39.2% | 0.0% | P=0.683 | 41.0% |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | | | | | |
| *Dental Sealants for Children Ages 6 to 9 at Elevated Caries Risk* | — | 23.8% | — | — | — |
| *Well-Child Visits in the First 15 Months of Life* | | | | | |
| *Six or More Well-Child Visits* | 57.7% | 59.5% | 3.1% | **P<0.001** | 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* | 61.0% | 60.7% | -0.5% | P=0.164 | 66.0% |
| **Preventive Screening** | | | | | |
| *Breast Cancer Screening[2]* | | | | | |
| *Breast Cancer Screening* | — | 54.4% | — | — | 50.0% |
| *Cervical Cancer Screening* | | | | | |
| *Cervical Cancer Screening* | 50.6% | 50.5% | -0.2% | P=0.265 | 64.0% |
| *Chlamydia Screening in Women* | | | | | |
| *Total* | 47.4% | 48.3% | 1.9% | **P=0.004** | 63.0% |
| **Utilization** | | | | | |
| *Ambulatory Care (per 1,000 Member Months)* | | | | | |
| *ED Visits—Total\** | 56.3 | 53.4 | -5.1% | — | 55.0 |

| Performance Measure | CYE 2016 Performance | CYE 2017 Performance | Relative Percentage Change | Significance Level (*p* value)[1] | MPS |
|---|---|---|---|---|---|
| *Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total* | | | | | |
| *Days per 1,000 Member Months (Total Inpatient)—Total* | 27.6 | 26.5 | -4.3% | — | — |
| *Plan All-Cause Readmissions* | | | | | |
| *Total\** | 11.2% | 12.0% | 7.1% | **P=0.001** | 11.0% |

*\* A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
[1] *Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 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] *Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.*
*— Indicates that the Contractors were not required to report the measure for the CYE 2016 reporting period, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.*

*Cells shaded green indicate that the rate met or exceeded the CYE 2017 MPS established by AHCCCS.*

# Appendix C. Validation of Performance Improvement Project Methodology

## Performance Improvement Project Design

AHCCCS updated the AHCCCS Medial Policy Manual, 980—Performance Improvement Projects in CYE 2018. AHCCCS' PIPs, either mandated or Contractor-initiated, are developed according to 42 CFR §438.330, Quality Assessment and Performance Improvement Program. AHCCCS requires Contractors to conduct PIPs that focus on both clinical and nonclinical areas. AHCCCS designs PIPs to correct significant system problems and/or achieve significant improvement in health outcomes and member satisfaction. Improvements need to be sustained over time through the measurement of performance using objective quality indicators, implementation and evaluation of interventions to achieve improvement in access to and quality of care, and planning and initiation of activities for increasing or sustaining improvement.

AHCCCS' clinical focus topics may include primary, secondary, and/or tertiary prevention of acute, chronic, or behavioral health conditions; care of acute, chronic, or behavioral health conditions; high-risk services; and continuity and coordination of care.

AHCCCS' nonclinical focus topics may include availability, accessibility, and adequacy of the Contractors' service delivery systems; cultural competency of services; interpersonal aspects of care; and appeals, grievances, and other complaints.

## Data Collection Methodology

AHCCCS' evaluation of the Contractors' performance on the selected measures is based on systematic, ongoing collection and analysis of accurate, valid, and reliable data, as collected and analyzed by AHCCCS. The Contractors' methodology (including project indicators, procedures, and timelines) aligns with the guidance and direction provided for all AHCCCS-mandated PIPs. The Contractors are required to include internal rates and results used as the basis for analysis (both quantitative and qualitative) and selection/modification of interventions, within the Contractors' annual PIP report submissions. Depending on the PIP, AHCCCS may direct Contractors to collect all or some of the data used to measure performance. In such cases, AHCCCS requires that the Contractors have qualified personnel collect data and ensure interrater reliability if more than one person is collecting and entering data. Contractors must submit specific documentation to verify that indicator criteria were met.

## Measurement of Significant Improvement

AHCCCS expects Contractors to implement interventions to meet a benchmark level of performance for any PIP. AHCCCS defines this benchmark level in advance for all AHCCCS-mandated PIPs. The Contractors must initiate interventions that result in significant improvement, sustained over time, in

their performance for the quality indicators being measured. AHCCCS requires that improvement be evidenced in repeated measurements of the quality indicators specified for each PIP undertaken by the Contractors.

AHCCCS determines a Contractor has demonstrated significant improvement when the Contractor:

- Meets or exceeds the AHCCCS overall average for the baseline measurement, if its baseline rate was below the average and the increase is statistically significant;
- Demonstrates a statistically significant increase, if its baseline rate was at or above the AHCCCS overall average for the baseline measurement; or
- Demonstrates the highest-performing (benchmark) plan in any remeasurement and maintains or improves its rate in a successive measurement.

AHCCCS determines a Contractor has demonstrated sustained improvement when the Contractor:

- Establishes how the significant improvement can be reasonably attributable to interventions implemented by the Contractor (i.e., improvement occurred due to the project and its interventions, not another unrelated reason), and
- Maintains, or increases, the improvements in performance for at least one year after the improvement in performance was first achieved.

## Performance Improvement Project Time Frames

AHCCCS-mandated PIPs begin on a date that corresponds with a contract year. Baseline data for the PIP are collected and analyzed at the beginning of the PIP. Depending on the PIP topic, AHCCCS may provide baseline data by Contractor and include additional data by age, race, sex, ethnicity, and/or geographic area to assist Contractors in refining interventions. During the first year of the PIP, AHCCCS requires the Contractors to implement interventions to improve performance based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance. An intervention may consider any unique factors, such as a Contractor's membership, provider network, or geographic area(s) served.

AHCCCS requires Contractors to use the Plan-Do-Study-Act (PDSA) method to test changes (interventions) quickly and refine them, as necessary. AHCCCS expects that Contractors will implement this process in as short a time frame as is practical, based on the PIP topic. Contractors are expected to use several PDSA cycles within the PIP lifespan and include the PDSA in the annual and final PIP report submissions.

AHCCCS will conduct annual measurements to evaluate Contractor performance and may conduct interim measurements, depending on the resources required, to collect and analyze data. Contractors must include internal annual measurements/rates and results, used as the basis for analysis (both

quantitative and qualitative) and selection/modification of interventions, within the Contractors' annual PIP report submissions.

AHCCS requires Contractors' participation in the PIP to continue until demonstration of significant and sustained improvement is shown, as outlined above.