Arizona Health Care Cost Containment System

Contract Year Ending 2019
External Quality Review Annual Report

for

Acute Care and Comprehensive Medical and Dental Program

Regional Behavioral Health Authorities

Children's Rehabilitative Services

July 2020

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

Overview of the Contract Year Ending 2019 External Review

The Code of Federal Regulations (CFR) at 42 CFR §438.3641 [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.

For contracts starting on or after July 1, 2018, and no later than one year from the issuance of the revised external quality review (EQR) protocol, according to requirements set forth in §438.68, the Centers for Medicare & Medicaid Services (CMS) has established validation of MCO, PIHP, or PAHP network adequacy as a mandatory activity.

In accordance with the 42 CFR §438.358(a), the state; its agent that is not an MCO, PIHP, PAHP, or primary care case management (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, Arizona Health Care Cost Containment System (AHCCCS) elected to retain responsibility for performing the four EQR mandatory activities described in 42 CFR §438.358 (b). AHCCCS prepared Contractor-specific reports of findings related to each of the activities, and, as applicable, required Contractors to prepare and submit their proposed corrective action plans (CAPs) to AHCCCS for review and approval.

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

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 88/Friday, May 6, 2016, Rules and Regulations, p. 27886. 42 CFR §438.364 Medicaid Program; External Quality Review, Final Rule.

HSAG is an EQRO that meets the competence and independence requirements set forth in 42 CFR §438.354. HSAG has extensive experience and expertise in both conducting the mandatory activities and in analyzing information obtained from AHCCCS' reviews of the activities. Accordingly, HSAG uses the information and data to draw conclusions and make recommendations about the quality and timeliness of, and access to care and services that AHCCCS' Contractors provide.

To meet the requirements set forth in 42 CFR §438.364, as the EQRO, HSAG used information obtained from AHCCCS to prepare and provide a detailed annual technical report. The report summarizes findings on the quality of, timeliness of, and access to healthcare services, and includes the following:

- A description of the manner in which the data from all activities conducted were aggregated and analyzed.
- For each 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:

- Introduction to the Annual Technical Report: An introduction to the annual technical report, including a description of the EQR mandatory activities.

- Overview of AHCCCS: An overview of AHCCCS' background including the Medicaid managed care history, AHCCCS' strategic plan with key accomplishments for contract year ending (CYE) 2019, AHCCCS' quality strategy, and waivers and legislative changes impacting AHCCCS' Medicaid programs.
- Performance Measure Results: A presentation of results for AHCCCS-selected performance measures for each Acute Contractor, the Comprehensive Medical and Dental Program (CMDP), and each KidsCare Contractor, as well as HSAG's associated findings and recommendations for CYE 2018.
- Performance Improvement Project Results: A presentation of Contractor-specific CYE 2018 rates for the *E-Prescribing* PIP and *Developmental Screening* PIP as well as qualitative analyses and interventions for the Contractors and CMDP.
- CAHPS Results: A presentation of General Child and Children with Chronic Conditions (CCC) results for KidsCare, as well as HSAG's associated findings and recommendations for CYE 2018.

Please see appendices A, B, and C for an overview of the AHCCCS methodology for the performance measures, performance improvement project, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] activities, including objectives, descriptions of data obtained, technical methods of data collection and analysis, scoring methodology, and corrective action statements.

Contractors Reviewed

During CYE 2018, AHCCCS contracted with the Contractors[1-3] listed below to provide services to members enrolled in the AHCCCS Acute Care, Behavioral Health, and Children's Rehabilitative Services (CRS) Medicaid managed care programs. Associated abbreviations are included.

Acute Contractors

- Care1st Health Plan Arizona, Inc. (Care1st)
- Health Choice Arizona (HCA)[1-4]
- Health Net Access (HNA)[1-5]
- Mercy Care Plan (MCP)
- University Family Care (UFC)[1-6]

[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[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.
[1-4] Health Choice Arizona (HCA) is doing business as Steward Health Choice Arizona (SHCA).
[1-5] Health Net Access (HNA) is doing business as Arizona Complete Health-Arizona Complete Care (AzCH-ACC), a health plan owned by Centene Corporation of Health Net Inc.
[1-6] Banner merged with University Family Care (UFC) and is doing business as Banner University Family Care (BUFC).

- UnitedHealthcare Community Plan-Acute (UHCCP-Acute)[1-7]
- Arizona Department of Child Safety (DCS)/Comprehensive Medical and Dental Program (CMDP)

Regional Behavioral Health Authority (RBHA) Contractors

- Cenpatico Integrated Care (CIC)[1-8]
- Health Choice Integrated Care (HCIC)[1-9]
- Mercy Maricopa Integrated Care (MMIC)[1-10]

CRS Contractor

- UnitedHealthcare Community Plan-Children's Rehabilitative Services (UHCCP-CRS)

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 for the performance measure and CAHPS activities conducted in CYE 2018.

Organizational Assessment and Structure Standards

All activities for the CYE 2016 operational review (OR) cycle have been closed.

Performance Measures

Aggregate Results for CYE 2018

AHCCCS collected data and reported Contractor performance for a set of performance measures for the CYE 2018 measurement period.

Contractor-specific results for performance measures with a minimum performance standard (MPS) are included in Section 4, with additional performance measures (i.e., without an established MPS) included in Appendix A of this report.

[1-7] UnitedHealthcare Community Plan-Acute (UHCCP-Acute) is doing business as UnitedHealthcare Community Plan-Arizona Complete Care (UHCCP-ACC).
[1-8] Cenpatico Integrated Care (CIC) is doing business as Arizona Complete Health-Regional Behavioral Health Authority (AzCH-RBHA), a health plan owned by Centene Corporation of Health Net Inc.
[1-9] Health Choice Integrated Care (HCIC) is doing business as Steward Health Choice Arizona (SHCA).
[1-10] Mercy Maricopa Integrated Care (MMIC) is doing business as Mercy Care-Regional Behavioral Health Authority (MC-RBHA).

Throughout the report, references to "significant" changes in performance indicate statistically significant differences between performance from CYE 2017 to CYE 2018. The threshold for a significant result is traditionally reached when the *p* value is ≤0.05.

Findings

Table 1-1 through Table 1-4 present the CYE 2017 and CYE 2018 aggregate performance measure results with an MPS for the Acute Care Contractors, CMDP, KidsCare Contractors, UHCCP-CRS, General Mental Health/Substance Use (GMH/SU), and RBHA Integrated SMI Contractors. Of note, the Acute Care aggregate rates include all members who met the enrollment criteria within the Acute Care Program line of business; therefore, members enrolled in CMDP were included in the Acute Care aggregate rate calculations in addition to those members enrolled in the six Acute Care Contractors. The GMH/SU aggregate rates include all members who met the eligibility criteria within the GMH/SU program (excluding SMI members).

The tables display the following information: CYE 2017 performance, where available; CYE 2018 performance; the relative percentage change between CYE 2017 and CYE 2018 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 2018 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 1-1—CYE 2017 and CYE 2018 Aggregate Performance Measure Results—Acute Care Contractors

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	60.8%	61.1%	0.5%	**P=0.002**	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	93.1%	94.8%	1.8%	**P<0.001**	93.0%
25 Months–6 Years	82.9%	84.2%	1.6%	**P<0.001**	84.0%
7–11 Years	89.0%	88.4%	-0.7%	**P<0.001**	83.0%
12–19 Years	86.4%	86.1%	-0.4%	**P=0.003**	82.0%
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	39.2%	40.6%	3.6%	**P<0.001**	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	59.5%	61.5%	3.4%	**P<0.001**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.7%	61.4%	1.2%	**P<0.001**	66.0%
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	54.4%	54.9%	0.9%	**P=0.035**	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	50.5%	50.8%	0.6%	**P=0.025**	64.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	53.4	54.8	2.6%	—	55.0

** 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 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Table 1-2—CYE 2017 and CYE 2018 Performance Measure Results—CMDP

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	73.8%	75.4%	2.2%	**P=0.034**	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	97.9%	97.7%	-0.2%	P=0.804	93.0%
25 Months–6 Years	91.8%	92.9%	1.2%	P=0.196	84.0%
7–11 Years	96.8%	96.2%	-0.6%	P=0.447	83.0%
12–19 Years	97.1%	96.4%	-0.7%	P=0.337	82.0%
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	72.3%	72.4%	0.1%	P=0.954	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	74.5%	72.6%	-2.6%	P=0.197	66.0%

[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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 2018 MPS established by AHCCCS.

Table 1-3—CYE 2017 and CYE 2018 Aggregate Performance Measure Results—KidsCare Contractors

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	74.3%	74.1%	-0.3%	P=0.847	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	97.4%	98.6%	1.2%	P=0.610	93.0%
25 Months–6 Years	92.3%	93.1%	0.9%	P=0.499	84.0%
7–11 Years	100.0%	95.7%	-4.3%	P=0.388	83.0%
12–19 Years	95.1%	95.4%	0.3%	P=0.851	82.0%
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	61.1%	59.3%	-3.0%	P=0.269	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	NA	28.9%	—	—	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	75.8%	75.7%	-0.1%	P=0.977	66.0%

NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Table 1-4—CYE 2017 and CYE 2018 Performance Measure Results—UHCCP-CRS

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	67.4%	67.7%	0.5%	P=0.606	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	96.9%	99.1%	2.3%	**P=0.042**	93.0%
25 Months–6 Years	92.7%	92.2%	-0.5%	P=0.422	84.0%
7–11 Years	95.8%	95.8%	0.0%	P=0.981	83.0%
12–19 Years	95.1%	95.1%	0.0%	P=0.912	82.0%
Pediatric Health					
Adolescent Well-Care Visits					

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Adolescent Well-Care Visits	48.9%	48.1%	-1.6%	P=0.409	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	49.2%	47.3%	-3.9%	P=0.690	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.8%	63.8%	-3.0%	P=0.137	66.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	55.4	55.2	-0.4%	—	43.0

** 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 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Table 1-5—CYE 2017 and CYE 2018 Aggregate Performance Measure Results—GMH/SU

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	48.1%	49.4%	2.7%	**P=0.034**	85.0%
30-Day Follow-Up	67.2%	67.1%	-0.2%	P=0.971	95.0%

[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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 2018 MPS established by AHCCCS.

Table 1-6—CYE 2017 and CYE 2018 Aggregate Performance Measure Results—RBHA Integrated SMI Contractors

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Total	92.2%	91.2%	-1.1%	**P<0.001**	75.0%
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	38.7%	37.3%	-3.6%	P=0.170	50.0%

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Cervical Cancer Screening					
Cervical Cancer Screening	46.0%	44.8%	-2.6%	**P=0.030**	64.0%
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	71.8%	68.5%	-4.6%	**P<0.001**	85.0%
30-Day Follow-Up	87.7%	85.6%	-2.4%	**P<0.001**	95.0%

[1] *Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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 2018 MPS established by AHCCCS.

Conclusions

Acute Care Contractors

For CYE 2018, the Acute Care Contractors aggregate performance measure rates for the **quality** area indicated opportunities for improvement, with four of five (80.0 percent) measure rates (*Adolescent Well-Care Visits*; *Cervical Cancer Screening*; *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 Contractors aggregate.

The Acute Care Contractors aggregate demonstrated positive performance in the **access** area, exceeding the MPS for all five performance measure rates (*Annual Dental Visits*; and all four *Children and Adolescents' Access to Primary Care Practitioners* indicators). However, two of five (40.0 percent) performance measure rates (*Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*) demonstrated significant declines from CYE 2017 to CYE 2018.

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

CMDP

Compared to the CYE 2018 MPS, CMDP's performance in the **quality** and **access** areas indicated strength as all seven performance measure rates exceeded the MPS.

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

KidsCare Contractors

For CYE 2018, the KidsCare Contractors aggregate performance measure rates for the **quality** and **access** areas indicated strength as seven of eight (87.5 percent) performance measure rates exceeded the MPS. *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* was the only performance measure rate within the **quality** area that fell below the MPS.

There were no performance measure rates related to **timeliness** selected for the KidsCare Contractors; therefore, this area was not discussed.

UHCCP-CRS

For CYE 2018, the UHCCP-CRS performance measure rates for the **quality** area indicated opportunities for improvement, with two of three (66.7 percent) measure rates (*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 MPS. *Adolescent Well-Care Visits* was the only performance measure rate within the **quality** area that exceeded the MPS.

UHCCP-CRS demonstrated positive performance in the **access** area, exceeding the MPS for all five performance measure rates (*Annual Dental Visits* and all four *Children and Adolescents' Access to Primary Care Practitioners* indicators).

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

GMH/SU and RBHA Integrated SMI Contractors

Compared to the CYE 2018 MPS, the GMH/SU aggregate and RBHA Integrated SMI aggregate performance in the **quality**, **access**, and **timeliness** areas indicated opportunities for improvement as both *Follow-Up After Hospitalization for Mental Illness* measure rates fell below the MPS.

Performance for the RBHA Integrated SMI aggregate within the **quality** area indicated opportunities for improvement as both measure rates (*Breast Cancer Screening* and *Cervical Cancer Screening*) fell below the MPS. *Adults' Access to Preventive/Ambulatory Health Services* was the only performance measure rate within the **access** area and it exceeded the MPS for the RBHA Integrated SMI aggregate.

Please see Table A-1 in Appendix A for more information about the assignment of performance measures with an MPS to the Quality, Timeliness, and Access areas.

Recommendations

HSAG recommends that AHCCCS work with the Acute Care Contractors and UHCCP-CRS to increase rates for the performance measures that failed to meet the CYE 2018 MPS related to pediatric health. AHCCCS, the Acute Care Contractors, and UHCCP-CRS should conduct root cause analyses for the

low rates of well-child and well-care visits to determine the nature and scope of the issue (e.g., provider billing issues, barriers to care, community perceptions, lack of continuity of care).[1-11] Once the causes are identified, AHCCCS, the Acute Care Contractors, and UHCCP-CRS 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*.[1-12]

HSAG recommends that AHCCCS work with the GMH/SU and RBHA Integrated SMI Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2018 MPS. AHCCCS and the Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). Effective transition of care programs have been shown to reduce readmissions and exacerbation of symptoms related to mental illness by engaging the patient and family members (e.g., structured discharge checklist for accountability, awareness of red flags), establishing clear transition and care plans (e.g., follow-up appointments scheduled prior to discharge), utilizing transition coaches and providers (e.g., visits and phone calls to review illness management and questions), and ensuring effective provider communication (e.g., healthcare professionals' understanding of transition and care plan).[1-13] After the key factors related to the low rates are identified, AHCCCS and the Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care.

Additionally, HSAG recommends that AHCCCS work with the Acute Care Contractors and RBHA Integrated SMI Contractors to increase preventive screenings for women. AHCCCS, the Acute Care Contractors, and the RBHA Integrated SMI Contractors should examine potential barriers to women receiving breast cancer (RBHA Integrated SMI Contractors only) and cervical cancer screenings and implement multicomponent interventions to reduce structural barriers. Evidence suggests multicomponent interventions lead to greater effects when they combine strategies to increase community demand for, and access to, cancer screening. Interventions include increasing community demand (e.g., patient reminders, one-on-one education, mass media [e.g., television, radio, newspapers]), increasing access to screenings (e.g., assisting with appointment scheduling, addressing transportation barriers, offering child care), and increasing provider participation (e.g., provider

[1-11] The well-child and well-care visits rates for the Acute Care Contractors represent the administrative-only rates. The rates for these performance measures could increase following medical record review.
[1-12] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: Mar. 12, 2020.
[1-13] Viggiano T, Pincus HA, and Crystal S. Care Transition Interventions in Mental Health. *Current Opinion in Psychiatry*. Vol. 25. No. 6. Nov. 2012.

incentives and provider reminders).[1-14,1-15] AHCCCS, the Acute Care Contractors, and the RBHA Integrated SMI Contractors should ensure that members receive screenings in accordance with the United States (U.S.) Preventive Services Task Force (USPSTF) screening recommendations for breast cancer and cervical cancer.[1-16, 1-17]

Performance Improvement Projects

In CYE 2015, AHCCCS implemented the *E-Prescribing* PIP for all lines of business. The baseline year for this PIP was CYE 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. As of CYE 2017, AHCCCS considers the *E-Prescribing* PIP closed for the ALTCS Contractors.

AHCCCS implemented the *Developmental Screening* PIP for the AHCCCS Complete Care (ACC), Comprehensive Medical and Dental Program (CMDP), and the DES/DDD lines of business. Early identification of developmental delays is important when providing effective interventions. During well-child visits, pediatricians look for potential concerns using both developmental surveillance and discussions with parents about their concerns. If any issues are noted, pediatricians should follow through with a developmental screening. Thus, AHCCCS has approved developmental screening tools that should be utilized for developmental screenings by all participating primary care physicians who care for EPSDT-age members.

The purpose of the *Developmental Screening* PIP is to increase the number of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. AHCCCS' goal is to demonstrate a statistically significant increase in the number and percentage of children receiving a developmental screening, followed by sustained improvement for one year.

The baseline year for this PIP was CYE 2016. The subsequent year was an "Intervention" year in which each Contractor implemented strategies and interventions to improve performance. AHCCCS conducted

[1-14] The Community Guide. *Cancer Screening: Multicomponent Interventions—Cervical Cancer*. Available at: https://www.thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-cervical-cancer. Accessed on: Mar. 12, 2020.

[1-15] The Community Guide. *Cancer Screening: Multicomponent Interventions—Breast Cancer*. Available at: https://www.thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-breast-cancer. Accessed on: Mar. 12, 2020.

[1-16] U.S. Preventive Services Task Force. *Breast Cancer: Screening*. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening. Accessed on: Mar. 12, 2020.

[1-17] U.S. Preventive Services Task Force. *Cervical Cancer: Screening*. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening. Accessed on: Mar. 12, 2020.

annual measurements to evaluate Contractor performance, with the first remeasurement reflective of CYE 2018.

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 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 plan 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:

- 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).
- Maintained or increased improvements in performance for at least one year after those improvements were first achieved.

Although DES/DDD increased its rate of children receiving a developmental screening, DES/DDD did not demonstrate significant improvement from baseline to Remeasurement Year 1.

Overall Assessment of Progress in Meeting EQRO Recommendations

During previous years, HSAG made recommendations in the annual reports for each activity conducted. Below are summaries of the follow-up actions per activity in response to HSAG's recommendations. Some of the Contractors have included rates in their responses to the recommendations. Please note that AHCCCS has not approved or validated these rates.

Acute Line of Business

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) 2017–2018.

Table 1-7—HSAG Recommendations With AHCCCS Responses to HSAG Recommendations

HSAG Recommendation	AHCCCS Activities
Operational Review	
AHCCCS should concentrate improvement efforts on the following standards: Corporate Compliance (CC); Claims and Information Systems (CIS); Adult, EPSDT, and Maternal Child Health (MCH); and Medical Management (MM) standards as these standards were problematic for Contractors during the three-year review cycle. For example, AHCCCS should consider distributing technical assistance documents to all Contractors and holding in-person meetings with Contractors that scored lowest in these standards.	Scores can change drastically each OR cycle based upon changes made in the tool related to review criteria. However, AHCCCS does offer technical assistance for each individual standard that does not meet the criteria. The MCO may request technical assistance or AHCCCS may offer technical assistance based upon outcomes of the OR score.
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 has a variety of venues to share lessons learned with Contractors. OR lessons learned are often discussed at each Contractor's exit interview when the OR is completed.
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	Items required to be reflected in the remittance advice sent to providers is clearly outlined in AHCCCS policy. For the ORs completed in CYE 2019, the scores for this element have been increased.

HSAG Recommendation	AHCCCS Activities
also consider reviewing the data capture and transfer processes used for the claims processing systems to ensure alignment with the requirements set forth in the CIS standard. 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	
The utilization performance measure rate (*Ambulatory Care*) for the Acute Care aggregate should be monitored for informational purposes.	AHCCCS continues to run the ambulatory care performance measure and will continue its efforts to monitor Acute Care aggregate performance.
AHCCCS works 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 AAP's *Recommendations for Preventive Pediatric Health Care*. Additionally, AHCCCS and the Acute Care Contractors should ensure that members receive screenings in accordance with USPSTF screening recommendations for cervical cancer and chlamydia in women.	AHCCCS Contractors not meeting the MPS set forth in the Contract for CYE 2017 Performance Measures were required to submit a proposed corrective action plan (CAP) for AHCCCS review and approval. This included the *Child and Adolescent Well Care*, *Cervical Cancer Screening*, and *Chlamydia Screening in Women* measures. Contractors are required to conduct a root cause analyses as part of their CAP proposals and implement interventions that are aimed at addressing the identified barriers.

Table 1-8 presents a summary of the follow-up actions per activity that the Acute Contractors reported completing in response to HSAG's recommendations included in the *CYE 2018 Acute Technical Report*.

Additionally, the text located after each HSAG recommendation box was submitted by the Contractor.

Table 1-8—Care1st's Responses to HSAG's Follow-Up Recommendations

Care1st
Performance Measures
HSAG Recommendation: Care1st's reported rate for the *Cervical Cancer Screening* measure demonstrated a statistically significant increase for CYE 2017 (52.3 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 increase screenings for cervical cancer in women.
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 patient-centered medical homes (PCMHs), with incentives to increase performance measure rates. • In CYE 2015, Care1st expanded the number of value-based purchasers 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. • Education was provided to adult members on recommended preventative services through the member newsletter. • 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 Care1st having contact with the member/family. • For CYE 2018, 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. • For CYE 2019, Care1st dedicated a quality improvement (QI) full-time employee (FTE) to make outreach calls to adults. In addition, the Contractor plans a systemwide initiative to identify members and increase engagement with PCPs. • For CYE 2019, Care1st planned 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 Healthcare Effectiveness Data and Information Set (HEDIS®)[1-18] Adult Resource Guide for providers. • For CYE 2019, WellCare planned to work on a systemwide initiative to better identify and reach members without visits (MWOV), to increase engagement with their PCPs.

[1-18] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Care1st
• In CYE 2020, Care1st plans to provide education to members 21–64 years old on human papillomavirus (HPV) as a risk factor for cervical cancer and the importance of cervical cancer screening with HPV co-testing, and explore the use of a patient education flyer or brochure, such as the CDC's *Inside Knowledge: Get the Facts About Gynecologic Cancer or Genital HPV: The Facts*. • In CYE 2020, Care1st plans to work with high-volume providers and/or community organizations to host community events to better engage and educate members.
HSAG Recommendation: Care1st's reported rate for the *Chlamydia Screening in Women* measure demonstrated an increase for CYE 2017 (51.2 percent). Although there was an increase, the rate was below the AHCCCS MPS of 63.0 percent. HSAG recommends that Care1st focus efforts on identifying the factors contributing to low rates for this measure and implement improvement strategies to increase screenings for chlamydia in women.
As a result of these data and trends, Care1st implemented performance improvement activities that included the following: • Education was provided to adult members on recommended preventative services through the member newsletter. • 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 Care1st having contact with the member/family. • 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. • 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. • For CYE 2019, Care1st dedicated a QI FTE to make outreach calls to adults. In addition, the Contractor plans a systemwide initiative to identify members and increase engagement with PCPs. • For CYE 2019, Care1st planned 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. • For CYE 2019, WellCare planned to work on a systemwide initiative to better identify and reach MWOV, to increase engagement with their PCPs. • In CYE 2020, Care1st plans to work with high-volume providers and/or community organizations to host community events to better engage and educate members.
HSAG Recommendation: Care1st's reported rate for *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* measure decreased for CYE 2017 (91.7 percent) and did not meet the AHCCCS

Care1st
MPS of 93.0 percent. HSAG recommends that Care1st continue efforts on identifying improvement strategies to raise rates for this measure.
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 measure rates. • In CYE 2015, Care1st expanded the number of value-based purchasers 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 Division of Developmental Disabilities (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 Quarter 4 (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. • Ten medical groups representing members have been recruited as value-based purchasers with Primary Care Incentives incorporated into contracts.

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. • 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. • An EPSDT Workgroup was convened in February 2018, which included QI, Medical Management, Claims, and NM 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. • For CYE 2019, Care1st planned to expand the text messaging program to members 0–15 months. • For CYE 2019, Care1st planned to continue and expand provider outreach through the QI team of QPAs, including distribution and the EPSDT Provider Toolkit and other materials. • In CYE 2020, Care1st plans to develop the WellCare "Healthy Rewards" member incentive program for implementation in Arizona. This program includes a financial incentive for completion of six well-child visits by 15 months.
HSAG Recommendation: Care1st's reported rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure demonstrated a decline from the previous year (CYE 2017 64.2 percent, CYE 2016 66.9 percent) and did not meet the AHCCCS MPS of 66.0 percent. HSAG recommends that Care1st focus efforts on identifying improvement strategies to raise rates for this measure.
Care1st has monitored *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* 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, Care1st's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* rate remained above the MPS of 66 percent through CYE 2016. Although the rate showed a decline in CYE 2017 (64.2 percent), Care1st had the highest rate for this measure among all the Contractors. Since then, internal monitoring has shown the following rates: 67.33 percent in CYE 2018 and 64.14 percent in CYE 2019 (CYE 2019 rate not final). 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 measure rates.

Care1st
• In CYE 2015, Care1st expanded the number of value-based purchasers 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 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. • 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. • Continue to send quarterly gaps-in-care rosters to providers identifying members with missing visits. • Continue to send monthly "practice pointers" with timely topics related to the EPSDT program and the AHCCCS Periodicity Schedule. • Continue intensive telephone outreach efforts to improve access to PCPs. • Continue to educate parents and caregivers of the value of the well-child visits and the recommended interval for these visits through the member newsletter. • 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 program is based on evidence that shows interactive and tailored text messages are successful in promoting self-activation among Medicaid members.
Performance Improvement Projects
HSAG Recommendation: 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). Although this is the last measurement year, HSAG recommends that Care1st continue to monitor outcomes associated with the reported interventions, particularly provider education.
CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. During the baseline period, 48.80 percent of Care1st's providers prescribed at least one prescription

Care1st
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 demonstrated statistically significant and substantively large improvements in the performance of the indicators for this PIP. 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 electronic prescribing of controlled substances (EPCS) represented an opportunity for improvement. Care1st addressed this barrier through consistent and sustained provider education focusing on EPCS in CYE 2018. Care1st implemented performance improvement activities that included the following: • Educating 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. • Incorporating incentives into value-based purchasing (VBP) agreements to encourage providers—particularly physicians, physician assistants, and nurse practitioners—to improve rates of e-prescribing. • Educating members, via repeated communications in member newsletter articles, about the benefits of sending prescriptions electronically to pharmacies. • Engaging providers to educate members about the benefits of sending prescriptions electronically to pharmacies. • Educating members about the benefits of having their prescriptions sent electronically to related pharmacies. • Providing targeted education through meetings with high-volume providers, such as PCMHs and provider specialties via fax blasts and during provider forums.

Table 1-9—HNA's Responses to HSAG's Follow-Up Recommendations

HNA
Operational Review
No associated HSAG recommendation.
HNA's OR conducted in calendar year (CY) 2017 identified issues in eight of the OR standard areas: MM, Delivery Systems (DS), Grievance Systems (GS), CIS, General Administration (GA), MCH, Quality Management (QM), and Third-Party Liability (TPL). Out of the eight OR standards identified, only three (CIS, GA, TPL) did not meet the 95 percent threshold. Due to these identified issues and scoring less than 95 percent in three standard areas, CAPs were

HNA
created and approved by AHCCCS immediately following the notification of results to HNA. All of the CAPs required have been subsequently 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.
Performance Measures
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 two measures demonstrated statistically significant declines from CY 2016 to CY 2017.
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 Committee is structured to ensure that data drill-down is completed with root cause analysis and Plan-Do-Study-Act (PDSA) cycles driving intervention development and implementation. 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, during outreach calls, EPSDT team members question the family/parent of the 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. If the EPSDT team is unable to make contact with the member, they coordinate with community-based health workers where possible to complete direct member outreach. The EPSDT team conducts provider site visits to educate providers about the children's measures, dental measures, and how to complete a developmental screening using an approved tool. The EPSDT team meets with the health plan provider engagement department and the topic of EPSDT, dental, and developmental surveillance will be presented at all upcoming providers forums. HNA plans to begin provider outreach and education via fax blasts regarding the EPSDT measures and available screening tools. Focused interventions on improvement of well-care visits for children and adolescents are performed through the EPSDT team. The EPSDT Subcommittee met quarterly during CY 2019 and reported on new and ongoing interventions. HNA has instituted a member outreach program utilizing interactive voice recording (IVR) calls, email, and text (short message service [SMS]) messaging with campaigns directed at members with care gaps for preventive screenings and well visits. These campaigns have a two-pronged approach. The first set of outreach approaches consist of IVR calls and emails with the focus on education of the screenings and/or well visits and why the member should complete them. The second set of outreach approaches consist of emails and text (SMS)

HNA
messages with the focus on reminding the member of the need to obtain their outstanding screenings and/or well visits. 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. In conjunction with the case management team, the QI team created and instituted gap closure letters for adult preventive screenings. The letters are available within the electronic health record so the health plan case manager, when completing a call with a member, can send a screening reminder timely. QM has instituted a multi-prong approach to utilize AHCCCS-approved letters, flyers, emails, and events to educate and remind members of the importance of getting needed health screenings. Quality management continues to develop and refine training materials, quick reference guides, and AHCCCS-approved member-facing materials for case management use when talking to members about care gaps. Quality management created provider facing toolkits and HEDIS quick reference guides to assist providers with understanding performance measures and actions related to performance improvement for these measures. Quality management utilized provider forums, monthly medical director meetings, and site visits to provide TA and increase collaboration to launch initiatives geared toward improving performance measures. Targeted provider visits are conducted by the QI/EPSDT team to provide education and distribute provider 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. The interventions incorporate lessons learned from previous PDSA projects and target both member and provider interventions.
Performance Improvement Projects
HSAG Recommendation: Continue to monitor and evaluate the effectiveness of interventions for the *E-Prescribing* PIP. Identify and rank providers with the 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

HNA
provider education. Beginning in February 2018, HNA actively engaged providers who encountered barriers or issues with e-prescribing through TA support and guidance. The *E-Prescribing* PIP was closed out in Quarter 1 (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 (e.g., Provider Engagement, Quality Management) to ensure that messaging and support to AHCCCS-contracted providers are consistent and ongoing.

Table 1-10—MCP's Responses to HSAG's Follow-Up Recommendations

MCP
Performance Measures
HSAG Recommendation: 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 AAP's *Recommendations for Preventive Pediatric Health Care*. Additionally, AHCCCS and the Acute Care Contractors should ensure that members receive screenings in accordance with USPSTF screening recommendations for cervical cancer and chlamydia in women. 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. 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. 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.
MCP conducted a root cause analysis in CYE 2018 for the *Well-Child Visits in the First 15 Months of Life* and *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* measures, elected to utilize those for our self-selected PIP topic, and implemented interventions aimed at addressing the identified barriers. Interventions will be continued for those measures where improvement has been achieved and the minimum performance standard has been met. For the *Chlamydia Screening in Women* performance measure, MCP performance has improved as compared to previous years, and is now within 1 percentage point of the MPS.

MCP
Given that the implemented interventions have proven successful in achieving rate improvement, they will be continued. Additionally, MCP's successes with performance measures were also highlighted in this paragraph of the report: "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."
Performance Improvement Projects
HSAG Recommendation: 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.
CYE 2018 represented the final year for the PIP. MCP was successful in achieving the goal of increasing the number of prescribers electronically prescribing prescriptions and of increasing the percentage of prescriptions which are submitted electronically in order to improve patient safety. Those improvements are evidenced in both the AHCCCS calculated data and the MCP internal calculations. Current interventions will continue and new interventions may be developed if a new opportunity for improvement is identified, or if MCP begins to identify a decline in performance.

Table 1-11—UFC's Responses to HSAG's Follow-Up Recommendations

UFC
Operational Review
HSAG Recommendation: Continue to conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations.
Banner UFC (BUFC) has continued to conduct internal reviews of barriers and continues to implement internal solutions to these barriers. Results of internal reviews are communicated internally at BUFC through metric-based dashboards and reported on in the appropriate forum (such as, but not limited to: Quality Management/Performance Improvement Committee, Compliance Committee, report to Health Plan Executives, or Board of Directors Report).

UFC
BUFC has also now restructured and increased its staffing to meet the demands of the ACC implementation. Highly qualified individuals have been incorporated into the overall structure. These new staff have also continued to infuse the organization with new ideas and ways of further streamlining processes.
HSAG Recommendation: Pay particular attention to the DS and MCH standard areas as the Contractor scored 74 percent on each.
Great improvements have continued to be implemented in DS and MCH standards. Regarding Delivery of Service standards, policies, procedures, and desktops were all updated and continue to be updated annually. Improvements have been implemented and continue to be implemented to the Provider Manuals and the dissemination of the information to keep providers abreast of these changes. BUFC has also continued to refine and improve its information systems capabilities and a move from historically manual processes to automated processes. All CYE 2016 cycle CAP-related processes, documentation, tasks, and monitoring activities adopted by the BUFC MCH continue to be carried out by the health plan's obstetrics (OB) and pediatric care management teams, ensuring the maintenance of successful program performance. Aside from this, based on the most recent CYE 2018 ALTCS OR, DS standards requiring CAPs decreased substantially in comparison to the previous OR. Similar findings were found with the MCH standards.
HSAG Recommendation: 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.
BUFC has continued to regularly monitor and update its provider and vendor contracts. Communications with providers and vendors have increased substantially. Provider forums continue to be held as well as quarterly on-site meetings with all value-based providers. BUFC communicates with its vendors through Joint Oversight Committees and other ad-hoc communications. Vendors are monitored by BUFC with results reported internally through dashboards and internal committee, and directly with contracted vendors.
Performance Measures
No associated HSAG recommendation.
BUFC will work with providers and members to establish potential performance improvement strategies and solutions to increase comprehensive visits for children and adolescents that follow the AAP's *Recommendations for Preventive Pediatric Health Care*. 1. Enlist/partner with the Office of Individual and Family Affairs (OIFA) to elicit its assistance in obtaining provider and member feedback through formal mechanisms like focus groups as to strategies for improving and increasing comprehensive visits to children and adolescents.

UFC
2. Leverage existing committee engagement and participation activities, such as the Member Advocacy Committee, to capture member/family perspectives/experiences to inform system-level process improvement as it pertains to increasing comprehensive visits for children and adolescents. 3. Present these recommendations at the QM/PI Committee for approval and implementation into the QM Work Plan. 4. Implement the top three strategies. 5. Measure the success of the strategies through the quarterly performance measure reports.
No associated HSAG recommendation.
BUFC will ensure that members receive screenings in accordance with USPSTF screening recommendations for cervical cancer and chlamydia in women. 1. BUFC will review its screening criteria to ensure that these continue to adhere to USPSTF screening recommendations. 2. Establish provider education materials to ensure that they are aware of the recommendations. 3. Provide provider education by incorporating the materials and BUFC expectations into the provider visits. 4. Include current information and expectations in the provider newsletter. 5. Include updated information into the Provider Manual.
Performance Improvement Projects
HSAG Recommendation: HSAG recommends Contractors to conduct another barrier analysis, prioritize the barriers, and develop interventions to increase the rate of Indicator 1 and maintain the momentum of Indicator 1. **HSAG Recommendation:** HSAG recommended that UFC continue to monitor outcomes associated with the reported interventions as well as any new interventions that UFC were to develop as a result of further barrier prioritization and analysis.
BUFC conducted a barrier analysis based on the rates presented in the CYE 2018 Acute Annual Technical Report and compiled a table delineating identified barriers, overall improvements noted to-date, and summarized progress.

Table 1-12—UHCCP-Acute's Responses to HSAG's Follow-Up Recommendations

UHCCP-Acute
Operational Review
HSAG Recommendation: Contractors should conduct internal reviews of operational systems to identify barriers that impact their compliance with AHCCCS standards, State rules, and federal regulations.
UHCCP-Acute adopts policies as needed and reviews said policies and procedures annually or as often as business or regulatory requirements dictate. UHCCP-Acute policies and procedures

UHCCP-Acute
are instrumental in translating the company's strategies, mission, and values into documented guidelines for management and staff to follow and act upon.
HSAG Recommendation: Contractors should regularly monitor and ensure that updates are made to contracts with providers and that policy manual updates from AHCCCS are also included in Contractors' policies, procedures, and manuals (if impacted by the updates) in a timely manner. Contractors should ensure that communication to all areas directly and indirectly impacted by these updates (including Contractor staff, providers, subcontractors, and members) is provided and documented. In addition, Contractors should assess their current monitoring processes and activities to identify strengths and opportunities for improvement within their operational processes.
UHCCP-Acute presents new and substantially revised policies and procedures to the Policy Committee. The Policy Committee recommends approval or denial to health plan management. If approved by health plan management, the Policy Committee finalizes approval of the policy 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 Portable Document Format (PDF) and uploaded to the UHCCP HEART SharePoint, where they can be accessible.
HSAG Recommendation: 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 issue across Contractors.
UHCCP-Acute has a process in place that allows for payment of interest on all claims, including overturned claim disputes. Interest paid is reported to providers on the UHCCP-Acute provider remit. The response is broken down into two parts: 1) Claims and 2) Overturned Claim Disputes. 1. If a clean claim is not paid to a healthcare professional or a hospital in a timely manner regardless of the provider's contract status, we will pay interest to a healthcare professional or a slow payment penalty to a hospital. In the absence of a contract specifying other late payment terms, we will apply the following rules to pay interest on late payments: • For hospital clean claims, in the absence of a contract specifying otherwise, we shall apply a quick pay discount of 1 percent on claims paid within 30 days of receipt of the clean claim. For hospital clean claims, in the absence of a contract specifying other late payment terms, we shall pay slow payment penalties (interest) on payments made after 60 days of receipt of the clean claim. Interest shall be paid at the rate of 1 percent per month for each month or portion of a month from the 61st day until the date of payment (Arizona Revised Statutes [ARS] §36-2903.01).

UHCCP-Acute
• For all non-hospital clean claims, in the absence of a contract specifying other late payment terms, we will pay interest on payments made after 45 days of receipt of the clean claim (as defined in the AHCCCS). Interest shall be at the rate of 10 percent per annum (prorated daily) from the 46th day until the date of payment. • In the absence of a contract specifying other late payment terms, a claim for an authorized service submitted by a licensed skilled nursing facility, assisted living ALTCS provider, or a home and community-based ALTCS provider shall be adjudicated within 30 calendar days after receipt. We will pay interest on payments made after 30 days of receipt of the clean claim. Interest shall be paid at the rate of 1 percent per month (prorated on a daily basis) from the date the clean claim is received until the date of payment (ARS §36-2943.D). • For non-claim dispute situations, interest shall be paid back to the date interest would have started to accrue. UHCCP-Acute's claim system calculates and applies interest on non-hospital claims paid past the 45-day time limit at 10 percent per annum (calculated daily) unless a different rate is stated in a written contract. The interest is prorated on a daily basis and paid at the time the clean claim is paid. If interest is due, it is paid based on the date of the receipt of the initial claim submission. For hospital, licensed skilled nursing facility, assisted living ALTCS provider, or a home and community-based ALTCS provider, interest shall be paid at the rate of 1 percent per month for each month or portion of a month from the 61st day until the date of payment (ARS §36-2903.01). 2. For claim dispute situations, interest shall be paid back to the date interest would have started to accrue. UHCCP-Acute's claim system calculates and applies interest on non-hospital claims paid past the 45-day time limit at 10 percent per annum (calculated daily) unless a different rate is stated in a written contract. The interest is prorated on a daily basis and paid at the time the clean claim is paid. If interest is due, it is paid based on the date of the receipt of the initial claim submission.
Performance Measures
HSAG Recommendation: Assess the cause of this decline in the two sub-measures, *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*.
UHCCP-Acute analyzed the historical performance on the two sub-measures, *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*. Although the rates for the two sub-measures declined from CYE 2016 to CYE 2017, the rates appear to be relatively stable when assessing the rates over a 6-year time period.
HSAG Recommendation: 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* (W34).
UHCCP-Acute formed an internal work group and conducted a root cause analysis on well-child visits and identified the following factors negatively impacting well-care visits for children ages 3–6 years old:

UHCCP-Acute
Provider barriers • Lack of member engagement • Lack of member reminders • Lack of interest in outreaching auto-assigned members • Lack of resources and/or knowledge on how to incorporate well-care visits with sick visits – Lack of schedule flexibility – Lack of planning for well-care services – Lack of staff to do member prep for well-care services • Lack of negative consequences for poor performance in measures • Knowledge deficit about amount of money lost by not incorporating well-care visits with sick visits *Member barriers* • Knowledge deficit on what constitutes a well-care visit • Knowledge deficit on importance of well-care visits • Lack of negative consequences for not scheduling well-care visit • Lack of flexibility to take time off work • Lack of compelling reason given by provider to get well-care visit • Lack of transportation • Cultural reasons • Lack of motivation to get well-care visit – UHCCP-Acute $50 incentive not motivating o Providers not aware of incentive • Lack of understanding due to language/communication barriers • Lack of education on value of well-care visit in member mailings sent by UHCCP-Acute • Lack of timely reminders—UHCCP-Acute late with sending out letters to guardians—miss school vacation period • Lack of extended provider hours • Seeks services from non-contracted providers (e.g., Indian Health Services for Native Americans) • Only utilize urgent care when sick *System barriers* • Tech Specs disregards other insurance • Assignment of rural members (2.5 percent drop) • Lack of correct member contact information – Member not notifying AHCCCS of changes

UHCCP-Acute
• Lack of ability to use hybrid data (NCQA hybrid rates are 7 percent higher) *UHCCP-Acute barriers* • Deficit in providing feedback on where member obtains services • Lack of consistent message to providers on how to engage members • Deficit receiving accurate claims—well-care services rendered but not reflected in HEDIS report – Issue with EPSDT screening modifier? • Lack of education in member mailings to four- and six-year-olds regarding well-care visits • Lack of effective member outreach • Lack of members answering calls • Lack of members who answer IVR calls listening to the message UHCCP has experienced an improvement in measure, *Well Child Visits 3 Years to 6 Years of Age* (W34) in comparison between UHCCP-Acute's internal rates with the previous year's AHCCCS-generated rates. UHCCP-Acute implemented a number of member- and provider-based interventions that directly impacted and improved the performance on the W34 measure including: • Member Initiatives – 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. The incentive was implemented in July 2018 and continues today. UHCCP-Acute's Associate Director Quality Management is responsible for oversight of this intervention; – UHCCP-Acute revised the member letter at 4 years of age and 6 years of age that emphasized obtaining missing immunizations, to a letter sent to guardians of members 3–6 years of age stressing the importance of a well child visit, not limited to immunizations but developmental assessment as well. This was implemented in February 2019 and continues today. UHCCP-Acute's Clinical Quality Analyst is responsible for this mailing. • Provider Initiatives – Provider financial incentive 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. The provider incentive was offered in October 2017 and continues today. UHCCP-Acute's Associate Director Quality Management is responsible for oversight of this intervention; – UHCCP-Acute initiated a quarterly provider gaps-in-care mailing, and included in the gaps-in-care mailing are the measures W34 and AWC. The report was initiated in October 2018 and continues today. UHCCP-Acute's Associate Director Quality Management is responsible for oversight of this intervention;

UHCCP-Acute
○ UHCCP-Acute created a report of members who were missing a well-child visit, but, based on claims data had a sick visit with the assigned PCP. The report was reviewed by the assigned clinical practice consultant (CPC) with the providers to review "missed opportunities." Best practices by groups who are able to integrate a well-child visit with a sick visit were shared by the CPC with other assigned groups.
HSAG Recommendation: Acute Care Contractors should focus efforts on identifying the factors contributing to low rates within the women's preventative screening measures and implement improvement strategies to increase screenings for cervical cancer and chlamydia in women.
UHCCP-Acute conducted a root cause analysis for cervical cancer screening and chlamydia screening in women. UHCCP-Acute identified the following root causes: • Not all provider groups with female members assigned to them were notified of gaps in care for screenings. • There was a lack of member education on the importance of obtaining the screenings. Based upon these findings, the following interventions were implemented in CYE 2017 and carried over into CYE 2018: • Approximately 90 percent of the Medicaid membership is assigned to groups that were assigned to CPCs. The CPCs review the adult gaps-in-care with their assigned providers. • UHCCP-Acute implemented 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. • UHCCP-Acute initiated IVR calls to women in need of a cervical cancer screening or chlamydia screening. • UHCCP-Acute has experienced marginal improvement in both measures, *Cervical Cancer Screening*: Women Ages 21–64 (CCS), and *Chlamydia Screening in Women* (CHL) as noted in the table below comparing UHCCP-Acute internal rates with the previous year AHCCCS generated rates. • UHCCP-Acute has realized improvement in rates for the CCS and CHL measures; however, continued efforts are underway to increase the percentage of members who received these important services. UHCCP recognizes that not all members will listen to an IVR message in its entirety. Therefore, a new written notification to members will be implemented in 2020 encouraging members to obtain a cervical cancer screening or a chlamydia test.
Performance Improvement Projects
HSAG Recommendation: 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 does not require prescribing providers be contracted with AHCCCS for a prescription claim to pay. To do so could cause access to care issues for our members that are

UHCCP-Acute
new to AHCCCS having transitioned into the program or discharged from urgent/emergent care. For future measures, UHCCP-Acute will investigate the feasibility of accurately identifying prescriptions from non-AHCCCS-contracted prescribing providers and removing them from the claims universe and calculations.
HSAG Recommendation: 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 PreCheck MyScript intervention makes a difference in the rates.
UHCCP-Acute is following up internally to see if these data can be extracted, measured, and monitored.

Table 1-13—CMDP's Responses to HSAG's Follow-Up Recommendations

CMDP
Performance Measures
No associated HSAG recommendation.
As reflected in the latest EQR, "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." CMDP is poised to apply continuous improvement practices to preventive services including adolescent engagement and services. CMDP will implement additional outreach interventions and build upon existing member outreach projects to support the health literacy of CMDP members and their caregivers as well as and healthcare engagement of CMDP members. In CYE 2020, interventions will be coordinated through the On-Boarding Unit. Tools for understanding developmental and age-specific needs will be developed and made available to member caregivers to support ongoing development of health literacy in caregivers and members. Additional adaptations for educative elements for any CMDP staff members coordinating or outreaching to members and their caregivers. CMDP's executive management team is currently in the process of "converting" temporary positions into state positions. This will provide stability within in the Onboarding Coordinator team and will strengthen CMDP's outreach documentation efforts. CMDP has also requested to hire a business analyst to assist in the tracking of preventative services and developing visual management tools for the Onboarding Unit to use on a weekly basis and implement interventions in a timelier manner.

Regional Behavioral Health Authority (RBHA) Line of Business

Table 1-14 is a summary of the follow-up actions per activity that AHCCCS completed in response to HSAG's recommendations during SFY 2017–2018.

Table 1-14—HSAG Recommendations With AHCCCS Responses to HSAG Recommendations

HSAG Recommendation	AHCCCS Activities
Operational Review	
AHCCCS should concentrate improvement efforts on the CIS, GA, and MCH standards as most RBHA Contractors scored below the 95 percent compliance threshold. For example, AHCCCS should consider distributing TA documents to the RBHA Contractors and holding in-person meetings with RBHA Contractors. In particular, AHCCCS might want to meet with the RBHA Contractors to determine what issues each RBHA Contractor has in implementing these requirements.	Scores can change drastically each OR cycle based upon changes made in the tool related to review criteria. However, AHCCCS does offer TA for each individual standard that does not meet the criteria. The MCO may request TA or AHCCCS may offer TA based upon outcomes of the OR score.
AHCCCS should consider using the quarterly meetings with RBHA Contractors as forums in which to share lessons learned from both the State and RBHA Contractor perspectives. For example, all RBHA Contractors were required to submit a CAP for the same element in the MCH standard. AHCCCS should present identified best practices regarding developing and implementing a written process to inform all primary care physicians, obstetrician/gynecologist providers, and members of the availability of women's preventative care services as this was problematic for all RBHA Contractors.	AHCCCS has a variety of venues to share lessons learned with Contractors. OR lessons learned are often discussed at each Contractor's exit interview when the OR is completed.
Performance Measures	
HSAG recommends that AHCCCS work with the GMH/SU and RBHA Integrated SMI Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2017 MPS. AHCCCS and the	AHCCCS Contractors not meeting the MPS set forth in the Contract for CYE 2017 Performance Measures were required to submit a proposed CAP for AHCCCS review and approval. This included the *Follow-Up After Hospitalization for Mental Illness*

HSAG Recommendation	AHCCCS Activities
Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). Effective transition of care programs have been shown to reduce readmissions and exacerbation of symptoms related to mental illness by engaging the patient and family members (e.g., structured discharge checklist for accountability, awareness of red flags), establishing clear transition and care plans (e.g., follow-up appointments scheduled prior to discharge), utilizing transition coaches and providers (e.g., visits and phone calls to review illness management and questions), and ensuring effective provider communication (e.g., healthcare professionals' understanding of transition and care plan). After the key factors related to the low rates are identified, AHCCCS and the Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care.	measure. Contractors are required to conduct root cause analyses as part of their CAP proposals and implement interventions that are aimed at addressing the identified barriers.
HSAG recommends that AHCCCS work with the RBHA Integrated SMI Contractors to increase preventive screenings for women. AHCCCS and the RBHA Integrated SMI Contractors should examine potential barriers to women receiving breast cancer and chlamydia screenings to understand the cause of the low rates (e.g., provider misconceptions, lack of education, member anxiety). Once the causes are identified, AHCCCS and the RBHA Integrated SMI Contractors should ensure that members receive screenings in accordance with USPSTF screening recommendations for breast cancer and chlamydia in women.	AHCCCS Contractors not meeting the MPS set forth in the Contract for CYE 2017 Performance Measures were required to submit a proposed CAP for AHCCCS review and approval. This included the *Breast Cancer Screening* and *Chlamydia Screening in Women* measures. Contractors are required to conduct root cause analyses as part of their CAP proposals and implement interventions that are aimed at addressing the identified barriers.

HSAG Recommendation	AHCCCS Activities
Performance Improvement Projects	
AHCCCS may want to consider offering and facilitating training opportunities to enhance the Contractors' capacity to implement robust interventions and QI processes and strategies for the *E-Prescribing* PIP. Increasing the Contractors' efficacy with QI tools such as root cause analyses, key driver diagrams, process mapping, failure modes and effects analysis (FMEA), and PDSA cycles should help to remove barriers to successfully achieving improvement in the PIP indicator rates.	Contractors demonstrate sustained improvement when they maintain, or increase, improvements in performance for at least one year after the improvement is first achieved. CYE 2017 reflected Remeasurement Year 2 data for all lines of business, with the exception of the RBHA Contractors. Based on the CYE 2017 rates, AHCCCS considered the *E-Prescribing* PIP closed for all Contractors with the exception of the aforementioned RBHAs. While the PIP remained open for the RBHAs, CYE 2018 rates demonstrated improvement from previous years (Baseline Year/ Remeasurement Year 1). Therefore, this workgroup did not occur during CYE 2019.
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 the ability to achieve meaningful improvement.	Throughout CYE 2019, AHCCCS utilized the Quarterly Clinical Quality Management Meetings as a venue to conduct training in various focus areas that would support the Contractors' efforts related to integrated care activities and included a focus on the following topics: • Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program and KidsCare • Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) • Arizona measles, mumps, and rubella (MMR) • Arizona Head Start • Pediatric oral health Throughout CYE 2019, AHCCCS also hosted the AHCCCS Community Forum, which AHCCCS Contractors, members, and community stakeholders are encouraged to attend. This meeting was conducted twice during the applicable year and included a focus on the following topics:

HSAG Recommendation	AHCCCS Activities
	• AHCCCS crisis activities • Behavioral health referral process • AHCCCS updates The agendas outlining the focus areas/training topics included as part of these meetings can be found in the supporting documentation folder.
AHCCCS should continue the collaboration among RBHA Contractors in the workgroup to improve the PIP study indicator rates. AHCCCS should consider including in the workgroup additional stakeholders who may help with improvement of the PIP study indicator rates.	Contractors demonstrate sustained improvement when they maintain, or increase, improvements in performance for at least one year after the improvement is first achieved. CYE 2017 reflected Remeasurement Year 2 data for all lines of business, with the exception of the RBHA Contractors. Based on the CYE 2017 Rates, AHCCCS considered the *E-Prescribing* PIP closed for all Contractors with the exception of the aforementioned RBHAs. While the PIP remained open for the RBHAs, CYE 2018 rates demonstrated improvement from previous years (Baseline Year/ Remeasurement Year 1). Therefore, this workgroup did not occur during CYE 2019.
AHCCCS may want to consider requiring, for the RBHA Contractors, new PIPs that pertain to aspects of the ACC activities.	AHCCCS is currently considering potential PIP topics for the ACC and RBHA Contractors that will align with the behavioral health aspects of system integration and ACC.

Table 1-15 presents a summary of the follow-up actions per activity that the RBHA Contractors reported completing in response to HSAG's recommendations included in the *CYE 2018 RBHA Technical Report*.

Additionally, the text located after each HSAG recommendation box was submitted by the Contractor.

Table 1-15—CIC's Responses to HSAG's Follow-Up Recommendations

CIC
Operational Review
HSAG Recommendations: • Contractors should continue to conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal

CIC
regulations. Specifically, Contractors should ensure that existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements are cross-referenced with AHCCCS standards, State rules, and federal regulations. • Contractors should continue to assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes. In addition, Contractors should implement periodic assessments of those elements reviewed by AHCCCS for which Contractors are found deficient and develop mechanisms to address such areas and enhance existing procedures. • Contractors should continue to implement control systems to address specific findings in the MCH standard related to women's preventative care services to ensure that services are provided in accordance with the AHCCCS Medical Policy Manual as this was a finding for both RBHA Contractors.
The OR conducted for CYE 2018 identified issues in seven of the OR standard areas: CIS, DS, GA, MCH, MM, MI, and QM. Out of the seven OR standards identified, only three (CIS, GA, and MCH) did not meet the 95 percent threshold. Due to these identified issues and scoring less than 95 percent in three standard areas, CAPs were created and approved by AHCCCS immediately following the notification of results to AzCH-RBHA. All of the CAPs required have been subsequently approved and closed through AHCCCS. AzCH 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.
Performance Measures
HSAG Recommendations: • Although the *Adults' Access to Preventive/Ambulatory Health Services* performance measure rates are considered an area of strength, the rates for CIC and the RBHA Integrated SMI Contractors aggregate declined significantly from CYE 2016 to CYE 2017. Despite the high performance for this measure, the cause of this decline should be assessed to ensure that performance stays above the MPS in future years. • The RBHA Integrated SMI Contractors should focus efforts on identifying the factors contributing to low rates for these measures and implement improvement strategies to increase screenings for breast cancer and chlamydia in women and follow-up visits after hospitalization for mental illness.
CIC relies on the QM/PI Committee as the body that reviews, monitors, evaluates, and develops interventions targeted at performance measures. The QM/PI Committee is structured to ensure data drill-down is completed with root cause analysis, and PDSA cycles are developed to drive intervention development and implementation. Focused interventions on improvement of performance measures are developed within the performance improvement team. The QI Subcommittee met quarterly during CY 2019 and reported on all AHCCCS-mandated performance standards, with particular focus and emphasis on interventions and

CIC
impact to the *Breast Cancer Screening, Cervical Cancer Screening,* and *Chlamydia Screening in Women* and *Follow-Up After Hospitalization* (FUH) measures. The Coordination of Care Performance Improvement Plan (COC-PIP), approved by AHCCCS, instituted the intervention year during CY 2018 and has continued through CY 2019. Performance measures make up one indicator for this plan, for which we have included breast cancer, cervical cancer, and chlamydia screenings. CIC has implemented two specific system-level interventions to sustain performance measure impact through coordination of care including actively engaging PCPs into a collaborative AzCH Integrated Care COC process; and HIE implementation. Both of these interventions aim to ensure health homes, PCPs, and specialists remain connected and communicate the completion of, or barriers to, completing health screenings as well as ongoing communication for follow-up when members are due for breast cancer, cervical cancer, and chlamydia screenings or other performance measures. Additionally, through the Population Health Administer program, CIC provided best practices and technical guidance to providers on understanding and tracking which members are eligible for and need breast cancer, cervical cancer, and chlamydia screening(s) completed. CIC has created the transitions of care management team (TCM), which provides intensive discharge planning assistance for high-risk members who do not have a case manager assignment. During the member's inpatient stay, the TCM team coordinates with both the member and the inpatient treatment team to develop a comprehensive and attainable discharge plan. The TCM team follows the member for up to seven days post discharge. If the team determines that the member needs additional support beyond the seven days, the TCM team will complete a warm handoff to care management. In addition to the TCM team's efforts, care management has two staff co-located at two high-volume hospitals to provide assistance in discharge planning and coordination of care. As a part of the COC-PIP, CIC identified a community agency with low FUH rates and partnered with that agency to pilot a program. Starting in June 2019, the health home opened a 23-hour facility, which they will utilize for members who present to the emergency department (ED) or the hospital but do not have acute symptoms to meet admission criteria. The health home will transport those members from the hospital to their facility and provide services, as well as assist in coordination with their care team for the following day. CIC developed provider materials containing information on the FUH measures and includes suggested best practices toward engaging the member to complete these follow-up appointments. CIC has instituted a member outreach program utilizing IVR calls, email, and text (SMS) messaging with a specific campaign directed at members with care gaps for breast cancer, cervical cancer, and chlamydia screenings, as well as members who need preventive care visits. These campaigns have a two-pronged approach. The first set of outreach approaches consist of an IVR call and an email with the focus on education of what are the screenings and/or well visits and why the member should complete them. The second set of outreach approaches consist of an email and a text (SMS) message with the focus on reminding the members of the need to obtain their needed screenings and preventive care visits.

CIC
Quality management has instituted a multi-prong approach to utilize AHCCCS-approved letters, flyers, emails, and events to educate and remind members of the importance of getting needed health screenings and complete their preventive care visits. Quality management continues to develop and refine training materials, which include quick reference guides and AHCCCS-approved member-facing materials for case management use when talking to members about care gaps. In conjunction with the case management team, the QI team created and instituted gap closure letters for adult preventive screenings, including, but not limited to breast and cervical cancer screenings. These letters are available within the electronic health record so the case manager, when completing a call with a member, can send a screening reminder timely. CIC 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 complete specific healthy activities. Cervical cancer screenings are an eligible screening to receive the $25 incentive. Because of the nature of well-woman exams, it is likely that a member will complete the chlamydia screening concurrently with an incentivized completion of the cervical cancer screening. CIC set up a mobile mammogram event in Tucson, Arizona, to increase access for members who are in need of their mammogram. CIC plans to hold another event during Q1, CY 2020. 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
HSAG Recommendations: • RBHA Contractors are encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, and then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period. • HSAG recommends that CIC provide monthly updates on interventions at the chief executive officer (CEO) meetings, especially the financial incentive and CAP interventions.
Monitoring and evaluation efforts continue to drive identification of provider deficiencies and best practices to ensure targeted education and interventions are successful at continuing to improve e-prescribing metrics. The pharmacy department will also continue to partner with various CIC departments (e.g. Provider Engagement, Quality Management) to ensure messaging and support to AHCCCS contracted providers is consistent and ongoing. CIC 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 AHCCCS contracted prescribers electronically. Compared to baseline year rates for both the GMH/SU and SMI populations, both AHCCCS

CIC
tracking indicators showed improvement over Remeasurement Years 1 and 2. Both indicators for GMH/SU and SMI populations have exceeded the AHCCCS mandated minimum performance standards throughout CY 2019. Additionally, CIC has been tracking and targeting interventions surrounding indicators stratified by age and geographical county that address the percentage of prescriptions submitted electronically to a pharmacy. Again, all stratified indicators for both the SMI and GMH/SU populations have shown improvement over baseline rates in both Remeasurement Year 1 and Remeasurement Year 2. CIC engaged heavily in the *E-Prescribing* PIP and showed ongoing quarterly improvement over both remeasurement periods. Interventions in CY 2018 targeted ongoing provider education. Beginning in February 2018, CIC actively engaged providers who encountered barriers or issues with e-prescribing through TA support and guidance. The improvement in e-prescribing utilization can be reasonably attributed to interventions, including extensive and ongoing quarterly education of and TA to Medical Directors and individual prescribers by CIC pharmacy staff, and issuance of CAPs to providers in need of additional support. In addition, financial incentives supported improvement, notably inclusion of e-prescribing incentive as a value-based payment measure effective Quarter 3 (Q3) CY 2017.

Table 1-16—HCIC's Responses to HSAG's Follow-Up Recommendations

HCIC
Operational Review
HSAG Recommendations: • Contractors should continue to conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should ensure existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements are cross-referenced with AHCCCS standards, State rules, and federal regulations. • Contractors should continue to assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes. In addition, Contractors should implement periodic assessments of those elements reviewed by AHCCCS for which Contractors are found deficient and develop mechanisms to address such areas and enhance existing procedures. • Contractors should apply lessons learned from improving performance for one category of standards to other categories. For example, Contractors should look at CAPs completed from previous ORs to determine best practices specific to their organizations to identify and correct policies, procedures, and practices so as to address deficient standards and monitor subsequent compliance. Further, Contractors should use opportunities to address and discuss issues identified during ORs. • Contractors should continue to implement control systems to address specific findings in the MCH standard related to the women's preventative care services to ensure that services

HCIC
are provided in accordance with the AHCCCS Medical Policy Manual, as this was a finding for all RBHA Contractors.
HCIC institutes a comprehensive compliance program, including the seven elements of a compliance program per industry standards (including internal monitoring and auditing). HCIC maintains a Compliance Committee Meeting template/format that includes a summary of tracking/monitoring of routine activities (such as deliverables, policies and procedures, fraud, waste, and abuse referrals, CAPs, and risk items). HCIC engages in various routine monitoring of operational functions (which ultimately are collectively reported to the State by way of scheduled deliverables). HCIC's performance as reported via these deliverables is then rolled up into the Compliance Committee Meeting, reflected in each Compliance Committee Meeting packet. HCIC updated Policy IBH.7.113, Provider Service Rep Training, to reference training for provider inquiry handling and tracking (including resolution time frames), internal procedures for initiating contracting or AHCCCS registration, claim submission methods and resources, and claim dispute and appeal procedures. HCIC revised Policy IBH.16.013 to clarify that the AZ OB Ambulatory Medical Record Review audits conducted by the third-party vendor include both OB/GYN and PCP records in an effort to monitor the provision of well-woman services. HCIC addressed AHCCCS' follow-up comments received and revised documents accordingly. • HCIC revised IBH.16.013 to: – Ensure it accurately details the covered services included as part of the well-woman preventive care visit (in accordance with AMPM 411 Section C-1). – More specifically address provider monitoring activities. While cervical cancer screening and mammograms are HEDIS measures, HCIC still uses this data in part in its monitoring of well-woman service utilization. – Provide more information about the methods HCIC uses for member outreach related to women's preventive benefits, including mention of services being available at no cost to the member and assistance with appointment scheduling and arrangement of medically necessary transportation. – Provide more information about the methods HCIC uses for provider education and outreach related to women's preventive care. • HCIC created a new chapter in the Provider Manual (Chapter 4.5) to address well-woman preventive care benefits, requirements, and provider monitoring. • HCIC drafted an informational handout about women's preventive care benefits. Once approved, it will be mailed to members within 30 days of enrollment and annually to educate members about their well-woman benefits to comply with AMPM Policy 411 Section B-3. • Provider outreach was enhanced through the revision of the IBH.16.013—Women's Preventive Care Services policy and procedure, the Provider Manual, Chapter 4.0—

HCIC
Covered Services, and through the Provider Newsletter sample addressing women's preventive care services. • Monitoring included: – Revision of IBH.16.013—Women's Preventive Care Services policy and procedure – Revision of IBH.9.002—Medical Record Review policy and procedure – Ambulatory Medical Record Review Tool: AZ OB Audit Tool 2017 • Member Outreach included: – Revision of IBH.16.013—Women's Preventive Care Services policy and procedure – Member Newsletter addressing women's preventive care services
Performance Measures
HSAG Recommendations: • The Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). After the key factors related to the low rates are identified, the Contractors should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care. • The RBHA Integrated SMI Contractors should examine potential barriers to women receiving breast cancer and chlamydia screenings to understand the cause of the low rates (e.g., provider misconceptions, lack of education, member anxiety). Once the causes are identified, AHCCCS and the RBHA Integrated SMI Contractors should ensure that members receive screenings in accordance with the U.S. Preventive Services Task Force (USPSTF) screening recommendations for breast cancer and chlamydia in women.
HCIC reviewed previous methods of tracking follow-up appointments; the review revealed that a number of members receive follow-up after hospitalization that does not meet the criteria to count in the numerator for this measure because they either take place with incorrect staff or are billed using codes that do not meet the criteria for the measure. A review of recently discharged members uncovered inconsistencies in appointments scheduled by discharging hospitals. It is not clear that all hospitals understand the requirements related to follow-up after discharge. A review of individual cases for purposes of root cause analysis was not able to uncover any single clear barrier to a member attending follow-up appointments, as each case is complex and the barriers unique. There also does not exist at this time a platform specifically designed for the discussion of these barriers within the system of care.
Performance Improvement Projects
HSAG Recommendations:

HCIC
• The RBHA Contractors may want to use the quarterly collaboration meetings with stakeholders as opportunities to identify and address systemwide barriers to the PIP process, which may be impacting ability to achieve meaningful improvement. • The RBHA Contractors should continue to identify and prioritize barriers so as to develop robust interventions for the *E-Prescribing* PIP. • The RBHA Contractors are encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, and then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.
HCIC participated in Health Current (formerly AzHec) in order to discuss and identify statewide barriers to e-prescribing. This was targeted internally to help bring HCIC expectations in line with the expectations of the other health plans. As part of HCIC's larger project to incentivize health homes and move toward value-based purchasing, HCIC started an incentive for health homes that e-prescribe 65 percent or more of their prescriptions. This is to encourage participation in e-prescribing. It is designed to encourage buy-in from agencies as a whole, and to encourage systems that support providers' use of e-prescribing. HCIC's overall number and percent of e-prescriptions from the first remeasurement to the second remeasurement showed a 10.81 percent increase in the rate of prescriptions sent electronically overall.

Table 1-17—MMIC's Responses to HSAG's Follow-Up Recommendations

MMIC
Performance Measures
HSAG Recommendations: • HSAG recommends that AHCCCS work with the GMH/SU and RBHA Integrated SMI Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2017 MPS. AHCCCS and the Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). • Following a member's discharge from an inpatient admission, Contractors should perform a follow-up call with that member within three days to address any questions or concerns and to discuss progress of the care plan. AHCCCS and the GMH/SU Contractors should ensure that these follow-up calls are being conducted and confirm during each call that the member has a follow-up visit scheduled with a mental health practitioner and access to necessary community resources.

MMIC
MMIC will continue to monitor the follow-up after hospitalization rates quarterly for statistically significant changes. As needed, MMIC will apply the PDSA model to assess the need to modify existing interventions or implement new interventions. Based on the improved outcomes, the current interventions will be continued.
HSAG Recommendation: Additionally, HSAG recommends that AHCCCS work with the RBHA Integrated SMI Contractors to increase preventive screenings for women. AHCCCS and the RBHA Integrated SMI Contractors should examine potential barriers to women receiving breast cancer and chlamydia screenings to understand the cause of the low rates (e.g., provider misconceptions, lack of education, member anxiety).
Based on the improved outcomes for the *Cervical Cancer Screening* and *Chlamydia Screening in Women* measures, the current interventions will be continued. MMIC will continue its current interventions for the *Breast Cancer Screening* measure, including sending birthday reminder notices to members needing well-woman screenings. MMIC has also recently included the SMI population in existing MMIC breast cancer screening interventions and outreaches, which MMIC has proven successful in improving rates for these measures in other populations, and will continue the interventions during CYE 2020.

2. Introduction to the Annual Technical Report

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 EQR annual report of findings and recommendations.

For contracts that started 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 is requiring validation of MCO, PIHP, and PAHP network adequacy as 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 EQR, means the degree to which an MCO, PIHP, PAHP, or 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 EQR, 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 ("standards" for the purpose of this report) 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.

[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)

For an overview of AHCCCS' programs, including a brief history of the AHCCCS Medicaid managed care programs and a description of AHCCCS' Strategic Plan for State Fiscal Years 2017–2022 (Strategic Plan), refer to the CYE 2019 ACC and RBHA reports.

4. Performance Measure Results

Methodology

The following section presents the results for the mandatory performance measure activity conducted during the CYE 2018 reporting period. To evaluate performance levels and to provide an objective, comparative review of the Contractors' performance, AHCCCS required its Contractors to report CYE 2018 data (i.e., October 1, 2017–September 30, 2018). 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 (Child Core Set) and CHIP. AHCCCS approved the CYE 2018 rates for inclusion in this report.

For a detailed explanation of the methodology, please see Appendix A. Validation of Performance Measure Methodology.

Required Performance Measures—Acute Care Contractors, CMDP, and KidsCare Contractors

The performance measures selected by AHCCCS for the Acute Care Contractors, CMDP, and KidsCare Contractors for CYE 2018 were grouped into the following domains of care: Access to Care, Medication Management, 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 4-1 displays the CYE 2018 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 4-1. An MPS had not been established for all reported performance measure rates.

Table 4-1—CYE 2018 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%

Performance Measure	Measure Specification	MPS
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%
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%
Medication Management		
*Use of Opioids at High Dosage in Persons Without Cancer***	Adult Core Set	—
Pediatric Health		
Adolescent Well-Care Visits†	Child Core Set	41.0%
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%
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	N/A
*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 KidsCare Contractors were required to report the performance measure for inclusion in this report, while CMDP was not required to report the performance measure.
— Indicates that an MPS had not 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 2018 MPS.*
*** For this indicator, a lower rate indicates better performance.*
± Due to changes in the calculation methodology used in CYE 2018, comparisons to the MPS are not made.
N/A indicates lower or higher rates are not considered to be an appropriate measure of care for this measure.

Performance Measure Results—Acute Care Contractors

Table 4-2 presents the CYE 2018 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 2018 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 4-2—CYE 2018 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	64.6%	57.0%	48.3%	63.9%	54.0%	61.9%	61.1%
Children and Adolescents' Access to Primary Care Practitioners							
12–24 Months	96.0%	93.1%	92.9%	95.3%	93.8%	94.9%	94.8%
25 Months–6 Years	85.6%	80.2%	81.6%	86.0%	83.5%	84.0%	84.2%
7–11 Years	88.2%	85.2%	81.7%	90.3%	86.9%	88.4%	88.4%
12–19 Years	85.6%	82.7%	80.7%	87.6%	85.8%	86.0%	86.1%
Pediatric Health							
Adolescent Well-Care Visits							
Adolescent Well-Care Visits	45.7%	35.0%	34.3%	43.0%	38.3%	39.5%	40.6%
Well-Child Visits in the First 15 Months of Life							
Six or More Well-Child Visits	67.1%	59.7%	61.0%	65.6%	62.3%	61.1%	61.5%
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	66.8%	56.0%	59.1%	62.7%	60.4%	61.2%	61.4%
Preventive Screening							
Breast Cancer Screening							
Breast Cancer Screening	51.0%	48.1%	51.7%	57.8%	55.7%	57.6%	54.9%
Cervical Cancer Screening							
Cervical Cancer Screening	53.8%	44.8%	49.3%	54.5%	54.1%	49.4%	50.8%
Utilization							
Ambulatory Care (per 1,000 Member Months)							
*ED Visits—Total**	50.6	58.0	51.5	55.9	53.2	54.7	54.8

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

Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Table 4-3 presents a comparison of the Acute Care Contractors' CYE 2017 to CYE 2018 rates. Performance measure rates were compared to determine if there was a significant difference between CYE 2017 and CYE 2018 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, because CYE 2018 was the first year that the measure was required to be reported (i.e., *Use of Opioids at High Dosage in Persons Without Cancer*), there was a change to the measure specifications and calculation methodology (i.e., *Plan All-Cause Readmissions*), or the measure data were not appropriate for statistical testing (i.e., *Ambulatory Care* and *Inpatient Utilization*).

Table 4-3—Trend Analysis From CYE 2017 to CYE 2018—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							
Breast Cancer Screening							
Breast Cancer Screening	—	—	—	—	—	↑	↑
Cervical Cancer Screening							
Cervical Cancer Screening	↑	↑	↑	↓	—	↑	↑

↑ *Indicates a significant improvement in the Contractor's rate from CYE 2017 to CYE 2018.*
↓ *Indicates a significant decline in the Contractor's rate from CYE 2017 to CYE 2018.*
— *Indicates no significant difference in the Contractor's rate from CYE 2017 to CYE 2018.*

Strengths and Opportunities for Improvement

For CYE 2018, the Acute Care Contractors demonstrated strength (i.e., the performance for at least four of the six Contractors met or exceeded the MPS) for the following performance measure rates:

- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *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 Acute Care Contractors demonstrated strength for the *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* performance measure indicator rate , the rates for three of six (50.0 percent) Acute Care Contractors and the Acute Care aggregate demonstrated significant declines in performance from CYE 2017 to CYE 2018. Similarly, the rates for two of six (33.3 percent) Acute Care Contractors and the Acute Care aggregate demonstrated significant declines in performance from CYE 2017 to CYE 2018 for the *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* performance measure indicator rate. Despite exceeding the MPS for these indicators, the Acute Care 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 2018, with 10 of 11 (90.9 percent) and eight out of 11 (72.7 percent) performance measure rates, respectively, meeting or exceeding the MPS. Additionally, Care1st, MCP, and UHCCP-Acute were the only Acute Care Contractors to meet or exceed the MPS for all five performance measures within the Access to Care domain (*Annual Dental Visits* and all four *Children and Adolescents' Access to Primary Care Practitioners* indicators).

For CYE 2018, the Acute Care Contractors demonstrated opportunities for improvement (i.e., the performance for at least four of the six Contractors fell below the MPS) for the following performance measure rates:

- *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*

No Acute Care Contractors met the MPS for the *Cervical Cancer Screening* performance measure, with all six Acute Care Contractors falling below the MPS by at least 9 percentage points; however, four of six (66.7 percent) Acute Care Contractors and the Acute Care aggregate demonstrated significant improvement in performance.

HCA and HNA demonstrated the most opportunities for improvement with only meeting or exceeding the CYE 2018 MPS for three of 11 (27.3 percent) and two of 11 (18.2 percent) performance measures, respectively. Additionally, HCA and MCP demonstrated significant declines in performance for two of 10 (20.0 percent) measure rates that were compared to the prior year.

Performance Measure Results—CMDP

Table 4-4 presents the CYE 2017 and CYE 2018 performance measure results for CMDP. The table displays the following information: CYE 2017 performance, where available; CYE 2018 performance; the relative percentage change between CYE 2017 and CYE 2018 rates, where available; the significance of the relative percentage change, where available; and the CYE 2018 aggregate for the Acute Care Contractors for comparison. Performance measure rate cells shaded green indicate that CMDP met or exceeded the CYE 2018 MPS established by AHCCCS.

Table 4-4—CYE 2017 and CYE 2018 Performance Measure Results—CMDP

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	Acute Care Aggregate
Access to Care					
Annual Dental Visits					
2–20 Years	73.8%	75.4%	2.2%	**P=0.034**	61.1%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	97.9%	97.7%	-0.2%	P=0.804	94.8%
25 Months–6 Years	91.8%	92.9%	1.2%	P=0.196	84.2%
7–11 Years	96.8%	96.2%	-0.6%	P=0.447	88.4%
12–19 Years	97.1%	96.4%	-0.7%	P=0.337	86.1%
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	72.3%	72.4%	0.1%	P=0.954	40.6%
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	74.5%	72.6%	-2.6%	P=0.197	61.4%

[1] *Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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 2018 MPS established by AHCCCS.

Strengths and Opportunities for Improvement

CMDP demonstrated overall strength for CYE 2018, exceeding the MPS for all seven performance measure rates. Of note, one performance measure rate (*Annual Dental Visits*) demonstrated significant improvement from CYE 2017 to CYE 2018. Additionally, CMDP's performance for all seven performance measures exceeded the Acute Care aggregate.

Performance Measure Results—KidsCare Contractors

The six Acute Care Contractors provide services to eligible children under age 19 enrolled in the KidsCare program (i.e., Arizona's CHIP). Table 4-5 presents the CYE 2018 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 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 2018 MPS established by AHCCCS.

Table 4-5—CYE 2018 Performance Measure Results—KidsCare Contractors

Performance Measure	Care1st	HCA	HNA	MCP	UFC	UHCCP	Aggregate
Access to Care							
Annual Dental Visits							
2–20 Years	76.5%	70.3%	64.8%	76.6%	67.8%	75.6%	74.1%
Children and Adolescents' Access to Primary Care Practitioners							
12–24 Months	NA	NA	NA	96.9%	NA	98.4%	98.6%
25 Months–6 Years	94.9%	88.3%	97.2%	94.7%	93.9%	92.1%	93.1%
7–11 Years	97.4%	97.3%	NA	97.9%	NA	92.6%	95.7%
12–19 Years	98.3%	93.4%	NA	96.4%	NA	93.9%	95.4%
Pediatric Health							
Adolescent Well-Care Visits							
Adolescent Well-Care Visits	58.4%	53.4%	56.0%	64.0%	57.4%	59.3%	59.3%
Well-Child Visits in the First 15 Months of Life							
Six or More Well-Child Visits	NA	NA	NA	NA	NA	NA	28.9%
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	81.2%	69.9%	85.6%	77.2%	76.7%	73.9%	75.7%

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 2018 MPS established by AHCCCS.

The KidsCare Contractors' performance measure rates were compared to determine if there was a significant difference between CYE 2017 and CYE 2018 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. The trend analysis determined that, for all performance measures, the change in performance between CYE 2017 and CYE 2018 was not significant, when the comparison between years was appropriate to perform.

Strengths and Opportunities for Improvement

The KidsCare aggregate demonstrated overall strength for the second year of reporting, as seven of eight (87.5 percent) performance measure rates met or exceeded the established MPS. The only performance measure rate not to exceed the MPS was *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*. 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 12 percentage points and two performance measure rates (*Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) exceeded the MPS by at least 9 percentage points.

Additionally, the KidsCare Contractors exceeded the established MPS for all measures in the Pediatric Health and Access to Care domains with reportable rates. None of the comparisons of the CYE 2017 to the CYE 2018 performance measure rates resulted in significant improvements or declines in performance.

Required Performance Measures—CRS

The performance measures selected by AHCCCS for UHCCP-CRS and UHCCP-CRS KidsCare for CYE 2018 were grouped into the following domains of care: Access to Care, Medication Management, Pediatric Health, and Utilization. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages the Contractor and AHCCCS to consider the measures as a whole rather than in isolation and to develop strategic changes required to improve overall performance.

Table 4-6 displays the CYE 2018 performance measures presented within this report; the associated measure specifications used to calculate each measure rate; and the established MPS, if applicable, for UHCCP-CRS and UHCCP-CRS KidsCare. Of note, UHCCP-CRS KidsCare was only required to report a subset of the following performance measures required for the Acute Care Contractors serving the KidsCare program for inclusion in this report, which are noted (†) in Table 4-6. An MPS had not been established for all reported performance measure rates.

Table 4-6—CYE 2018 Performance Measures for UHCCP-CRS and UHCCP-CRS KidsCare

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%
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%
Medication Management		
*Use of Multiple Concurrent Antipsychotics in Children and Adolescents***	Child Core Set	—
Pediatric Health		
Adolescent Well-Care Visits†	Child Core Set	41.0%
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%
Utilization		
*Ambulatory Care (per 1,000 Member Months)—ED Visits—Total**	HEDIS	43.0
Inpatient Utilization—General Hospital/Acute Care—Days per 1,000 Member Months (Total Inpatient)—Total	HEDIS	N/A
*Plan All-Cause Readmissions—Total***	Adult Core Set	—

† Indicates that UHCCP-CRS KidsCare was required to report the performance measure for inclusion in this report
— Indicates that an MPS had not 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 2018 MPS.*
*** For this indicator, a lower rate indicates better performance.*
N/A indicates lower or higher rates are not considered to be an appropriate measure of care for this measure.

Performance Measure Results—CRS

Table 4-7 presents the CYE 2017 and CYE 2018 performance measure results for UHCCP-CRS. The table displays the following information: CYE 2017 performance, where available; CYE 2018 performance; the relative percentage change between CYE 2017 and CYE 2018 rates, where available;

and the significance of the relative percentage change, where available. Performance measure rate cells shaded green indicate that performance met or exceeded the CYE 2018 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 4-7—CYE 2017 and CYE 2018 Performance Measure Results—UHCCP-CRS

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]
Access to Care				
Annual Dental Visits				
2–20 Years	67.4%	67.7%	0.5%	P=0.606
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	96.9%	99.1%	2.3%	**P=0.042**
25 Months–6 Years	92.7%	92.2%	-0.5%	P=0.422
7–11 Years	95.8%	95.8%	0.0%	P=0.981
12–19 Years	95.1%	95.1%	0.0%	P=0.912
Medication Management				
Use of Multiple Concurrent Antipsychotics in Children and Adolescents[2]				
*Total**	0.7%	0.7%	0.0%	P=1.000
Pediatric Health				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	48.9%	48.1%	-1.6%	P=0.409
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	49.2%	47.3%	-3.9%	P=0.690
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.8%	63.8%	-3.0%	P=0.137
Utilization				
Ambulatory Care (per 1,000 Member Months)				
*ED Visits—Total**	55.4	55.2	-0.4%	—
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total[2+]				
Days per 1,000 Member Months (Total Inpatient)—Total	78.5	88.4	12.7%	—

** For this indicator, a lower rate indicates better performance.*
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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 been established for this measure.
— Indicates that the Contractor was not required to report the measure for the CYE 2017 reporting period or that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
[+] Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Strengths and Opportunities for Improvement

UHCCP-CRS demonstrated overall strength for CYE 2018, exceeding the MPS for six of nine (66.7 percent) performance measure rates with an established MPS. Of note, the performance measure rates for *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*; and *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* fell below the MPS.

Despite the high performance for *Children and Adolescents' Access to Primary Care Practitioners*, rates for the well-child visit measures indicate that members ages 6 and younger are not receiving the recommended number of well-child visits. Children with chronic conditions who do not receive the recommended number of comprehensive well-child visits have been associated with increased number of injuries, ED visits, and ambulatory care-sensitive hospitalizations. Additionally, children with chronic conditions require increased communication and continuity of care among multiple providers and between providers and parents in order to avoid breakdowns in communication leading to fragmented care.[4-1] AHCCCS and UHCCP-CRS should focus efforts on identifying the factors contributing to the low rates of well-child visits and implement improvement strategies to increase well-child visits for children with chronic conditions.

Performance Measure Results—UHCCP-CRS KidsCare

Table 4-8 presents the CYE 2018 performance measure results for UHCCP-CRS KidsCare. The table displays the following information: CYE 2017 performance, where available; CYE 2018 performance; the relative percentage change between CYE 2017 and CYE 2018 rates, where available; and the significance of the relative percentage change, where available. Performance measure rate cells shaded green indicate that performance met or exceeded the CYE 2018 MPS established by AHCCCS.

Table 4-8—CYE 2018 Performance Measure Results—UHCCP-CRS KidsCare

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]
Access to Care				
Annual Dental Visits				
2–20 Years	80.7%	75.0%	-7.1%	P=0.395
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	NA	NA	—	—
25 Months–6 Years	NA	NA	—	—
7–11 Years	NA	NA	—	—

[4-1] Tom JO, Tseng C, Davis J, et al. Missed Well-Child Care Visits, Low Continuity of Care, and Risk of Ambulatory Care–Sensitive Hospitalizations in Young Children. *Arch Pediatr Adolesc Med*. 2010;164(11):1052–1058. doi:10.1001/archpediatrics.2010.201.

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]
12–19 Years	NA	NA	—	—
Pediatric Health				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	73.0%	63.1%	-13.6%	P=0.308
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	NA	NA	—	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NA	NA	—	—

NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Strengths and Opportunities for Improvement

UHCCP-CRS KidsCare demonstrated overall strength for CYE 2018 with the rates for the *Annual Dental Visits* and *Adolescent Well-Care Visits* performance measures exceeding the MPS by 15.0 and 22.1 percentage points, respectively. However, the performance measure rates decreased from CYE 2017 by 5.7 and 9.9 percentage points, respectively. Despite exceeding the MPS for these indicators, the Contractor should assess the cause of these declines to ensure that performance stays above the MPS in future years.

Required Performance Measures—GMH/SU and RBHA Integrated SMI Contractors

The performance measures selected by AHCCCS for GMH/SU and RBHA Integrated SMI Contractors for CYE 2018 were grouped into the following domains of care: Access to Care, Preventive Screening, Behavioral Health, Medication Management, 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 4-9 displays the CYE 2018 performance measures presented within this report; the associated measure specifications used to calculate each measure rate; and the established MPS, if applicable, for the GMH/SU and RBHA Integrated SMI Contractors. GMH/SU was only required to report a subset of the following performance measures for inclusion in this report; therefore, GMH/SU's required

performance measures are noted († and ††) in Table 4-9. An MPS had not been established for all reported performance measure rates.

Table 4-9—CYE 2018 Performance Measures for GMH/SU and RBHA Integrated SMI Contractors

Performance Measure	Measure Specification	MPS
Access to Care		
Adults' Access to Preventive/Ambulatory Health Services—Total	HEDIS	75.0%
Preventive Screening		
Breast Cancer Screening	Adult Core Set	50.0%
Cervical Cancer Screening	Adult Core Set	64.0%
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up†	Adult Core Set	85.0%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up†	Adult Core Set	95.0%
Medication Management		
*Use of Multiple Concurrent Antipsychotics in Children and Adolescents††**	Child Core Set	—
*Use of Opioids at High Dosage in Persons Without Cancer†**	Adult Core Set	—
Utilization		
*Ambulatory Care (per 1,000 Member Months)—ED Visits—Total**	HEDIS	—
Inpatient Utilization—General Hospital/Acute Care—Days per 1,000 Member Months (Total Inpatient)—Total	HEDIS	N/A
Mental Health Utilization—Any Service—Total†	HEDIS	—
*Plan All-Cause Readmissions—Total**	Adult Core Set	—

† Indicates that GMH/SU was required to report the performance measure for inclusion in this report.
†† Indicates that GMH/SU was required to report the performance measure for inclusion in this report, while the RBHA Integrated SMI Contractors were not required to report the performance measure.
— Indicates that an MPS had not been established by AHCCCS.
** For this indicator, a lower rate indicates better performance.*
N/A indicates lower or higher rates are not considered to be an appropriate measure of care for this measure.

Performance Measure Results—GMH/SU and RBHA Integrated SMI Contractors

GMH/SU

Table 4-10 presents the CYE 2018 performance measure rates with an MPS for the GMH/SU population and statewide aggregate. The following results include performance measure rates for the RBHA Integrated SMI Contractors, which include members eligible for the GMH/SU program while enrolled in their respective program. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the CYE 2018 MPS established by AHCCCS.

Table 4-10—CYE 2018 Performance Measure Results—GMH/SU Contractors

Performance Measure	CIC	HCIC	MMIC	Aggregate
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	58.8%	56.3%	45.5%	49.4%
30-Day Follow-Up	76.1%	71.0%	63.6%	67.1%

Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Table 4-10 presents a comparison of the GMH/SU CYE 2017 to CYE 2018 rates. Performance measure rates were compared to determine if there was a significant difference between CYE 2017 and CYE 2018 using a Chi-square test of proportions. In cases where the numerator 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, statistical significance testing was not performed, either because CYE 2018 was the first year that the measure was required to be reported (i.e., *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* and *Use of Opioids at High Dosage in Persons Without Cancer*) or the measure data were not appropriate for statistical testing (i.e., *Mental Health Utilization*).

Table 4-11—Trend Analysis From CYE 2017 to CYE 2018—GMH/SU Contractors

Performance Measure	CIC	HCIC	MMIC	Aggregate
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	↑	—	—	↑
30-Day Follow-Up	—	—	—	—

↑ *Indicates a significant improvement in the Contractor's rate from CYE 2017 to CYE 2018.*
↓ *Indicates a significant decline in the Contractor's rate from CYE 2017 to CYE 2018.*
— *Indicates no significant difference in the Contractor's rate from CYE 2017 to CYE 2018.*

Strengths and Opportunities for Improvement

For CYE 2018, none of the GMH/SU Contractors' rates met or exceeded the MPS for the *Follow-Up After Hospitalization for Mental Illness* indicators, demonstrating opportunities to improve care. However, CIC's rate for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator demonstrated a significant improvement from CYE 2017 to CYE 2018 and none of the GMH/SU Contractors' rates for the *7-Day Follow-Up* or *30-Day Follow-Up* measure indicators demonstrated a significant decline in performance.

Research related to hospitalization for mental illness indicates that appropriate discharge planning and follow-up visits are contributing factors to lowering readmission rates.[4-2] The Reducing Avoidable Readmissions Effectively (RARE) Campaign—a collaboration of the Institute for Clinical Systems Improvement, Minnesota Hospital Association, and Stratis Health—recommends improving care transitions following an inpatient hospital admission by focusing on patient and family engagement, medication management, comprehensive transition planning, care transition support, and transition communications. Patients should have follow-up appointments scheduled prior to discharge, and mental health practitioners should ensure availability to review each patient's progress and care plan within the first seven days post discharge.[4-3] Following a member's discharge from an inpatient admission, Contractors should perform a follow-up call with that member within three days to address any questions or concerns and to discuss progress of the care plan.[4-4,4-5] AHCCCS and the GMH/SU Contractors should ensure that these follow-up calls are being conducted and confirm during each call that the member has a follow-up visit scheduled with a mental health practitioner and access to necessary community resources.

RBHA Integrated SMI

Table 4-12 presents the CYE 2018 performance measure rates with an MPS for each RBHA Integrated SMI Contractor and the statewide aggregate. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the CYE 2018 MPS established by AHCCCS.

[4-2] Lien, Lars. Are readmission rates influenced by how psychiatric services are organized? *Nordic Journal of Psychiatry.* Vol. 56, No. 1, 2002.

[4-3] Reducing Avoidable Readmissions Effectively. *Recommended Actions for Improved Care Transitions: Mental Illness and/or Substance Use Disorders*. Available at: http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf. Accessed: Mar. 12, 2020.

[4-4] Arizona Health Care Cost Containment System. *How A Hospital Discharge Plan Helps AHCCCS Members Return to Good Health*. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/HospitalDischarge.pdf. Accessed on: Mar. 12, 2020.

[4-5] Arizona Health Care Cost Containment System. *AHCCCS Presentation Care Coordination Discharge Planning*. Available at: http://files.constantcontact.com/b108b018001/a0e54380-8b8a-4cda-abfa-464c2a417bbf.pdf. Accessed on: Mar. 12, 2020.

Table 4-12—CYE 2018 Performance Measure Results—RBHA Integrated SMI Contractors

Performance Measure	CIC	HCIC	MMIC	Aggregate
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	89.4%	89.3%	92.9%	91.2%
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	38.2%	31.8%	38.1%	37.3%
Cervical Cancer Screening				
Cervical Cancer Screening	45.7%	40.7%	45.5%	44.8%
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	62.9%	64.4%	71.2%	68.5%
30-Day Follow-Up	83.9%	81.2%	86.7%	85.6%

Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Table 4-13 presents comparison of the RBHA Integrated SMI Contractors' CYE 2017 to CYE 2018 rates. Performance measure rates were compared to determine if there was a significant difference between CYE 2017 and CYE 2018 using a Chi-square test of proportions. In cases where the numerator 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, statistical significance testing was not performed, because CYE 2018 was the first year that the measure was required to be reported (i.e., *Use of Opioids at High Dosage in Persons Without Cancer*), there was a change to the measure specifications and calculation methodology (i.e., *Plan All-Cause Readmissions*), or the measure data were not appropriate for statistical testing (i.e., *Ambulatory Care*, *Inpatient Utilization,* and *Mental Health Utilization*).

Table 4-13—Trend Analysis From CYE 2017 to CYE 2018—RBHA Integrated SMI Contractors

Performance Measure	CIC	HCIC	MMIC	Aggregate
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	↓	—	↓	↓
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	NC	NC	—	—
Cervical Cancer Screening				
Cervical Cancer Screening	—	—	—	↓

Performance Measure	CIC	HCIC	MMIC	Aggregate
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	—	—	↓	↓
30-Day Follow-Up	—	—	↓	↓

↑ *Indicates a significant improvement in the Contractor's rate from CYE 2017 to CYE 2018.*
↓ *Indicates a significant decline in the Contractor's rate from CYE 2017 to CYE 2018.*
— *Indicates no significant difference in the Contractor's rate from CYE 2017 to CYE 2018.*
NC indicates that a comparison of performance between CYE 2017 and CYE 2018 was not appropriate.

Strengths and Opportunities for Improvement

For CYE 2018, the RBHA Integrated SMI Contractors demonstrated high performance within the Access to Care domain as all Contractors exceeded the MPS for *Adults' Access to Preventive/Ambulatory Health Services* by at least 14 percentage points. Although the *Adults' Access to Preventive/Ambulatory Health Services* performance measure rates are considered an area of strength, the rates for CIC, MMIC, and the RBHA Integrated SMI aggregate declined significantly from CYE 2017 to CYE 2018. Despite the high performance for this measure, the cause of this decline should be assessed to ensure that performance stays above the MPS in future years.

Conversely, no performance measure rates within the Preventive Screening (*Breast Cancer Screening* and *Cervical Cancer Screening*) or Behavioral Health (*Follow-Up After Hospitalization for Mental Illness*) domains met or exceeded the CYE 2018 MPS, demonstrating opportunities to improve care coordination and access to screenings for members with SMI. Research shows that women with SMI experience disparities in the timely screening for preventive diseases and care; yet, women with SMI develop cancer at the same rate as the general population.[4-6] Women with SMI have cited lack of preventive care due to perceived discrimination, provider characteristics (e.g., gender), and inaccurate health perception.[4-7] AHCCCS and the RBHA Integrated SMI Contractors should focus efforts on identifying the factors contributing to low rates for these measures and implement improvement strategies to increase screenings for breast cancer in women and follow-up visits after hospitalization for mental illness.

[4-6] Woodhead C, Cunningham R, Ashworth M, et al. Cervical and breast cancer screening uptake among women with serious mental illness: a data linkage study. *BMC Cancer*. 2016 Oct 21;16(1):819. doi: 10.1186/s12885-016-2842-8.
[4-7] Xiong GL, Iosif AM, Bermudes RA, et al. Preventive Medical Services Use Among Community Mental Health Patients With Severe Mental Illness: The Influence of Gender and Insurance Coverage. *Prim Care Companion J Clin Psychiatry*. 2010; 12(5): PCC.09m00927.

5. Performance Improvement Project Results

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 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 no less than once per year.

Conducting the Review

In the AMPM, 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 member 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 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 2016 (October 1, 2015, through September 30, 2016), AHCCCS implemented the *Developmental Screening* PIP for the ACC, CMDP, and DES/DDD lines of business. The CYE 2016 baseline year for this PIP was followed by 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 2018.

Early identification of developmental delays is important when providing effective interventions. During well-child visits, pediatricians look for potential concerns using both developmental surveillance and discussions with parents about their concerns. If any issues are noted, pediatricians should follow through with a developmental screening. Thus, AHCCCS has approved developmental screening tools

that should be utilized for developmental screenings by all participating PCPs who care for EPSDT-age members.

The purpose of the *Developmental Screening* PIP is to increase the number of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. AHCCCS' goal is to demonstrate a statistically significant increase in the number and percentage of children receiving a developmental screening, followed by sustained improvement for one year.

Contractor-specific findings for the ALTCS DES/DDD Contractors regarding the *Developmental Screening* PIP are included in the section below.

This annual report includes CYE 2016 baseline measurement data; CYE 2018 Remeasurement 1 data; percentage change from baseline to Remeasurement 1; overall relative percentage changes from baseline data; statistical significance data; qualitative and quantitative analyses, including limitations and lessons learned identified by the Contractors; and interventions.

E-Prescribing Performance Improvement Project

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).

Upon initiation of the *E-Prescribing* PIP, all behavioral health services were provided under the Division of Behavioral Health Services (DBHS), an AHCCCS Contractor. However, behavioral health services for the general mental health/substance abuse (GMH/SU) and serious mental illness (SMI) populations within Maricopa County transitioned to MMIC effective April 1, 2014. GMH/SU and SMI members outside Maricopa County transitioned to either CIC or HCIC effective October 1, 2015. Therefore, the RBHA Contractors' PIP measurement periods differ from those for all other lines of business.

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.

As of CYE 2017, AHCCCS considers the *E-Prescribing* PIP closed for the all lines of business, except for the RBHAs. Contractor-specific findings for the RBHAs regarding the *E-Prescribing* PIP are included in the section below.

RBHA Contractors

AHCCCS provided HSAG with its Contractors' CYE 2017 *E-Prescribing* PIP information including qualitative analysis, with limitations and lessons learned, and interventions for three RBHA Contractors: CIC, HCIC and MMIC. During CYE 2018, the *E-Prescribing* PIP was in the Remeasurement 2 period for MMIC while CIC and HCIC were in the Remeasurement 1 period. Baseline data were used to assist the RBHA Contractors in identifying and/or implementing strategies to increase the number of providers ordering prescriptions electronically and to increase the percentage of prescriptions submitted electronically. AHCCCS expected that RBHA Contractor, provider, and member education efforts during this intervention period would result in a greater percentage of AHCCCS members being prescribed prescriptions electronically.

This section includes RBHA Contractors' PIP results as calculated by AHCCCS, along with specific activities conducted during CYE 2018. HSAG has minimally edited the analysis and interventions for grammar and punctuation; otherwise, they appear as provided by the RBHA Contractors.

Mercy Maricopa Integrated Care (MMIC)

Findings

Table 5-1 presents the baseline and Remeasurement 2 period results for the *E-Prescribing* PIP for MMIC's GMH/SU member population. CYE 2015 and CYE 2016 were intervention years for MMIC's GMH/SU line of business; therefore, rates will not be reported.

Table 5-1—MMIC GMH/SU *E-Prescribing* PIP

PIP Measure	Baseline Period Jan. 1, 2014, to Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2016, to Sept. 30, 2017	Remeasurement Period 2 Oct. 1, 2017, to Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 2	Statistical Significance
Indicator 1: The percentage (overall and by	48.44%	59.24%	65.17%	34.54%	**P<.001**

PIP Measure	Baseline Period Jan. 1, 2014, to Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2016, to Sept. 30, 2017	Remeasurement Period 2 Oct. 1, 2017, to Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 2	Statistical Significance
Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically					
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	31.96%	58.49%	66.23%	107.23%	**P<.001**

CYE 2014 was MMIC's GMH/SU baseline measurement period for the statewide *E-Prescribing* PIP. Table 5-1 shows that, for MMIC's GMH/SU population baseline measurement period, 48.44 percent of MMIC's providers prescribed at least one prescription electronically and 31.96 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the GMH/SU population, MMIC's Remeasurement 2 rate at 65.17 percent for Indicator 1 demonstrated a relative percentage change from baseline of 34.54 percent, while the Remeasurement 2 rate of 66.23 percent for Indicator 2 demonstrated a relative percentage change from baseline of 107.23 percent. MMIC demonstrated statistically significant improvements for both indicators for this PIP.

Table 5-2 presents the baseline results for the *E-Prescribing* PIP for MMIC's integrated members. CYE 2016 was an intervention year for MMIC; therefore, rates will not be reported.

Table 5-2—MMIC Integrated *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2014, to Sept. 30, 2015	Remeasurement Period 1 Oct. 1, 2016, to Sept. 30, 2017	Remeasurement Period 2 Oct. 1, 2017, to Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 2	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	51.54%	59.51%	65.20%	26.50%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed	42.34%	58.19%	63.19%	49.24%	**P<.001**

PIP Measure	Baseline Period Oct. 1, 2014, to Sept. 30, 2015	Remeasurement Period 1 Oct. 1, 2016, to Sept. 30, 2017	Remeasurement Period 2 Oct. 1, 2017, to Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 2	Statistical Significance
by an AHCCCS-contracted provider and sent electronically					

CYE 2015 was MMIC's integrated baseline measurement period for the statewide *E-Prescribing* PIP. Table 5-2 shows that, for the integrated population baseline measurement period, 51.54 percent of MMIC's providers prescribed at least one prescription electronically and 42.34 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the integrated population, MMIC's Remeasurement 2 rate at 65.20 percent for Indicator 1 demonstrated a relative percentage change from Remeasurement 1 of 26.50 percent, while the Remeasurement 2 rate of 63.19 percent for Indicator 2 demonstrated a relative percentage change from Remeasurement 1 of 49.24 percent. MMIC demonstrated statistically significant improvements for both indicators for this PIP.

MMIC submitted the following qualitative analysis:

Limitations:

MMIC reported that the Contractor (Mercy Care RBHA) will continue to monitor the interventions that have built-in sustainability, such as requiring providers to create formal processes to monitor and improve their own rates and advocating that electronic health records (EHRs) add e-prescribing capability, are expected to have a stronger potential of success than one-time interventions such as provider newsletter articles. Providers required to implement electronic prescribing and written procedures have given feedback to Mercy Care RBHA indicating these interventions are causing them to take ownership of improving their own practices and rates.

MMIC and another Acute Care Contractor, MCP, collaborated to survey the physical health providers because the two share a provider network. Among the 12 physical health providers who responded to the survey, 42 percent reported being unaware of the legality of e-prescribing controlled substances. When MMIC and MCP stratified the physical health providers by age, the Contractors did not find a correlation between the age of the provider and the provider's knowledge of or choice to use e-prescribing.

MMIC 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:[5-1] "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

[5-1] 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.

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."

MMIC reported that this research also identified the following barriers to the implementation of e-prescribing:

- Cost of implementing an e-prescribing system—according to the research, more than 80 percent of primary care providers reported 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 and are produced excessively. This may lead to "alert fatigue" in which prescribers tend to stop reading the alerts and just quickly scroll through them, possibly causing significant system alerts to be ignored.
  - Hardware problems.
  - Workflow issues.
  - Software problems.
  - Other problems such as cost, time consumption, and connection issues.
- Privacy and legal issues include:
  - A potential for patient information to be leaked from a web-based EHR system if proper firewalls and intrusion prevention systems are not in place.
  - EPCS has the potential to cause legal issues. Although the Drug Enforcement Administration (DEA) made a final ruling on e-prescribing of controlled substances in 2010, many standards contained in the ruling make e-prescribing difficult, including the following:
    - Identity proofing
    - Two-factor authentication
    - Digital certificates
    - Monthly logs
    - Third-party audits of software
    - Requirement to keep two years of records.

Lessons learned:

MMIC reported the following challenges and barriers:

- Implementation of provider-specific interventions, such as providing assistance to improve rates.
- In-person education to providers helped to improve rates.

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

- MMIC continues to participate in the workgroup. The workgroup is continuing development on the following strategies/interventions:
  - Data mining to identify opportunities for meaningful impact. MMIC has pulled data extracts by pharmacy and by prescriber and merged the data into a software tool that allows for data analysis and target identification. MMIC reported that, at the present time, due to a lack of claims history, the data mining activities include data from AHCCCS Acute Care Contractors, including MCP. MMIC plans to conduct its internal analysis on behavioral health providers.
  - Member education to communicate the benefits of e-prescribing. Patient opt-out appears to be a barrier; however, education by Contractors and pharmacies about the value of e-prescribing to the member will help break down this barrier.
  - Provider education related to the value of e-prescribing, and communicated the ability and requirements around EPCS, including for providers a fact sheet about EPCS.
  - Provider assistance to identify the reason(s) for slow adoption of e-prescribing and EPCS and use resources to address the barriers.

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

- Provided prescribers feedback regarding their rates and educated them about the importance of prescribing electronically. SMI clinic prescribers were provided their rates in 2015 and early 2016. MMIC encountered limitations with connecting prescribers to the clinic where the prescriptions were prescribed. MMIC is revising the intervention and will list only prescribers and their rates.
- Collaborated with the Arizona Association of Health Plans to develop a fact sheet for providers on the topic of EPCS.
- Included e-prescribing implementation as a required onboarding step for new integrated clinics.
- Required SMI clinics to create and implement formal written procedures to improve e-prescribing rates.

Strengths

MMIC was successful in increasing performance rates for the GMH/SU population for Indicator 1 with a rate of 65.17 percent, an increase from Remeasurement 1 of 34.54 percent, and for Indicator 2 with a rate of 66.23 percent, an increase of 107.23 percent. MMIC was also successful in increasing performance rates for the integrated population for Indicator 1 with a rate of 65.20 percent, an increase from baseline of 26.50 percent, and for Indicator 2 with a rate of 63.19 percent, an increase of 49.24 percent. MMIC demonstrated statistically significant improvements for both indicators for this PIP. In addition, MMIC provided feedback to prescribers regarding their e-prescribing rates and educated them about the importance of e-prescribing, and aided in the development of a fact sheet on EPCS. MMIC continued to require e-prescribing implementation as an onboarding step for new integrated clinics and require SMI clinics to create and implement formal written procedures to improve their e-prescribing rates.

Opportunities for Improvement and Recommendations

MMIC has an opportunity for improvement for the rate of providers prescribing prescriptions electronically for both populations. MMIC collaborated with another Acute Care Contractor to survey physical health providers because they share a provider network. HSAG recommends that MMIC continue this collaboration to increase the rates for both indicators.

MMIC included e-prescribing implementation as a required onboarding step for new integrated clinics and required SMI clinics to create and implement formal written procedures to improve their e-prescribing rates. HSAG recommends that MMIC develop a monitoring system that tracks the improvement rates for both indicators at the integrated and SMI clinics.

HSAG recommends that MMIC continue to support and participate in the workgroup.

Cenpatico Integrated Care (CIC)

Findings

Table 5-3 presents the baseline results for the *E-Prescribing* PIP for CIC's GMH/SU members. CYE 2017 was an intervention year for CIC; therefore, rates will not be reported.

Table 5-3—CIC GMH/SU *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement 1 Oct. 1, 2017, Through Sept. 30, 2018	Remeasurement 2 Oct. 1, 2018, Through Sept. 30, 2019	Relative Percentage Change From Baseline	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	57.29%	70.54%	NA	23.13%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	50.35%	76.44%	NA	51.82%	**P<.001**

CYE 2016 was the GMH/SU baseline measurement period for the statewide *E-Prescribing* PIP. Table 5-3 shows that, for the GMH/SU population baseline measurement period, 57.29 percent of CIC's providers prescribed at least one prescription electronically and 50.35 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the GMH/SU population, CIC's Remeasurement 1 rate at 70.54 percent for Indicator 1 demonstrated a relative percentage change from baseline of 23.13 percent, while the Remeasurement 1 rate of 76.44 percent for Indicator 2 demonstrated a relative percentage change from baseline of 51.82 percent. CIC demonstrated statistically significant improvements for both indicators for this PIP.

Table 5-4 presents the baseline results for the *E-Prescribing* PIP for CIC's integrated members. CYE 2017 was an intervention year for CIC; therefore, rates will not be reported.

Table 5-4—CIC Integrated *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement 1 Oct. 1, 2017, Through Sept. 30, 2018	Remeasurement 2 Oct. 1, 2018, Through Sept. 30, 2019	Relative Percentage Change From Baseline	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	57.17%	68.59%	NA	19.98%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	59.10%	73.69%	NA	24.69%	**P<.001**

CYE 2016 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 5-4 shows that, for the integrated population baseline measurement period, 57.17 percent of CIC's providers prescribed at least one prescription electronically and 59.10 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the integrated population, CIC's Remeasurement 1 rate at 68.59 percent for Indicator 1 demonstrated a relative percentage change from a baseline of 19.98 percent, while the Remeasurement 1 rate of 73.69 percent for Indicator 2 demonstrated a relative percentage change from baseline of 24.69 percent. CIC demonstrated statistically significant improvements for both indicators for this PIP.

CIC submitted the following qualitative analysis:

CIC reported that improvement in e-prescribing utilization was observed steadily throughout the project. CIC reported that by the end of the intervention year the overall MPS was exceeded for all indicators. CIC attributes the improvement in e-prescribing utilization to interventions, including extensive and ongoing quarterly education of and TA to medical directors and individual prescribers by CIC pharmacy staff members as well as issuance of CAPs to providers in need of additional support. In addition, financial incentives supported improvement, notably inclusion of an e-prescribing incentive as a value-based payment measure effective in the third quarter of the intervention year. CIC used surveys to identify barriers to implementation of e-prescribing of controlled and noncontrolled substances. Participation in the surveys was sufficient to identify targets for intervention with pharmacy providers and to indicate prescriber participation in e-prescribing.

Limitations:

CIC reported that data suggests that the elimination of Walgreens Pharmacy from the network may have affected the e-prescribing rates. It is expected that the rates will normalize. No other methodological factors were identified that may jeopardize the validity of the findings.

CIC identified a difference between the AHCCCS and CIC baseline rates that CIC believes may be due to methodological factors. For example, CIC e-prescribing prescription rates were reported monthly instead of annually or quarterly. Furthermore, for Indicator 2, CIC focused on intake and coordination of care agencies' (ICCAs') prescriber performance instead of individual prescriber performance, resulting in very different data methodologies. CIC believes an opportunity may exist to bring this indicator into alignment with AHCCCS PIP measurements in the future. No other methodological factors were identified that may jeopardize the validity of the findings.

CIC performed a root cause analysis about the source of system variation between actual and model status of e-prescribing and identified several barriers:

- Handwritten prescriptions are provided to members.
- An electronic prescription is not generated or sent to the pharmacy, thereby lowering e-prescribing utilization.
- The handwritten prescription is not delivered to the pharmacy.
- Members do not receive the prescription, which lowers adherence rates and positive member outcomes.

In addition, CIC distributed an e-prescribing survey and identified the following barriers:

- EHRs have not been certified to e-prescribe controlled substances
- Telemedicine
- Additional costs
- Software is not configured for e-prescribing

Lessons learned:

CIC learned that the quality of information, frequency, and consistency of provider education by qualified staff members and pharmacists as well as quarterly feedback on provider improvements in e-prescribing are important interventions to improve performance. CIC used CAPs to improve performance for a few providers new to the network. CIC instituted VBP as an intervention to provide a financial incentive but was not able to evaluate the effect as the intervention was too new.

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

- Provide a report indicating all prescriptions filled through the pharmacy benefits manager (PBM), and the percentage sent electronically, by fax, or other methods each month. The data will be analyzed by the pharmacy director at least quarterly.
- Provide detailed information to providers in the monthly provider meeting. The pharmacy administrator will meet with low scoring providers to review e-prescribing data and provide TA as needed.
- Provide financial incentives for health homes who meet e-prescribing goals that will increase quarterly. For Quarter 2 (Q2) fiscal year (FY) 2015, health home e-prescribing at over 60 percent will receive an incentive. The Q3 goal will be set at 70 percent, and the Q4 goal will be 80 percent. (This measure was added to Value-Based Purchasing in April 2017.)

In addition, CIC engaged in the following strategies for implementing interventions identified above:

- Planned to track and trend e-prescribing utilization overall and by health homes and ICCAs and communicate e-prescribing data directly to health homes and ICCAs in an effort to improve utilization.
- Participated in AHCCCS PIP meetings and interventions as well as reporting PIP information at required intervals.
- Voted to issue corrective action letters (CALs) for health homes and ICCAs not meeting the AHCCCS MPS of 70 percent for Quarter 2, calendar year 2016.
- Provided financial incentives to health homes and ICCAs for meeting or exceeding e-prescribing performance goals each quarter.
- Improved communication and outreach to medical practitioners, including three presentations each quarter.
- Provided educational presentations in the provider QI meeting and CEO meeting, including details on EPCS, pharmacy acceptance of EPCS, cost of certification, and improvement of healthcare and outcomes using EPCS. The pharmacy administrator met individually with each prescriber quarterly to review e-prescribing data and provide TA as needed.
- Identified how prescriptions are sent to pharmacies and analyzed the data monthly. CIC's data analytics department provided a report by the eighth of each month, indicating all prescriptions filled

through the PBM and the percentage sent electronically, by fax, or via other method. The pharmacy director analyzed the data monthly.

Strengths

CIC conducted process mapping and root cause analysis to identify barriers related to e-prescribing, surveyed providers to identify barriers to improvement, and developed interventions to address the barriers. In response to the barriers, CIC developed strong interventions to improve the two PIP indicators. CIC provided VBP incentives to ICCAs and home health prescribers. CIC analyzed data monthly for reporting in the monthly CEO meeting and in quarterly meetings with prescribers. Finally, CIC issued CAPs to ICCAs that did not meet the MPS.

Opportunities for Improvement and Recommendations

CIC has an opportunity to increase the percentage of providers prescribing electronically and prescriptions sent electronically. One intervention that CIC implemented was to identify how prescriptions are sent to pharmacies, analyzing the data monthly and providing a report that indicates all prescriptions filled through the PBM as well as the percentage sent electronically, by fax, or via other method. HSAG recommends that CIC provide monthly updates on all interventions at the CEO meeting, especially the financial incentive and CAP interventions. In addition, HSAG recommends that AHCCCS continue the collaboration among RBHA Contractors to improve performance for these indicators. CIC developed no new interventions. Finally, HSAG recommends that CIC monitor outcomes associated with the reported interventions, making applicable adjustments to any current interventions.

Health Choice Integrated Care (HCIC)

Findings

Table 5-5 presents the baseline results for the *E-Prescribing* PIP for HCIC's GMH/SU members. CYE 2017 was an intervention year for HCIC; therefore, rates will not be reported.

Table 5-5—HCIC GMH/SU *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement 1 Oct. 1, 2017, Through Sept. 30, 2018	Remeasurement 2 Oct. 1, 2018, Through Sept. 30, 2019	Relative Percentage Change From Baseline	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least	57.37%	68.52%	NA	19.44%	**P<.001**

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement 1 Oct. 1, 2017, Through Sept. 30, 2018	Remeasurement 2 Oct. 1, 2018, Through Sept. 30, 2019	Relative Percentage Change From Baseline	Statistical Significance
one prescription electronically					
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	62.29%	76.45%	NA	22.73%	**P<.001**

CYE 2016 was the GMH/SU baseline measurement period for the statewide *E-Prescribing* PIP. Table 5-5 shows that, for the GMH/SU population baseline measurement period, 57.37 percent of HCIC's providers prescribed at least one prescription electronically and 62.29 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the GMH/SU population, HCIC's Remeasurement 1 rate at 68.52 percent for Indicator 1 demonstrated a relative percentage change from baseline of 19.44 percent, while the Remeasurement 1 rate of 76.45 percent for Indicator 2 demonstrated a relative percentage change from baseline of 22.73 percent. HCIC demonstrated statistically significant improvements for both indicators for this PIP.

Table 5-6 presents the baseline results for the *E-Prescribing* PIP for HCIC's integrated members. CYE 2017 was an intervention year for HCIC; therefore, rates will not be reported.

Table 5-6—HCIC Integrated *E-Prescribing* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement 1 Oct. 1, 2017, Through Sept. 30, 2018	Remeasurement 2 Oct. 1, 2018, Through Sept. 30, 2019	Relative Percentage Change From Baseline	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	52.64%	66.42%	NA	26.18%	**P<.001**
Indicator 2: The percentage (overall and by Contractor) of	54.99%	69.89%	NA	27.10%	**P<.001**

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement 1 Oct. 1, 2017, Through Sept. 30, 2018	Remeasurement 2 Oct. 1, 2018, Through Sept. 30, 2019	Relative Percentage Change From Baseline	Statistical Significance
prescriptions prescribed by an AHCCCS-contracted provider and sent electronically					

CYE 2016 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 5-6 shows that, for the integrated population baseline measurement period, 52.64 percent of HCIC's providers prescribed at least one prescription electronically and 54.99 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the integrated population, HCIC's Remeasurement 1 rate at 66.42 percent for Indicator 1 demonstrated a relative percentage change from baseline of 26.18 percent, while the Remeasurement 1 rate of 69.89 percent for Indicator 2 demonstrated a relative percentage change from baseline of 27.10 percent. HCIC demonstrated statistically significant improvements for both indicators for this PIP.

HCIC submitted the following qualitative analysis:

Limitations:

HCIC identified the following limitations:

- HCIC identified that one major limitation to the PIP project design was the dramatic increase in the number of prescribers and prescriptions in the system of care, due to a new contract and increased membership. HCIC reported that this limitation added a new unknown to the equation; however, HCIC determined that this limitation did not appear to be a barrier to success as HCIC was able to increase PIP rates of performance. However, HCIC reported that the limitation made analysis of the direct results of individual interventions difficult.
- HCIC reported that provider turnover was a factor within the system. HCIC found that new prescribers were hired or left positions, resulting in agencies using locum tenens as part of the medical team. This limitation required ongoing support and communication to ensure that new team members were aware of the benefits and practices related to electronic prescribing.
- Through discussions with health homes' medical directors and prescribers, HCIC determined that a lack of understanding existed about the procedure to obtain individual accreditation to electronically prescribe controlled substances as did a lack of understanding about the benefits of e-prescribing related to member safety and time savings for support staff members.
- HCIC discovered that inconsistent practices and procedures related to using e-prescribing existed throughout the system.

Lessons learned:

HCIC reported that, for Remeasurement 1, HCIC exceeded its internal goal of 70 percent of prescriptions prescribed electronically for all populations and all eligibility groups.

Additionally, HCIC has learned about the unique difficulties and barriers experienced by each provider and agency serving members. HCIC determined that differing technologies used by each agency provided specific challenges for e-prescribers. HCIC found that most providers were in support of e-prescribing as its challenges were no greater than challenges in a system where only handwritten prescriptions were used. HCIC noted that the improvement in member safety was worth the effort of changing practices to newer technologies.

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

- Implemented a value-based payments incentive for e-prescribing, with payments made to providers with e-prescribing rates greater than 65 percent.
- Disseminated information and changes to HCIC's system of care at regular meetings with various entities discussing e-prescribing with health home behavioral health medical professionals.
- Shared e-prescribing data within HCIC at the quality management meeting and with behavioral health homes meeting.
- Participated in the workgroup identifying barriers to e-prescribing. Monitored e-prescribing at the State level, with benchmarking and identification of outliers for targeted interventions. Developed standardized educational tools for all plans for consistency and ease of use.
- Published provider newsletter section titled "The Importance of E-Prescribing."
- Continued individualized support and TA for prescribers and support staff members.

Strengths

HCIC implemented VBP incentives for providers who e-prescribe with rates greater than 65 percent. In addition, HCIC developed provider online material that informed providers about the importance of e-prescribing. HCIC also developed standardized educational tools for all plans for consistency and ease of use. HCIC continued individualized support and TA for prescribers and support staff members. Finally, HCIC remained an active collaborator with the workgroup.

Opportunities for Improvement and Recommendations

HCIC reported that, after noting positive effects from the interventions, the decision was made that no further PDSA cycles were needed and that the planned interventions would be continued as the interventions were improving the utilization of e-prescribing. Consequently, HCIC developed no new interventions. HSAG recommends that HCIC monitor outcomes associated with the reported interventions, making applicable adjustments to any current interventions, and possibly developing more interventions. In addition, HSAG recommends that AHCCCS continue the collaboration among Contractors to improve these indicators.

Recommendations for RBHA Contractors

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

- AHCCCS has made significant progress in making PIP process improvements in the past year, including the development of a new reporting template. AHCCCS may want to consider offering and facilitating training opportunities to enhance the RBHA Contractors' capacities to implement robust interventions, QI processes, and strategies for the *E-Prescribing* PIP. Increasing the RBHA Contractors' efficacy with QI tools such as root cause analyses, key driver diagrams, process mapping, FMEA, and PDSA cycles should help to remove barriers to successfully achieving improvement for the PIP indicator rates.
- AHCCCS and the RBHA Contractors may want to use the quarterly collaboration meetings with stakeholders as opportunities to identify and address systemwide barriers to the PIP process, which may be impacting the ability to achieve meaningful improvement.
- AHCCCS should continue the collaboration among RBHA Contractors in the workgroup to improve the PIP study indicator rates. AHCCCS should consider including in the workgroup additional stakeholders who may help with improvement of the PIP study indicator rates.
- The RBHA Contractors should continue to identify and prioritize barriers so as to develop robust interventions for the *E-Prescribing* PIP.
- The RBHA 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 may want to use more timely data to support performance improvement activities that can be monitored in real time.

Developmental Screening Performance Improvement Project (PIP)

In CYE 2016 (October 1, 2015, through September 30, 2016) AHCCCS implemented the *Developmental Screening* PIP, for the Acute, CMDP, and DES/DDD lines of business. The CYE 2016 baseline year for this PIP was followed by 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 2018.

Early identification of developmental delays is important when providing effective interventions. During well-child visits, pediatricians look for potential concerns using both developmental surveillance and discussions with parents about their concerns. If any issues are noted, pediatricians should follow through with a developmental screening. Thus, AHCCCS has approved developmental screening tools that should be utilized for developmental screenings by all participating PCPs who care for EPSDT-age members.

The purpose of the *Developmental Screening* PIP is to increase the number of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. AHCCCS' goal is to demonstrate a statistically significant increase in the number and percent of children receiving a developmental screening, followed by sustained improvement for one year.

This annual report includes CYE 2016 baseline measurement data; CYE 2018 Remeasurement 1 data; percentage change from a baseline to Remeasurement 1; overall relative percentage changes from baseline data; statistical significance data; qualitative and quantitative analyses, including limitations and lessons learned identified by the Contractors; and interventions.

Acute Care Contractors

AHCCCS provided HSAG with its Contractors' CYE 2018 *Developmental Screening* PIP information including qualitative analysis, with limitations and lessons learned, and interventions for the seven Acute Care Contractors: Care1st, HCA, HNA, MCP, UHCCP, UFC, and CMDP. During CYE 2018, the *Developmental Screening* PIP was in the Remeasurement 1 period. Baseline data were used to assist the Acute Care Contractors in identifying and/or implementing strategies to serve the purpose of the AHCCCS-defined PIP. AHCCCS expected that Acute Care Contractor, provider, and member education efforts during this intervention period would result in a greater percentage of AHCCCS-enrolled children receiving a developmental screening.

Contractor-specific findings for the Acute Care Contractors regarding the *Developmental Screening* PIP are displayed in the section below. Acute Care Contractors' PIP results, as calculated by AHCCCS, are included, along with specific activities conducted during CYE 2018.

Care1st Health Plan Arizona, Inc. (Care1st)

Findings

Table 5-7 presents the baseline and draft Remeasurement 1 results for the *Developmental Screening* PIP for Care1st's members. The table also presents draft relative percentage changes from baseline to Remeasurement 1 and draft statistical significance of changes in rates. CYE 2017 was an intervention year; therefore, rates will not be reported.

Table 5-7—Care1st *Developmental Screening* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement Period 1* Oct. 1, 2017, Through Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 1*	Statistical Significance*
Indicator: The percentage (overall and by Contractor) of AHCCCS-enrolled members who received a screening for risk of developmental, behavioral, and social delays using a standardized screening tool in the first 12 months preceding their first, second, or third birthday.	23.6%	31.2%	32.2%	**P<.001**

*Draft data, as provided by AHCCCS. Final data will be included in subsequent report.

CYE 2016 was the baseline measurement period for the statewide *Developmental Screening* PIP. Table 5-7 shows that, during the baseline period, 23.6 percent of Care1st's members from 0 to 3 years of age received a developmental screening. For draft Remeasurement 1, 31.2 percent of Care1st members ages 0 to 3 years received a developmental screening. Care1st's draft Remeasurement 1 rate demonstrated a relative percentage change from baseline of 32.2 percent. Care1st demonstrated a statistically significant and substantively large improvement in the performance of this PIP indicator.

Care1st submitted the following analyses:

Limitations:

Prior to the implementation of the PIP, Care1st identified as a potential limitation that the discrepancy between the PIP methodology and AHCCCS policy and practice limits the reliability of PIP results. Since data are collected for the PIP from administrative data (encounters), the numerator is based only on claims with the Current Procedural Terminology (CPT) code that can only be used for screenings at 9, 18, or 24 months.

Following a qualitative analysis, Care1st reported that the most common barriers to completion of developmental screening that have been cited by physicians include time constraints, cost burden, lack of consensus on the most suitable tools, and lack of physician confidence because of insufficient training and expertise. Time/cost barriers have been addressed by the implementation of AHCCCS policy providing additional reimbursement for administering approved tools, in addition to the overall visit reimbursement. AHCCCS has designated three tools for additional reimbursement, including the Parent's Evaluation of Developmental Status (PEDS) tool and the Ages and Stages Questionnaire (ASQ), validated tools that are two of the most extensively evaluated parent-completed tools. In addition, AHCCCS has addressed the barrier of insufficient training and expertise by requiring completion and certification of training before providers can be reimbursed an additional amount for developmental screening. Care1st also reported that barriers to the use of parent report instruments, such

as the PEDS tool, are the inability of parents/guardians to read or understand the language; however, the ASQ and PEDS tool reading levels are grades 4 to 6 and 4 to 5, respectively, and are available in several languages.

In addition, Care1st conducted quantitative analyses. At the end of CYE 2015, Care1st conducted a focused audit, in collaboration with UHCCP, of providers who had billed for developmental screening to monitor whether one of the AHCCCS-approved tools (PEDS, ASQ, or Modified Checklist for Autism in Toddlers [M-CHAT]) was used and whether the provider had completed training on the screening tool used for a particular patient. Reviewers found 62.7 percent of cases were completed by providers with training on the utilized screening tool.

Care1st conducted medical record reviews in CYE 2016 to determine compliance with overall provider recordkeeping practices included monitoring of developmental screening at 9, 18, and 24 months and the tool used. Approximately 95 percent of pediatric providers reviewed had documented developmental surveillance at each visit for sampled members; however, only about half demonstrated that they were using an AHCCCS-approved tool at 9-, 18-, or 24-month visits. The findings underscored the need to ensure that providers are trained in and using the appropriate screening tools, as a first step to increasing performance under the PIP.

In CYE 2018, Care1st conducted a barrier analysis that included a literature review to assess the approach and materials of the Centers for Disease Control and Prevention's "Learn the Signs. Act Early." (LTSAE) health education campaign, which aims to improve awareness of developmental milestones and early warning signs of developmental delay among parents of young children, particularly those with low socioeconomic backgrounds. The study found that parents of children who were identified with delays or disabilities said it would have been helpful to have more specific information about what to expect at different ages before identification of their child's delay.

Lessons learned:

While the rate of developmental screenings using one of the AHCCCS-approved tools increased from CYE 2016 to CYE 2017, Care1st discovered that a substantial portion of the screenings were conducted outside the age range of 7 to 29 months (which was used to capture screenings during and adjacent to the 9-, 18-, and 24-month time frame). Future provider education will emphasize the appropriate timing for using each of the three AHCCCS-approved screening tools.

Interventions, documented in Care1st's report to AHCCCS, reflected an analysis of quantitative and qualitative data. Care1st reported the following interventions to improve the rate of children receiving a developmental screening:

- Educate providers about current recommendations and AHCCCS requirements for developmental screening, including use of AHCCCS-approved standardized screening tools, completion/certification of training in tool(s) used, and maintaining documentation of tool(s) used in members' medical records.

- Monitor provider use of AHCCCS-approved standardized screening tools at the appropriate age intervals, in order to identify opportunities for additional individual or network-wide training and education.
- Engage parents/guardians in learning about and tracking their child's developmental milestones, to support compliance with well-child visits and communication between parents/guardians and PCPs about the child's developmental status.

Strengths

Care1st's rates for children receiving a developmental screening increased in Remeasurement 1 by 32.2 percent and was above the AHCCCS aggregate rate (AHCCCS aggregate rate: 29.9 percent). Care1st completed a thorough barrier analysis and formulated interventions to address the barriers. Care1st developed strong interventions, including educating providers about current recommendations and AHCCCS requirements for developmental screening; monitoring provider use of AHCCCS-approved standardized screening tools at the appropriate age intervals; and engaging parents/guardians in learning about and tracking their child's developmental milestones.

Opportunities for Improvement and Recommendations

Care1st identified that ensuring providers are trained on and are using the appropriate screening tools would impact one barrier and plans to address this through focused provider education and monitoring. HSAG recommends that Care1st continue to monitor outcomes associated with the reported interventions, particularly provider education and parental/guardian engagement.

Health Choice Arizona (HCA)

Findings

Table 5-8 presents the baseline and draft Remeasurement 1 results for the *Developmental Screening* PIP for HCA's members. The table also presents draft relative percentage changes from baseline to Remeasurement 1 and draft statistical significance of changes in rates. CYE 2017 was an intervention year; therefore, rates will not be reported.

Table 5-8—HCA *Developmental Screening* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement Period 1* Oct. 1, 2017, Through Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 1*	Statistical Significance*
Indicator: The percentage (overall and by Contractor) of AHCCCS-enrolled members who received a screening for risk of	24.1%	29.9%	24.1%	**P<.001**

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement Period 1* Oct. 1, 2017, Through Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 1*	Statistical Significance*
developmental, behavioral, and social delays using a standardized screening tool in the first 12 months preceding their first, second, or third birthday.				

*Draft data, as provided by AHCCCS. Final data will be included in subsequent report.

CYE 2016 was the baseline measurement period for the statewide *Developmental Screening* PIP. Table 5-8 shows that, during the baseline period, 24.1 percent of HCA's members from 0 to 3 years of age received a developmental screening. For draft Remeasurement 1, 29.9 percent of HCA members from 0 to 3 years of age received a developmental screening. HCA's draft Remeasurement 1 rate demonstrated a relative percentage change from baseline of 24.1 percent. HCA demonstrated a statistically significant and substantively large improvement in the performance of this PIP indicator.

HCA submitted the following analyses:

Limitations:

For Remeasurement 1, HCA noted a large discrepancy in the stratified results between the first two age groups and the third age group, and that the information has been shared with the Maternal Health and EPSDT Team for targeted outreach in its regular activities.

HCA reported that, following a barrier analysis, HCA identified the need for additional provider education regarding *Developmental Screening* measures and how to correctly code for the service.

Lessons learned:

HCA has learned throughout the remeasurement period that continuous provider education may be related to improved rates of developmental screening.

HCA reported that, in CY 2016, the *Developmental Screening* measure was added to the Provider Quality Performance Reports that allows providers to track, trend, and monitor their performance. Providers are able to see how they are performing in relation to this measure monthly. In addition, providers receive a Quality Performance Member Roster, which provides a list of members in need of a developmental screening. HCA also reported that the measure was added to the Physician Toolkit, which is used to educate providers on performance measures and tips and tricks on how to maximize billing to capture performance measures.

Additionally, in CYE 2018, July and August were observed as Pediatric Health and Developmental Screening Month to help members schedule appointments with their PCPs and help close gaps in care.

HCA continued to outreach members through the EPSDT department, and provider representatives educated providers during on-site visits and through telephonic outreach on the requirement related to developmental screenings.

Additionally, HCA reported acting to improve developmental screening for children 0 to 3 years old with the following interventions:

- Identified providers who were not checking off Developmental Screening on the EPSDT tracking forms and letters were sent educating them on the need to complete the tracking forms correctly.
- Educated providers on the developmental screenings for appropriate age groups through HCA's network provider representatives.
- Conducted outreach calls through HCA's EPSDT staff members to parents/family to discuss any concerns with the child's development at their medical appointments.
- Notified providers to use CPT code 96110 with an EP modifier in order to receive the enhanced reimbursement for doing a developmental screening.

Strengths

HCA's rates for the percentage of children receiving a developmental screening increased in draft Remeasurement 1 by 24.1 percent and HCA performed at the AHCCCS aggregate rate for the percentage of children receiving a developmental screening (AHCCCS aggregate rate: 29.9 percent). HCA completed a barrier analysis and formulated interventions to address the barriers. HCA developed strong interventions, such as including the *Developmental Screening* measure in the Provider Quality Performance Reports (allowing providers to track, trend and monitor performance monthly), providing a list of members in need of a developmental screening to providers monthly, including the *Developmental Screening* performance measure in the provider toolkit, and raising member awareness of the need to schedule appointments by observing July and August as Pediatric Health and Developmental Screening Month.

Opportunities for Improvement and Recommendations

HCA has identified that continuous provider education is needed regarding *Developmental Screening* measures and how to correctly code for the service. HSAG recommends that HCA continue to outreach members through the EPSDT department, and provider representatives educate providers during on-site visits and through telephonic outreach on the requirement related to developmental screenings. In addition, HSAG recommends that HCA continue to assess specific barriers impacting the rate of developmental screenings, while determining if the method(s) for identifying barriers are adequate.

Health Net Access (HNA)

Findings

Table 5-9 presents the baseline and draft Remeasurement 1 results for the *Developmental Screening* PIP for HNA's members. The table also presents draft relative percentage changes from baseline to Remeasurement 1 and draft statistical significance of changes in rates. CYE 2017 was an intervention year; therefore, rates will not be reported.

Table 5-9—HNA *Developmental Screening* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement Period 1* Oct. 1, 2017, Through Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 1*	Statistical Significance*
Indicator: The percentage (overall and by Contractor) of AHCCCS-enrolled members who received a screening for risk of developmental, behavioral, and social delays using a standardized screening tool in the first 12 months preceding their first, second, or third birthday.	20.6%	29.1%	41.3%	**P<.001**

*Draft data, as provided by AHCCCS. Final data will be included in subsequent report.

CYE 2016 was the baseline measurement period for the statewide *Developmental Screening* PIP. Table 5-9 shows that, during the baseline period, 20.6 percent of HNA's members from 0 to 3 years of age received a developmental screening. For draft Remeasurement 1, 29.1 percent of HNA members from 0 to 3 years of age received a developmental screening. HNA's draft Remeasurement 1 rate demonstrated a relative percentage change from baseline of 41.3 percent. HNA demonstrated a statistically significant and substantively large improvement in the performance of this PIP indicator.

HNA submitted the following analyses:

Limitations:

HNA identified that the CMS Core Specification manual allows providers the opportunity to use multiple screening tools that are not recognized by AHCCCS.

As a result of HNA's barrier analysis, HNA identified the following initial barriers:

- Lack of provider knowledge about the approved developmental screening tools, including where and how to obtain the tools, and how to code for the completion of one of the tools.

- Lack of member knowledge on the importance of developmental screening as part of the EPSDT visit.

Lessons learned:

One lesson learned is that a multi-pronged approach to provider education can result in statistically significant improvements in observed rates. Additionally, HNA learned that some providers did not understand the need to submit their certificates to the Council for Affordable Quality Healthcare (CAQH). HNA also found that some billing representatives were not aware of the process for billing for the developmental tool using an EP modifier.

Interventions documented in HNA's report to AHCCCS reflected an analysis of quantitative and qualitative data. HNA reported the following interventions to improve the rate of children receiving a developmental screening:

- Develop and distribute a provider online news article that details the various developmental screening tools available to providers.
- Develop and provide education on developmental screening at an upcoming provider forum.
- Develop and distribute targeted education to providers identified as having low rates of screening.
- Develop frequently asked questions (FAQs) flyer about developmental tools and distribute via a fax blast.
- Provide flyers about developmental screenings at provider forums.
- Mail monthly member postcards at 9, 18, and 24 months of age that include developmental screenings.
- Educate and train providers, as needed, that submit a developmental tool without a found claim.
- Develop and distribute member newsletter article about developmental screenings.
- Conduct internal training for EPSDT staff members on developmental tools, codes, and age groups.

Strengths

HNA's rates for the percentage of children receiving a developmental screening increased in draft Remeasurement 1 by 41.3 percent. HNA completed a thorough barrier analysis and formulated interventions to address the barriers. HNA developed strong interventions, including developing and distributing provider and member education through a variety of methods, and identifying and educating providers that submit a developmental tool without an associated claim.

Opportunities for Improvement and Recommendations

HNA was below the AHCCCS aggregate rate for the percentage of children receiving a developmental screening (AHCCCS aggregate rate: 29.9 percent). HNA has already identified that increasing internal staff, provider, and member education about the approved developmental screening tools would impact identified barriers. HSAG recommends that HNA continue to monitor outcomes associated with the

reported interventions. HSAG also recommends that HNA continue the collaboration between the provider relations and internal HNA staff members as HNA has identified that multiple provider educational articles and updates, online updates and news, provider forums, and provider office visits have resulted in an improvement in the PIP rate. In addition, HSAG recommends that HNA develop intervention(s) that address providers' consideration that billing for the screening is an inefficient use of resources.

Maricopa Health Plan (MHP)

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

Mercy Care Plan (MCP)

Findings

Table 5-10 presents the baseline and draft Remeasurement 1 results for the *Developmental Screening* PIP for MCP's members. The table also presents draft relative percentage changes from baseline to Remeasurement 1 and draft statistical significance of changes in rates. CYE 2017 was an intervention year; therefore, rates will not be reported.

Table 5-10—MCP *Developmental Screening* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement Period 1* Oct. 1, 2017, Through Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 1*	Statistical Significance*
Indicator: The percentage (overall and by Contractor) of AHCCCS-enrolled members who received a screening for risk of developmental, behavioral, and social delays using a standardized screening tool in the first 12 months preceding their first, second, or third birthday.	25.5%	30.1%	18.0%	**P<.001**

*Draft data, as provided by AHCCCS. Final data will be included in subsequent report.

CYE 2016 was the baseline measurement period for the statewide *Developmental Screening* PIP. Table 5-10 shows that, during the baseline period, 25.5 percent of MCP's members from 0 to 3 years of age received a developmental screening. For draft Remeasurement 1, 30.1 percent of MCP members from 0 to 3 years of age received a developmental screening. MCP's draft Remeasurement 1 rate demonstrated

a relative percentage change from baseline of 18.0 percent. MCP demonstrated a statistically significant and substantively large improvement in the performance of this PIP indicator.

MCP submitted the following analyses:

Limitations:

When comparing the data calculated by AHCCCS to the data calculated by MCP, it has been noted that there is a significant difference in the numerator count for all four indicators. MCP would like to continue collaborative efforts with AHCCCS to identify the causative factors for why the MCP numerator counts fall far below the counts identified by AHCCCS.

During CYE 2018, AHCCCS provided MCP with a CYE 2017 member-level detail file for the *Developmental Screening* performance measure. MCP plans to utilize this file to perform deep dive data review to identify the reasons for the discrepancies in data, and if necessary, correct MCP processes for determining compliance.

As a result of an internal analysis, MCP identified the following barriers:

- Lack of understanding of the importance of routine developmental screening
- Lack of understanding of the AHCCCS required schedule for developmental screening at 9, 18, and 24 months
- Limited data triggers to indicate the need for developmental screening
- Provider concerns with navigating the system, especially when a developmental delay is identified
- Incomplete claims information to demonstrate the volume of developmental screenings that are being conducted

Lessons learned:

MCP has identified that internal data may be reflecting an under-reporting of compliance, as compared to AHCCCS data. MCP requested CYE 2017 member-level detail from AHCCCS, to determine where the discrepancies are in the internal MCP data.

In reviewing the percentage of EPSDT forms that have been submitted to the plan with evidence of completion of developmental screening at a 9-, 18-, or 24-month visit utilizing the PEDS, ASQ, or M-CHAT, MCP has identified that the percentage of developmental screenings that are being reported utilizing claims data seems to be under-reported (the rate of compliance appears to be approximately 40 percent). As a result, during CYE 2019, MCP planned to partner with providers, on process changes to ensure that claims reflect the completion of the screening.

MCP reported the following interventions to improve the rate of children receiving a developmental screening:

- Monitored CAQH to determine if providers that are submitting developmental screenings have evidence of a developmental screening training certificate.
- Implemented the revised written provider outreach process, which includes mailings to PCPs for members in need of an EPSDT visit(s) and/or immunizations, which includes a reminder on the requirement to conduct developmental screenings at the 9-, 18-, and 24-month visits.
- Implemented a provider mailing listing the requirements for developmental screening, which also includes resources for providers.
- Worked with the MCP Value-Based Purchasing (VBP) program to consider inclusion of developmental screening in the succeeding incentive contract.
- Conducted face-to-face site visits with providers to provide education on developmental screening.
- Developed and shared the Developmental Screening 101 flyer with other pediatric providers at the Sedona chapter of Arizona American Academy of Pediatrics (AzAAP) conference in June 2017 and included the flyer in the MC EPSDT Provider Manual.
- Conducted the following presentations: Early Identification and Management of Autism Spectrum Disorder (ASD) for Primary Care Providers (at the MCP Provider Forum), and the Developmental Screening and Integrated Care for Autism Spectrum Disorder: Navigating the System (at the PCP integrated training academy).

Strengths

MCP's rates for the percentage of children receiving a developmental screening increased in draft Remeasurement 1 by 18.0 percent. In addition, MCP was above the AHCCCS aggregate rate (29.9 percent). MCP completed a thorough barrier analysis and formulated interventions to address all identified barriers. MCP developed strong interventions, such as revising a process to ensure developmental screening reminders are sent to PCPs with members in need of an EPSDT visit(s) and/or immunizations. The revised process serves as a way to address the limited data triggers to indicate the need for developmental screenings. MCP also conducted provider education through presentations, provider materials, and in-person visits.

Opportunities for Improvement and Recommendations

MCP has identified that there is a significant difference in the numerator count between the indicator data calculated by AHCCCS and the MCP-calculated data. MCP obtained the CYE 2017 member-level detail file for the *Developmental Screening* performance measure and plans to complete a thorough data review to identify the reasons for the discrepancies, and if needed, correct MCP processes used for determining compliance. HSAG recommends that MCP reconcile the PIP indicator data and continue to monitor for data discrepancies. In addition, HSAG recommends that MCP continue to monitor outcomes associated with the reported interventions.

UnitedHealthcare Community Plan (UHCCP)

Findings

Table 5-11 presents the baseline and draft Remeasurement 1 results for the *Developmental Screening* PIP for UHCCP's members. The table also presents draft relative percentage changes from baseline to Remeasurement 1 and draft statistical significance of changes in rates. CYE 2017 was an intervention year; therefore, rates will not be reported.

Table 5-11—UHCCP *Developmental Screening* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement Period 1* Oct. 1, 2017, Through Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 1*	Statistical Significance*
Indicator: The percentage (overall and by Contractor) of AHCCCS-enrolled members who received a screening for risk of developmental, behavioral, and social delays using a standardized screening tool in the first 12 months preceding their first, second, or third birthday.	22.3%	30.2%	35.4%	**P<.001**

*Draft data, as provided by AHCCCS. Final data will be included in subsequent report.

CYE 2016 was the baseline measurement period for the statewide *Developmental Screening* PIP. Table 5-11 shows that, during the baseline period, 22.3 percent of UHCCP's members from 0 to 3 years of age received a developmental screening. For draft Remeasurement 1, 30.2 percent of UHCCP members from 0 to 3 years of age received a developmental screening. UHCCP's draft Remeasurement 1 rate demonstrated a relative percentage change from baseline of 35.4 percent. UHCCP demonstrated a statistically significant and substantively large improvement in the performance of this PIP indicator.

UHCCP submitted the following analyses:

Limitations:

UHCCP has not received the remeasurement data from AHCCCS. Although UHCCP has used the CMS Core Child technical specifications when programming the internal report, the results could be different from the AHCCCS report.

As a result of a barrier analysis, UHCCP identified the following barriers to increasing the rate of developmental screenings:

- Historically, developmental screening services were non-billable, or limited to a small population of children who were placed in a neonatal intensive care unit at birth; therefore, the providers were not accustomed to using a developmental screening tool and billing it as a service.
- AHCCCS-approved developmental screening tools are limited to the following: The PEDS, M-CHAT, and ASQ. Other developmental screening tools recognized by "Bright Futures" and AAP include: Battelle Developmental Inventory Screening Tool (BINS); Brigance Screens-II; Child Development Inventory (CDI); and Infant Development Inventory. UHCCP determined that providers required education on AHCCCS-approved tools.
- Members may not recognize age-appropriate developmental milestones and, therefore, not alert their doctor of concerns with their child's developmental delay.

Lessons learned:

Initial results appear to be favorable and provider and implemented member interventions will continue into CYE 2019.

UHCCP created a provider education tool in December 2017 to assist in the reaching target goals. The tool titled, "Arizona Educational EPSDT Binder," included several EPSDT requirements, including a section on "Developmental Screening" that discussed when a developmental screening should be used, the billing codes for reimbursement of the screening tool, and the approved developmental screening tools and the corresponding website for certification. UHCCP's CPCs reviewed the "Arizona Educational EPSDT Binder." As a result of CPCs' review, member education was addressed through a member letter and live outbound calls (as detailed in the list of interventions below).

UHCCP reported implementation of the following interventions to improve the rate of children receiving a developmental screening:

- Provider reports listing all members under 2 years of age assigned to the provider's care.
- CPC monthly meetings with assigned providers. UHCCP reports that the talking points for the monthly meetings include a review of AHCCCS-approved developmental screening tools and the process to obtain certification for completion of the course as a prerequisite to use the tool(s).
- Member letters to guardians of 9-month-olds encouraging the guardian to schedule a well-child visit and to have a developmental screening done for their child.
- Live outbound calls to guardians of 9-month-olds to encourage the guardian to request from their doctor a developmental screening for their child at the next well-child visit.

Strengths

UHCCP's rates for the percentage of children receiving a developmental screening increased in draft Remeasurement 1 by 35.4 percent. In addition, UHCCP was above the AHCCCS aggregate rate (29.9 percent). UHCCP completed a barrier analysis and formulated interventions to address barriers. UHCCP developed strong interventions involving member education, including member letters and live

outbound calls encouraging guardians of nine-month old children to schedule or request that their doctor complete a developmental screening for their child.

Opportunities for Improvement and Recommendations

UHCCP implemented a provider report that lists all members under 2 years of age assigned to the provider's care and that include discussion on the process to obtain certification for using AHCCCS-approved tools during CPC monthly meetings with assigned providers. HSAG recommends that UHCCP utilize targeted interventions that directly align with identified barriers, including the barrier that providers are not accustomed to using a developmental screening tool and billing it as a service. HSAG also recommends that UHCCP continue to monitor outcomes associated with the reported interventions, particularly provider education.

University Family Care (UFC)

Findings

Table 5-12 presents the baseline and draft Remeasurement 1 results for the *Developmental Screening* PIP for UFC's members. The table also presents draft relative percentage changes from baseline to Remeasurement 1 and draft statistical significance of changes in rates. CYE 2017 was an intervention year; therefore, rates will not be reported.

Table 5-12—UFC *Developmental Screening* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement Period 1* Oct. 1, 2017, Through Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 1*	Statistical Significance*
Indicator: The percentage (overall and by Contractor) of AHCCCS-enrolled members who received a screening for risk of developmental, behavioral, and social delays using a standardized screening tool in the first 12 months preceding their first, second, or third birthday.	23.2%	25.9%	11.6%	**P<.001**

*Draft data, as provided by AHCCCS. Final data will be included in subsequent report.

CYE 2016 was the baseline measurement period for the statewide *Developmental Screening* PIP. Table 5-12 shows that, during the baseline period, 23.2 percent of UFC's members from 0 to 3 years of age received a developmental screening. For Remeasurement 1, 25.9 percent of UFC members from 0 to 3 years of age received a developmental screening. UFC's draft Remeasurement 1 rate demonstrated a

relative percentage change from baseline of 11.6 percent. UFC demonstrated a statistically significant and substantively large improvement in the performance of this PIP indicator.

UFC submitted the following analyses:

Limitations:

BUFC did not report any limitations at this time. However, as a result of BUFC's barrier analysis, BUFC identified that the most salient barriers were the lack of provider knowledge regarding requirements, the correct screening tools, and the provision and coding of the applicable developmental screening tools.

Lessons learned:

UFC reported that the developmental screening project illuminated the fact that some providers were unaware of the requirement for EPSDT developmental screening at 9, 18, or 24 months. UFC determined that providers were utilizing outdated/incorrect developmental screening tools, and were also lacking current EPSDT certification.

UFC reported the following interventions to improve the rate of children receiving a developmental screening:

- Sent letters to providers who did not indicate that a developmental screening was completed at the 9-, 18-, or 24-month EPSDT appointment.
- Conducted reviews of the forms received for the developmental screening to ensure that the child was of the appropriate age, that an AHCCCS-approved tool was used, and that the provider has been trained to administer the chosen developmental screening tool.
- Provided education during site visits to educate site managers and providers by including developmental screenings as one of the highlighted talking points when visiting providers who serve EPSDT members, and providing a handout specific to developmental screening requirements to providers.
- Reminded non-certified providers of certification requirements.
- Conducted provider forums where providers were educated on developmental screening requirements.

UFC reported that the implemented changes will benefit all lines of quality management by ensuring providers are aware of their current performance, have required certifications, ongoing education, and open lines of communication to address provider questions and concerns.

Strengths

UFC's rates for the percentage of children receiving a developmental screening increased in Remeasurement 1 by 11.6 percent. UFC completed a barrier analysis and formulated interventions to address the barriers. UFC developed strong interventions, including conducting reviews of submitted

provider forms to assess compliance with the developmental screening requirements, and provided education during site visits to educate site managers and providers.

Opportunities for Improvement and Recommendations

UFC remained below the AHCCCS aggregate rate for the percentage of children receiving a developmental screening (AHCCCS aggregate rate: 29.9 percent). UFC has already identified that there was a need to increase provider education on developmental screening requirements and the provision and coding of the applicable tools. HSAG recommends that UFC continue to monitor outcomes associated with the reported interventions. In addition, HSAG recommends that UFC ensure that requirements for the coding of applicable screening tools are addressed through UFC's provider education efforts, as it was specifically identified as a barrier to increasing the rate of developmental screenings.

Comprehensive Medical and Dental Program (CMDP)

Findings

Table 5-13 presents the baseline and draft Remeasurement 1 results for the *Developmental Screening* PIP for CMDP's members. The table also presents draft relative percentage changes from baseline to Remeasurement 1 and draft statistical significance of changes in rates. CYE 2017 was an intervention year; therefore, rates will not be reported.

Table 5-13—CMDP *Developmental Screening* PIP

PIP Measure	Baseline Period Oct. 1, 2015, Through Sept. 30, 2016	Remeasurement Period 1* Oct. 1, 2017, Through Sept. 30, 2018	Relative Percentage Change From Baseline to Remeasurement 1*	Statistical Significance*
Indicator: The percentage (overall and by Contractor) of AHCCCS-enrolled members who received a screening for risk of developmental, behavioral, and social delays using a standardized screening tool in the first 12 months preceding their first, second, or third birthday.	30.0%	37.7%	25.7%	**P<.001**

*Draft data, as provided by AHCCCS. Final data will be included in subsequent report.

CYE 2016 was the baseline measurement period for the statewide *Developmental Screening* PIP. Table 5-13 shows that, during the baseline period, 30.0 percent of CMDP's members from 0 to 3 years of age received a developmental screening. For draft Remeasurement 1, 37.7 percent of CMDP members from

0 to 3 years of age received a developmental screening. CMDP's draft Remeasurement 1 rate demonstrated a relative percentage change from baseline of 25.7 percent. CMDP demonstrated a statistically significant and substantively large improvement in the performance of this PIP indicator.

CMDP submitted the following analyses:

Limitations:

CMDP identified a discrepancy with the numerator, leading to a concern about data collection and analysis. CMDP reported that there will be ongoing evaluation of data collection and metric calculation.

CMDP identified the following barriers to increasing the rate of developmental screenings:

- Provider update forms used to determine the number of providers with developmental screening certifications were not completed consistently or accurately. The data collected were determined to be unreliable.

Lessons learned:

CMDP reported that data integrity continues to be a challenge and changes have been scheduled. Narrowing CMDP's focus to providers within a preferred provider network, rather than every AHCCCS registered provider, offered greater oversight of provider adherence to utilization of development screening tools. CMDP reported that this resulted in a more efficient maintenance of certification of providers.

CMDP reported that CMDP plans to make the following system-level changes:

- CMDP continues to broaden its use of DCS management tools to monitor activities related to this project and other applicable processes, as process adherence checks are vital to the success of the interventions.
- CMDP also plans to conduct refresher training for those staff members associated with the process.

CMDP reported the following interventions to improve the rate of children receiving a developmental screening:

- Educate providers via provider newsletters, which include informative articles with instruction on how to obtain developmental screening certification and the importance.
- Provide education at site visits regarding developmental screening certification.
- Notify members newly assigned to a PCP home on the importance of reviewing developmental, behavioral, and social concerns with the PCP.
- Outreach providers billing for developmental screening who do not have certification on file.
- Outreach foster caregivers and other placements upon a child's entry into DCS care (CMDP enrollment) to provide education on the importance of EPSDT and developmental screening among other topics.

Strengths

CMDP's rates for the percentage of children receiving a developmental screening increased in Remeasurement 1 by 25.7 percent. In addition, CMDP was above the AHCCCS aggregate rate (29.9 percent). CMDP developed interventions, including educating providers on the developmental screening certification process and importance, and educating and encouraging members to discuss developmental, behavioral, and social concerns with their PCP.

Opportunities for Improvement and Recommendations

HSAG recommends that CMDP conduct a thorough barrier analysis, as interventions should address identified barriers driven by analysis. For example, it was not clear (in the documentation submitted) how it was determined that member education was an existing barrier to increasing the rate of developmental screenings. In addition, HSAG recommends that CMDP continue to monitor outcomes associated with the reported interventions.

Recommendations for AHCCCS and ACC[5-2] Contractors

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

- AHCCCS should continue the collaboration among ACC Contractors in the workgroup to improve the PIP study indicator rates. AHCCCS should consider including in the workgroup additional stakeholders who may help with improvement of the PIP study indicator rates.
- The ACC Contractors should continue to identify and prioritize barriers so as to develop robust strategies and interventions for the PIP.
- The ACC Contractors are encouraged to monitor the progress of the PIP interventions employed to increase the rate of children receiving a developmental screening, then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.
- AHCCCS may consider working with Contractors to address the misalignment of the screening tools that are allowed by CMS and the tools recognized by AHCCCS, as this was a barrier cited by multiple Contractors.
- AHCCCS may want to use more timely data to support performance improvement activities that can be monitored in real time.

[5-2] Many of the Acute Care Contractors are now operating as AHCCCS Complete Care (ACC) Contractors; therefore, ACC Contractors could benefit from the recommendations provided in this section.

6. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Results

KidsCare

General Child Results

Table 6-1 presents the 2018 top-box scores for the KidsCare general child population compared to 2018 NCQA child Medicaid national averages. Additionally, the overall member experience ratings (i.e., star ratings) resulting from the KidsCare population's top-box scores compared to NCQA's 2018 HEDIS Benchmarks and Thresholds for Accreditation are displayed below.

Table 6-1—KidsCare General Child CAHPS Results

Measure	2018 Scores	Star Ratings
Global Ratings		
Rating of Health Plan	76.6%	★★★★★
Rating of All Health Care	75.1%	★★★★★
Rating of Personal Doctor	78.2%	★★★★★
Rating of Specialist Seen Most Often	73.3%+	★★★★+
Composite Measures		
Getting Needed Care	82.9%	★
Getting Care Quickly	88.5%	★★
How Well Doctors Communicate	93.5%	★★★
Customer Service	86.1%	★★
Shared Decision Making	76.0%+	NA
Individual Item Measures		
Coordination of Care	87.6%+	★★★+
Health Promotion and Education	71.0%	NA

Cells highlighted in yellow represent scores that are at or above the 2018 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2018 NCQA child Medicaid national averages.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA indicates NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and the Health Promotion and Education individual item measure; therefore, overall member experience ratings could not be derived for these CAHPS measures.
Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Strengths

The following four measures met or exceeded the 2018 NCQA child Medicaid national averages for the KidsCare general child population:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Coordination of Care*

Compared to national benchmarks, the KidsCare general child population scored at or above the 75th percentile on four measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

Areas for Improvement

The following seven measures were below the 2018 NCQA child Medicaid national averages for the KidsCare general child population:

- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*
- *Health Promotion and Education*

Compared to national benchmarks, the KidsCare general child population scored at or below the 49th percentile on three measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*

Key Drivers of Member Experience

HSAG performed an analysis of key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. The analysis provides information on (1) how ***well*** KidsCare is performing on the survey item (i.e., question), and (2) how ***important*** the item is to overall member experience.

Key drivers of member experience are defined as those items that (1) have a problem score that is greater than or equal to the program's median problem score for all items examined, and (2) have a correlation that is greater than or equal to the program's median correlation for all items examined. Table 6-2 depicts those survey items identified for each of the three measures as being key drivers of member experience for the KidsCare general child population.[6-1]

Table 6-2—KidsCare Key Drivers of Member Experience

Rating of Health Plan
Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not talk about the reasons they might not want their child to take a medicine.
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
Respondents reported that it was often not easy for their child to obtain appointments with specialists.
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.
Respondents reported that forms from their child's health plan were often not easy to fill out.
Rating of All Health Care
Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not talk about the reasons they might not want their child to take a medicine.
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
Respondents reported that it was often not easy for their child to obtain appointments with specialists.
Respondents reported that forms from their child's health plan were often not easy to fill out.
Rating of Personal Doctor
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
Respondents reported that when their child did not need care right away, they did not obtain an appointment for healthcare as soon as they thought they needed.
Respondents reported that their child's personal doctor did not always spend enough time with them.
Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.

[6-1] The Key Drivers of Satisfaction analysis was limited to the responses of parents/caretakers of child members selected from the general child population (i.e., responses from the general child sample).

The following key driver was identified for all three global ratings:

- Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.

Additionally, the following key drivers were identified for the *Rating of Health Plan* and *Rating of All Health Care* global ratings:

- Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not talk about the reasons they might not want their child to take a medicine.
- Respondents reported that it was often not easy for their child to obtain appointments with specialists.
- Respondents reported that forms from their child's health plan were often not easy to fill out.

Children with Chronic Conditions (CCC) Results

Table 6-3 presents the 2018 top-box scores for the KidsCare CCC population compared to 2018 NCQA CCC Medicaid national averages.[6-2]

Table 6-3—KidsCare CCC CAHPS Results

Measure	2018 Scores
Global Ratings	
Rating of Health Plan	74.7%
Rating of All Health Care	72.3%
Rating of Personal Doctor	74.9%
Rating of Specialist Seen Most Often	78.8%+
Composite Measures	
Getting Needed Care	83.4%
Getting Care Quickly	90.3%
How Well Doctors Communicate	95.6%
Customer Service	84.8%+
Shared Decision Making	80.5%+
Individual Item Measures	
Coordination of Care	81.6%+
Health Promotion and Education	78.1%
CCC Composite Measures and Items	
Access to Specialized Services	77.0%+

[6-2] NCQA does not release HEDIS Benchmarks and Thresholds for Accreditation for the CCC population; therefore, HSAG could not generate star ratings.

Measure	2018 Scores
Family-Centered Care (FCC): Personal Doctor Who Knows Child	89.9%
Coordination of Care for Children with Chronic Conditions	82.4%+
FCC: Getting Needed Information	93.5%
Access to Prescription Medicines	90.7%

Cells highlighted in yellow represent scores that are at or above the 2018 NCQA CCC Medicaid national averages.
Cells highlighted in red represent scores that are below the 2018 NCQA CCC Medicaid national averages.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Strengths

The following six measures met or exceeded the 2018 NCQA CCC Medicaid national averages for the KidsCare CCC population:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*
- *Coordination of Care for Children with Chronic Conditions*
- *FCC: Getting Needed Information*

Areas for Improvement

The following 10 measures were below the 2018 NCQA CCC Medicaid national averages for the KidsCare CCC population:

- *Rating of Personal Doctor*
- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Shared Decision Making*
- *Coordination of Care*
- *Health Promotion and Education*
- *Access to Specialized Services*
- *FCC: Personal Doctor Who Knows Child*
- *Access to Prescription Medicines*

Appendix A. Validation of Performance Measure Methodology and Additional Results

In accordance with 42 CFR §438.240(b), AHCCCS requires Contractors to have a 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 §438.358(b)(2). The requirement §438.358(a) allows states, their agents that are not MCOs or PIHPs, or an EQRO to conduct the mandatory activities. MCOs/PIHPs may report performance results to a state (as required by the state), or the state may calculate the MCOs'/PIHPs' performance on the measures for the preceding 12 months. Performance must be reported by the MCOs/PIHPs—or calculated by the state—and validated annually.

As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the functions associated with the mandatory activity of validating performance measures. In accordance with and satisfying the requirements of 42 CFR §438.364(a)(1–5), AHCCCS contracted with HSAG as an EQRO to use the information that AHCCCS obtained from the performance measure calculations and data validation activities to prepare this CYE 2019 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 2018.

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 2018.

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 2018 review period (i.e., measurement year ending September 30, 2018), AHCCCS conducted the following activities:

- Collected Contractor encounter data associated with each State-selected measure.
- Contracted with HSAG to calculate 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 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 2019, AHCCCS required Contractors to propose and implement CAPs for CYE 2017 performance measures that did not meet the MPS. Once a CAP proposal was submitted to and approved by AHCCCS, the Contractors implemented the CAP and 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 Medical Management Information System (PMMIS). The administrative methodology used for data collection in the current measurement period differed slightly from the methodology used for the previous measurement period (e.g., identification of paid claims, continuous enrollment, and removal of linked members in enrollment files). 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. (See Table A-1 for the assignment of performance measures with an MPS to the Quality, Timeliness, and Access areas.) When applicable, HSAG formulated and presented recommendations to improve Contractor performance rates.

Table A-1—Assignment of Performance Measures With an MPS to the Quality, Timeliness, and Access Areas

Performance Measure	Quality	Timeliness	Access
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services—Total			✓
Annual Dental Visits			✓
Children and Adolescents' Access to Primary Care Practitioners			✓
Pediatric Health			

Performance Measure	Quality	Timeliness	Access
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	✓		
Preventive Screening			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Utilization			
Ambulatory Care (per 1,000 Member Months)—ED Visits—Total	N/A	N/A	N/A
Plan All-Cause Readmissions	✓		
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓

N/A indicates Not Applicable.

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 2017 performance, where available; CYE 2018 performance; the relative percentage change between CYE 2017 and CYE 2018 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 2018 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 A-2—CYE 2017 and CYE 2018 Performance Measure Results—Care1st

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	61.6%	64.6%	4.9%	**P<0.001**	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	91.7%	96.0%	4.7%	**P<0.001**	93.0%
25 Months–6 Years	83.3%	85.6%	2.8%	**P<0.001**	84.0%
7–11 Years	89.1%	88.2%	-1.0%	**P=0.049**	83.0%
12–19 Years	85.6%	85.6%	0.0%	P=0.953	82.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	7.8%	—	—	—
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	42.1%	45.7%	8.6%	**P<0.001**	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	65.8%	67.1%	2.0%	P=0.338	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.2%	66.8%	4.1%	**P<0.001**	66.0%
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	52.0%	51.0%	-1.9%	P=0.396	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	52.3%	53.8%	2.9%	**P=0.002**	64.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	50.9	50.6	-0.6%	—	55.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	27.4	29.7	8.0%	—	—

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Plan All-Cause Readmissions[3]					
*Total**	—	15.2%	—	—	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 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.
— Indicates that the Contractors were not required to report the measure for the CYE 2017 reporting period, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Health Choice Arizona (HCA)

Table A-3—CYE 2017 and CYE 2018 Performance Measure Results—HCA

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	56.8%	57.0%	0.4%	P=0.395	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	91.1%	93.1%	2.2%	**P<0.001**	93.0%
25 Months–6 Years	79.4%	80.2%	1.0%	**P=0.030**	84.0%
7–11 Years	86.3%	85.2%	-1.3%	**P=0.001**	83.0%
12–19 Years	83.4%	82.7%	-0.8%	**P=0.022**	82.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	10.1%	—	—	—
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	34.5%	35.0%	1.5%	P=0.113	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	56.9%	59.7%	4.9%	**P=0.004**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	56.4%	56.0%	-0.7%	P=0.372	66.0%
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	49.0%	48.1%	-1.8%	P=0.201	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	44.0%	44.8%	1.8%	**P=0.010**	64.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	56.2	58.0	3.3%	—	55.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	26.9	33.4	24.3%	—	—
Plan All-Cause Readmissions[3]					
*Total**	—	15.2%	—	—	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 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.

[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.— Indicates that the Contractors were not required to report the measure for the CYE 2017 reporting period, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.

† Lower or higher rates are not considered to be an appropriate measure of care for this measure.

Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Health Net Access (HNA)

Table A-4—CYE 2017 and CYE 2018 Performance Measure Results—HNA

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	41.5%	48.3%	16.4%	**P<0.001**	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	91.8%	92.9%	1.2%	P=0.265	93.0%
25 Months–6 Years	77.9%	81.6%	4.8%	**P<0.001**	84.0%
7–11 Years	81.4%	81.7%	0.4%	P=0.808	83.0%
12–19 Years	78.7%	80.7%	2.5%	**P=0.026**	82.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	10.4%	—	—	—
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	30.9%	34.3%	11.0%	**P<0.001**	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	57.5%	61.0%	6.1%	P=0.092	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	55.3%	59.1%	6.9%	**P<0.001**	66.0%
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	50.0%	51.7%	3.4%	P=0.166	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	47.7%	49.3%	3.4%	**P=0.012**	64.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	52.7	51.5	-2.1%	—	55.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	32.1	36.7	14.2%	—	—
Plan All-Cause Readmissions[3]					

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
*Total**	—	13.1%	—	—	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 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.— Indicates that the Contractors were not required to report the measure for the CYE 2017 reporting period, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Mercy Care Plan (MCP)

Table A-5—CYE 2017 and CYE 2018 Performance Measure Results—MCP

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	63.8%	63.9%	0.2%	P=0.520	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	93.9%	95.3%	1.5%	**P<0.001**	93.0%
25 Months–6 Years	84.8%	86.0%	1.4%	**P<0.001**	84.0%
7–11 Years	90.8%	90.3%	-0.6%	**P=0.025**	83.0%
12–19 Years	87.7%	87.6%	-0.1%	P=0.646	82.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	13.3%	—	—	—
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	41.0%	43.0%	4.9%	**P<0.001**	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	63.2%	65.6%	3.8%	**P=0.001**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	62.1%	62.7%	1.0%	P=0.114	66.0%
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	58.1%	57.8%	-0.5%	P=0.561	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	55.2%	54.5%	-1.3%	**P=0.014**	64.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	56.9	55.9	-1.7%	—	55.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	30.3	32.6	7.6%	—	—
Plan All-Cause Readmissions[3]					
*Total**	—	15.0%	—	—	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 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.

[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.— Indicates that the Contractors were not required to report the measure for the CYE 2017 reporting period, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.

† Lower or higher rates are not considered to be an appropriate measure of care for this measure.

Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

University Family Care (UFC)

Table A-6—CYE 2017 and CYE 2018 Performance Measure Results—UFC

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	56.1%	54.0%	-3.7%	**P<0.001**	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	92.5%	93.8%	1.4%	P=0.055	93.0%
25 Months–6 Years	81.5%	83.5%	2.5%	**P<0.001**	84.0%
7–11 Years	87.2%	86.9%	-0.3%	P=0.488	83.0%
12–19 Years	86.1%	85.8%	-0.4%	P=0.354	82.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	12.4%	—	—	—
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	38.3%	38.3%	0.0%	P=0.932	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	60.1%	62.3%	3.7%	P=0.110	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=0.040**	66.0%
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	55.5%	55.7%	0.4%	P=0.855	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	53.4%	54.1%	1.3%	P=0.140	64.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	50.2	53.2	6.0%	—	55.0

Performance Measure	CYE 2017 Performance	CYE 2018 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	24.1	33.3	38.3%	—	—
Plan All-Cause Readmissions[3]					
*Total**	—	13.1%	—	—	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 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed. — Indicates that the Contractors were not required to report the measure for the CYE 2017 reporting period, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

UnitedHealthcare Community Plan-Acute (UHCCP-Acute)

Table A-7—CYE 2017 and CYE 2018 Performance Measure Results—UHCCP-Acute

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	61.2%	61.9%	1.1%	**P<0.001**	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	93.3%	94.9%	1.7%	**P<0.001**	93.0%
25 Months–6 Years	82.7%	84.0%	1.6%	**P<0.001**	84.0%
7–11 Years	88.7%	88.4%	-0.3%	P=0.191	83.0%
12–19 Years	86.6%	86.0%	-0.7%	**P=0.012**	82.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	14.0%	—	—	—
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	38.2%	39.5%	3.4%	**P<0.001**	41.0%

Performance Measure	CYE 2017 Performance	CYE 2018 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	59.1%	61.1%	3.4%	**P=0.006**	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.4%	61.2%	1.3%	**P=0.027**	66.0%
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	56.6%	57.6%	1.8%	**P=0.027**	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	48.1%	49.4%	2.7%	**P<0.001**	64.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	51.7	54.7	5.8%	—	55.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	24.2	33.3	37.7%	—	—
Plan All-Cause Readmissions[3]					
*Total**	—	13.6%	—	—	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 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.

[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.— Indicates that the Contractors were not required to report the measure for the CYE 2017 reporting period, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.

† Lower or higher rates are not considered to be an appropriate measure of care for this measure.

Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Acute Care Aggregate

Table A-8—CYE 2017 and CYE 2018 Performance Measure Results—Acute Care Contractors

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	60.8%	61.1%	0.5%	**P=0.002**	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	93.1%	94.8%	1.8%	**P<0.001**	93.0%
25 Months–6 Years	82.9%	84.2%	1.6%	**P<0.001**	84.0%
7–11 Years	89.0%	88.4%	-0.7%	**P<0.001**	83.0%
12–19 Years	86.4%	86.1%	-0.4%	**P=0.003**	82.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	12.4%	—	—	—
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	39.2%	40.6%	3.6%	**P<0.001**	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	59.5%	61.5%	3.4%	**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	60.7%	61.4%	1.2%	**P<0.001**	66.0%
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	54.4%	54.9%	0.9%	**P=0.035**	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	50.5%	50.8%	0.6%	**P=0.025**	64.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	53.4	54.8	2.6%	—	55.0
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	26.5	32.8	23.8%	—	—
Plan All-Cause Readmissions[3]					

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
*Total**	—	14.4%	—	—	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 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.— Indicates that the Contractors were not required to report the measure for the CYE 2017 reporting period, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Performance Measure Results—KidsCare Contractors

The following tables include performance measure results for the KidsCare Contractors. The tables display the following information: CYE 2017 performance, where available; CYE 2018 performance; the relative percentage change between CYE 2017 and CYE 2018 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 2018 MPS established by AHCCCS.

Care1st Health Plan Arizona, Inc. (Care1st)

Table A-9—CYE 2017 and CYE 2018 Performance Measure Results—Care1st

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	74.2%	76.5%	3.1%	P=0.438	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	NA	NA	—	—	93.0%
25 Months–6 Years	92.7%	94.9%	2.4%	P=0.521	84.0%
7–11 Years	NA	97.4%	—	—	83.0%
12–19 Years	NA	98.3%	—	—	82.0%
Pediatric Health					
Adolescent Well-Care Visits					

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Adolescent Well-Care Visits	64.1%	58.4%	-8.9%	P=0.315	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	NA	NA	—	—	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	85.0%	81.2%	-4.5%	P=0.566	66.0%

NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Health Choice Arizona (HCA)

Table A-10—CYE 2017 and CYE 2018 Performance Measure Results—HCA

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	73.0%	70.3%	-3.7%	P=0.251	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	NA	NA	—	—	93.0%
25 Months–6 Years	93.1%	88.3%	-5.2%	P=0.136	84.0%
7–11 Years	NA	97.3%	—	—	83.0%
12–19 Years	NA	93.4%	—	—	82.0%
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	59.8%	53.4%	-10.7%	P=0.106	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	NA	NA	—	—	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.5%	69.9%	2.0%	P=0.786	66.0%

NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Health Net Access (HNA)

Table A-11—CYE 2017 and CYE 2018 Performance Measure Results—HNA

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	57.8%	64.8%	12.1%	P=0.175	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	NA	NA	—	—	93.0%
25 Months–6 Years	95.2%	97.2%	2.1%	P=0.536	84.0%
7–11 Years	NA	NA	—	—	83.0%
12–19 Years	NA	NA	—	—	82.0%
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	48.6%	56.0%	15.2%	P=0.419	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	NA	NA	—	—	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	76.5%	85.6%	11.9%	P=0.229	66.0%

NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Mercy Care Plan (MCP)

Table A-12—CYE 2017 and CYE 2018 Performance Measure Results—MCP

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	78.9%	76.6%	-2.9%	P=0.204	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	NA	96.9%	—	—	93.0%
25 Months–6 Years	94.2%	94.7%	0.5%	P=0.775	84.0%
7–11 Years	NA	97.9%	—	—	83.0%
12–19 Years	97.4%	96.4%	-1.0%	P=0.768	82.0%
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	61.5%	64.0%	4.1%	P=0.428	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	NA	NA	—	—	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	80.0%	77.2%	-3.5%	P=0.474	66.0%

NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

University Family Care (UFC)

Table A-13—CYE 2017 and CYE 2018 Performance Measure Results—UFC

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	64.4%	67.8%	5.3%	P=0.378	60.0%

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	NA	NA	—	—	93.0%
25 Months–6 Years	93.5%	93.9%	0.4%	P=0.914	84.0%
7–11 Years	NA	NA	—	—	83.0%
12–19 Years	NA	NA	—	—	82.0%
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	62.5%	57.4%	-8.2%	P=0.415	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	NA	NA	—	—	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	81.1%	76.7%	-5.4%	P=0.579	66.0%

NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

UnitedHealthcare Community Plan-KidsCare (UHCCP-KidsCare)

Table A-14—CYE 2017 and CYE 2018 Performance Measure Results—UHCCP-KidsCare

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	72.6%	75.6%	4.1%	P=0.080	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	NA	98.4%	—	—	93.0%
25 Months–6 Years	88.7%	92.1%	3.8%	P=0.125	84.0%
7–11 Years	NA	92.6%	—	—	83.0%
12–19 Years	98.2%	93.9%	-4.4%	P=0.206	82.0%
Pediatric Health					

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	59.2%	59.3%	0.2%	P=0.978	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	NA	NA	—	—	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	74.0%	73.9%	-0.1%	P=0.988	66.0%

NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

KidsCare Aggregate

Table A-15—CYE 2017 and CYE 2018 Performance Measure Results—KidsCare Contractors

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Annual Dental Visits					
2–20 Years	74.3%	74.1%	-0.3%	P=0.847	60.0%
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	97.4%	98.6%	1.2%	P=0.511	93.0%
25 Months–6 Years	92.3%	93.1%	0.9%	P=0.499	84.0%
7–11 Years	100.0%	95.7%	-4.3%	P=0.177	83.0%
12–19 Years	95.1%	95.4%	0.3%	P=0.851	82.0%
Pediatric Health					
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	61.1%	59.3%	-3.0%	P=0.269	41.0%
Well-Child Visits in the First 15 Months of Life					
Six or More Well-Child Visits	NA	28.9%	—	—	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.8%	75.7%	-0.1%	P=0.977	66.0%

NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.
— Indicates that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Performance Measure Results—CRS

Table A-16—CYE 2017 and CYE 2018 Performance Measure Results—UHCCP-CRS

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]
Access to Care				
Annual Dental Visits				
2–20 Years	67.4%	67.7%	0.5%	P=0.606
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	96.9%	99.1%	2.3%	**P=0.042**
25 Months–6 Years	92.7%	92.2%	-0.5%	P=0.422
7–11 Years	95.8%	95.8%	0.0%	P=0.981
12–19 Years	95.1%	95.1%	0.0%	P=0.912
Medication Management				
Use of Multiple Concurrent Antipsychotics in Children and Adolescents[2]				
*Total**	0.7%	0.7%	0.0%	P=1.000
Pediatric Health				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	48.9%	48.1%	-1.6%	P=0.409
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	49.2%	47.3%	-3.9%	P=0.690
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.8%	63.8%	-3.0%	P=0.137
Utilization				
Ambulatory Care (per 1,000 Member Months)				
*ED Visits—Total**	55.4	55.2	-0.4%	—

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total[2+]				
Days per 1,000 Member Months (Total Inpatient)—Total	78.5	88.4	12.7%	—
Plan All-Cause Readmissions[2]				
*Total**	—	22.2%	—	—

** For this indicator, a lower rate indicates better performance.*
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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 been established for this measure.
— Indicates that the Contractor was not required to report the measure for the CYE 2017 reporting period or that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate.
[+] Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Performance Measure Results—GMH/SU Contractors

The following tables include performance measure results for the GMH/SU Contractors. The tables display the following information: CYE 2017 performance, where available; CYE 2018 performance; the relative percentage change between CYE 2017 and CYE 2018 rates, where available; the statistical 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 2018 MPS established by AHCCCS.

Cenpatico Integrated Care (CIC)

Table A-17—CYE 2017 and CYE 2018 Performance Measure Results—CIC

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	56.2%	58.8%	4.6%	**P=0.033**	85.0%
30-Day Follow-Up	76.0%	76.1%	0.1%	P=0.928	95.0%
Medication Management					
Use of Multiple Concurrent Antipsychotics in Children and Adolescents					
*Total**	1.8%	1.3%	-27.8%	P=0.331	—
Use of Opioids at High Dosage in Persons Without Cancer[2]					

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
*Total**	—	NA	—	—	—
Utilization					
Mental Health Utilization[2]					
Any Service—Total	—	12.1%	—	—	—

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the CYE 2017 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Health Choice Integrated Care (HCIC)

Table A-18—CYE 2017 and CYE 2018 Performance Measure Results—HCIC

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	56.5%	56.3%	-0.4%	P=0.904	85.0%
30-Day Follow-Up	70.8%	71.0%	0.3%	P=0.914	95.0%
Medication Management					
Use of Multiple Concurrent Antipsychotics in Children and Adolescents					
*Total**	1.2%	1.3%	8.3%	P=0.856	—
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	NA	—	—	—
Utilization					
Mental Health Utilization[2]					
Any Service—Total	—	12.1%	—	—	—

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the CYE 2017 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Mercy Maricopa Integrated Care (MMIC)

Table A-19—CYE 2017 and CYE 2018 Performance Measure Results—MMIC

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	44.3%	45.5%	2.7%	P=0.103	85.0%
30-Day Follow-Up	63.5%	63.6%	0.2%	P=0.889	95.0%
Medication Management					
Use of Multiple Concurrent Antipsychotics in Children and Adolescents					
*Total**	0.7%	0.6%	-14.3%	P=0.636	—
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	NA	—	—	—
Utilization					
Mental Health Utilization[2]					
Any Service—Total	—	10.9%	—	—	—

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the CYE 2017 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

GMH/SU Aggregate

Table A-20—CYE 2017 and CYE 2018 Performance Measure Results—GMH/SU Contractors

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	48.1%	49.4%	2.7%	**P=0.034**	85.0%
30-Day Follow-Up	67.2%	67.1%	-0.2%	P=0.971	95.0%
Medication Management					
Use of Multiple Concurrent Antipsychotics in Children and Adolescents					
*Total**	1.0%	0.8%	-20.0%	P=0.285	—

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	NA	—	—	—
Utilization					
Mental Health Utilization[2]					
Any Service—Total	—	11.3%	—	—	—

** A lower rate indicates better performance for this measure; therefore, an increase in the rate indicates a decline in performance.*
NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
— Indicates that the CYE 2017 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Performance Measure Results—RBHA Integrated SMI Contractors

The following tables include performance measure results for the RBHA Integrated SMI Contractors. The tables display the following information: CYE 2017 performance, where available; CYE 2018 performance; the relative percentage change between CYE 2017 and CYE 2018 rates, where available; the statistical 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 2018 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.

Cenpatico Integrated Care (CIC)

Table A-21—CYE 2017 and CYE 2018 Performance Measure Results—CIC

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Total	90.4%	89.4%	-1.1%	**P=0.010**	75.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	12.9%	—	—	—

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	NA	38.2%	—	—	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	47.0%	45.7%	-2.8%	P=0.178	64.0%
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	65.8%	62.9%	-4.4%	P=0.060	85.0%
30-Day Follow-Up	85.9%	83.9%	-2.3%	P=0.093	95.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	123.0	105.0	-14.7%	—	—
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	67.3	62.0	-7.8%	—	—
Mental Health Utilization[2]					
Any Service—Total	—	86.7%	—	—	—
Plan All-Cause Readmissions[3]					
*Total**	—	26.4%	—	—	—

** A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.*
NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.
— Indicates that the CYE 2017 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Health Choice Integrated Care (HCIC)

Table A-22—CYE 2017 and CYE 2018 Performance Measure Results—HCIC

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Total	90.3%	89.3%	-1.1%	P=0.132	75.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	13.8%	—	—	—
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	NA	31.8%	—	—	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	42.6%	40.7%	-4.5%	P=0.217	64.0%
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	61.9%	64.4%	4.0%	P=0.374	85.0%
30-Day Follow-Up	81.0%	81.2%	0.3%	P=0.930	95.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	107.2	128.2	19.6%	—	—
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	36.3	61.5	69.2%	—	—
Mental Health Utilization[2]					
Any Service—Total	—	83.9%	—	—	—
Plan All-Cause Readmissions[3]					
*Total**	—	15.5%	—	—	—

** A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.*
NA indicates that the rate was withheld because the denominator was less than 30.
[1] Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.
[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.
— Indicates that the CYE 2017 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.
† Lower or higher rates are not considered to be an appropriate measure of care for this measure.
Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Mercy Maricopa Integrated Care (MMIC)

Table A-23—CYE 2017 and CYE 2018 Performance Measure Results—MMIC

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Total	93.9%	92.9%	-1.1%	**P<0.001**	75.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	12.7%	—	—	—
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	38.7%	38.1%	-1.6%	P=0.606	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	46.3%	45.5%	-1.7%	P=0.273	64.0%
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	75.4%	71.2%	-5.6%	**P<0.001**	85.0%
30-Day Follow-Up	89.2%	86.7%	-2.8%	**P<0.001**	95.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	146.6	51.5	-64.9%	—	—
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	86.1	89.8	4.2%	—	—
Mental Health Utilization[2]					
Any Service—Total	—	96.8%	—	—	—
Plan All-Cause Readmissions[3]					
*Total**	—	25.8%	—	—	—

** A lower rate indicates better performance for this measure; therefore, an increase in a 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 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.

[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.

— Indicates that the CYE 2017 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.

† Lower or higher rates are not considered to be an appropriate measure of care for this measure.

Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

RBHA Integrated SMI Aggregate

Table A-24—CYE 2017 and CYE 2018 Performance Measure Results—RBHA Integrated SMI Contractors

Performance Measure	CYE 2017 Performance	CYE 2018 Performance	Relative Percentage Change	Significance Level (*p* value)[1]	MPS
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Total	92.2%	91.2%	-1.1%	**P<0.001**	75.0%
Medication Management					
Use of Opioids at High Dosage in Persons Without Cancer[2]					
*Total**	—	13.0%	—	**—**	—
Preventive Screening					
Breast Cancer Screening					
Breast Cancer Screening	38.7%	37.3%	-3.6%	P=0.170	50.0%
Cervical Cancer Screening					
Cervical Cancer Screening	46.0%	44.8%	-2.6%	**P=0.030**	64.0%
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up	71.8%	68.5%	-4.6%	**P<0.001**	85.0%
30-Day Follow-Up	87.7%	85.6%	-2.4%	**P<0.001**	95.0%
Utilization					
Ambulatory Care (per 1,000 Member Months)					
*ED Visits—Total**	133.1	122.1	-8.3%	—	—
Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total†					
Days per 1,000 Member Months (Total Inpatient)—Total	72.8	76.6	5.3%	—	—
Mental Health Utilization[2]					
Any Service—Total	—	90.8%	—	**—**	—
Plan All-Cause Readmissions[3]					
*Total**	—	25.1%	—	—	—

** A lower rate indicates better performance for this measure; therefore, an increase in a 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 2017 and CYE 2018 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, a break in trending between CYE 2018 and prior years is recommended; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.

[3] Due to changes in the calculation methodology used for this measure in CYE 2018, comparisons to the MPS are not made, prior year rates are not displayed, and statistical significance testing was not performed.

— Indicates that the CYE 2017 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2017 and CYE 2018 was not possible or appropriate, or that an MPS had not been established by AHCCCS.

† Lower or higher rates are not considered to be an appropriate measure of care for this measure.

Cells shaded green indicate that the rate met or exceeded the CYE 2018 MPS established by AHCCCS.

Appendix B. Validation of Performance Improvement Project Methodology

Performance Improvement Project Design

AHCCCS' PIPs, either mandated or Contractor-initiated, are developed according to 42 CFR §438.330, QAPI 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 inter-rater 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 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.

Appendix C. CAHPS Methodology

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the Children with Chronic Conditions (CCC) measurement set to child members. Child members eligible for the survey had to be 19 years or younger as of March 31, 2018.[C-1]

A mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys) was used. Parents/caretakers of child members completed the surveys from July to September 2018. The CAHPS surveys were administered in English and Spanish. Members who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Members that were not identified as Spanish-speaking received an English version of the survey. The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing members that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire.

The CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental and CCC measurement sets includes 83 core questions that yield 16 measures of member experience. These measures include four global ratings, five composite measures, two individual item measures, and five CCC composite measures/items. The global ratings reflect overall member experience with the health plan, healthcare, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Getting Needed Care* and *Getting Care Quickly*). The individual item measures are individual questions that look at a specific area of care (i.e., *Coordination of Care* and *Health Promotion and Education*). The CCC composite measures/items are a set of questions focused on specific healthcare needs and domains (e.g., *Access to Prescription Medicines* and *Coordination of Care for Children with Chronic Conditions*).

The measures were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[C-2] The scoring of the measures involved assigning top-box responses a score of "1," with all other responses receiving a score of "0." A "top-box" response for the CAHPS survey measures was defined as follows:

- "9" or "10" for the global ratings;

[C-1] For purposes of the 2018 CAHPS surveys, the age criteria for KidsCare members eligible for inclusion in the CAHPS Child Medicaid Health Plan Survey was modified to include members up to 19 years of age or younger as of March 31, 2018. Please note, this deviates from standard NCQA HEDIS specifications, which define eligible child members as 17 years of age or younger.

[C-2] National Committee for Quality Assurance. *HEDIS 2018*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2017.

- "Usually" or "Always" for the *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service* composite measures; the *Coordination of Care* individual item measure; the *Access to Specialized Services* CCC composite measure; and the *FCC: Getting Needed Information* and *Access to Prescription Medicines* CCC items.
- "Yes" for the *Shared Decision Making* composite measure; the *Health Promotion and Education* individual item measure; and the *FCC: Personal Doctor Who Knows Child* and *Coordination of Care for Children with Chronic Conditions* CCC composite measures.

After applying this scoring methodology, the percentage of top-box responses was calculated in order to determine the top-box scores.

An analysis of the KidsCare general child population's results was conducted using NCQA's 2018 HEDIS Benchmarks and Thresholds for Accreditation.[C-3] Although NCQA requires a minimum of at least 100 responses on each item in order to obtain a reportable CAHPS survey result, HSAG presented results with fewer than 100 responses. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+).

A three-point mean score was determined for each measure. HSAG compared the resulting three-point mean scores to published NCQA HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member experience ratings (i.e., star ratings). Ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure using the percentile distributions shown in Table C-1.

Table C-1—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

[C-3] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2018.* Washington, DC: NCQA, August 20, 2018.

The KidsCare general child and CCC populations' top-box scores were compared to 2018 NCQA child Medicaid and CCC Medicaid national averages, respectively. A cell was highlighted in yellow if the top-box score was at or above the national average. A cell was highlighted in red if the top-box score was below the national average.

HSAG performed an analysis of key drivers of member experience for the following measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. The purpose of the key drivers of member experience analysis is to help decision makers identify specific aspects of care that will most benefit from QI activities. The analysis provides information on: 1) how ***well*** KidsCare is performing on the survey item, and 2) how ***important*** that item is to overall experience.

HSAG evaluated these global ratings to determine if particular CAHPS items (i.e., questions) have a high problem score (i.e., CHIP has demonstrated poor performance) and are strongly correlated with one or more of these measures. These individual CAHPS items, which HSAG refers to as "key drivers," have the greatest potential to affect change in overall member experience with the global ratings and, therefore, are areas of focus for possible QI efforts.

HSAG measured each survey item's performance by calculating a problem score, in which a negative experience with care was defined as a problem and assigned a "1," and a positive experience with care (i.e., non-negative) was assigned a "0." The higher the problem score, the lower the member's experience with the aspect of service measured by that question. The problem score could range from 0 to 1. Table C-2 depicts the problem score assignments for the different response categories.

Table C-2—Problem Score Assignment

Response Category	Classification	Code
Never/Sometimes/Usually/Always Format		
Never	Problem	1
Sometimes	Problem	1
Usually	Not a Problem	0
Always	Not a Problem	0
No Answer	Not classified	Missing
No/Yes Format		
No	Problem	1
Yes	Not a Problem	0
No Answer	Not classified	Missing

For each item evaluated, HSAG calculated the relationship between the item's problem score and performance on each of the three measures using a Pearson product moment correlation, which is defined as the covariance of the two scores divided by the product of their standard deviations. This conversion modifies the distributions of both variables so that they conform to the standard normal distribution and can be compared. HSAG then prioritized items based on their overall problem score and

their correlation to each measure. The correlation can range from -1 to 1, with negative values indicating a negative relationship between overall member experience and a particular survey item. However, the correlation analysis conducted is not focused on the direction of the correlation, but rather on the degree of correlation. Therefore, the absolute value of the correlation is used in the analysis, and the range for the absolute value of the correlation is 0 to 1. An absolute value of "0" indicates no relationship between the response to a question and the parents/caretakers' experience with the child member's healthcare. As the absolute value of the correlation increases, the importance of the question to the respondent's overall experience increases.

The median, rather than the mean, is used to ensure that extreme problem scores and correlations do not have disproportionate influence in prioritizing individual questions. Key drivers of member experience are defined as those items that:

- Have a problem score that is greater than or equal to the median problem score for all items examined.
- Have a correlation that is greater than or equal to the median correlation for all items examined.