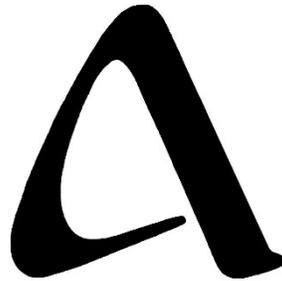


# Arizona Health Care Cost Containment System (AHCCCS)



AHCCCS

## 2014–2015 EXTERNAL QUALITY REVIEW ANNUAL REPORT *for* ALTCS EPD AND DES/DDD CONTRACTORS

February 2016



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## 1. Executive Summary

Section 1932(c) of the Medicaid managed care act requires state Medicaid agencies to provide for an annual external independent review of the quality and timeliness of, and access to, services covered under each managed care organization (MCO) and prepaid inpatient health plan (PIHP) contract. The Code of Federal Regulations (CFR) outlines the Medicaid managed care act requirements related to external quality review (EQR) activities.

The CFR describes the mandatory activities at 42 CFR, Part 438, Managed Care, Subpart E, External Quality Review, 438.358(b) and (c). The three mandatory activities are (1) validating performance improvement projects (PIPs), (2) validating performance measures, and (3) conducting reviews to determine compliance with standards established by the state to comply with the requirements of 42 CFR 438.204(g). According to 42 CFR 438.358(a), “The state, its agent that is not an MCO or PIHP, or an external quality review organization (EQRO) may perform the mandatory and optional EQR-related activities.”

The Arizona Health Care Cost Containment System (AHCCCS), the first statewide Medicaid managed care system in the nation, continues as a national leader and innovator in designing and administering effective and efficient financing, contracting, and service delivery models for Medicaid managed care programs.

As permitted by the Centers for Medicare & Medicaid Services (CMS), and as allowed under federal regulation, AHCCCS elected to retain responsibility for performing the three mandatory activities described in 42 CFR 438. AHCCCS also conducted overall validation of encounter data according to industry standards, an optional EQR activity. AHCCCS prepared Contractor-specific reports of findings related to each of the activities, and as applicable, required its Contractors to prepare and submit their proposed corrective action plans to AHCCCS for review and approval.

AHCCCS contracted with HSAG, as its CMS-required EQRO, to prepare this annual 2014–2015 EQR technical report. This report presents AHCCCS’ findings from conducting each of the activities, as well as HSAG’s analysis and assessment of the Contractors’ performance and, as applicable, recommendations to improve their performance.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR 438.354(b) and (c). HSAG has extensive experience and expertise in both conducting the mandatory activities and in using the information that either HSAG derived from directly conducting the activities or that a State Medicaid agency derived from conducting the activities. HSAG uses the information and data to draw conclusions and make recommendations about the quality and timeliness of, and access to, care and services the State’s MCOs and PIHPs provide.

To meet the requirements of 42 CFR 438.358(b), as the EQRO, HSAG must use the information AHCCCS obtained and provided for each Contractor to prepare and provide AHCCCS its EQR annual technical report. The report must include, at a minimum, HSAG’s:

- ◆ Analysis of the data and information.
- ◆ Conclusions drawn from the analysis of the quality and timeliness of, and access to, Medicaid managed care services provided to members by AHCCCS’ Contractors.

- ◆ Recommendations for improving the Contractors' service quality, timeliness, and access.

HSAG has prepared the annual report for AHCCCS for 11 consecutive years. The report complies with requirements set forth at 42 CFR 438.364.

This Executive Summary includes an overview of HSAG's 2014–2015 external quality review 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 requirements for AHCCCS-selected performance measures and for conducting valid and effective AHCCCS-required PIPs. AHCCCS also conducted an operational review for the Elderly and Physically Disabled (EPD) Contractors during the Contract Year Ending (CYE) in 2014, and the results are presented in this report. AHCCCS conducted a focused OR for DES/DDD in early CYE 2014, and the results of this OR were reported in the previous EQR annual report. Additional sections of this annual 2014–2015 EQR technical report include the following:

- ◆ Section 2—An overview of the history of the AHCCCS program and a summary of AHCCCS' quality assessment and performance improvement (QAPI) strategy goals and objectives.
- ◆ Section 3—A description of the 2014–2015 EQR activities.
- ◆ Section 4—An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care programs and those that are specific to its Arizona Long Term Care System (ALTCS) and Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD) Contractors.
- ◆ Section 5—An overview of the Contractors' best and emerging practices.
- ◆ Section 6 (Organizational Assessment and Structure Performance)—A presentation of findings for the Contractors in complying with select AHCCCS contract requirements, and as applicable, HSAG's recommendations to improve Contractor performance and members' timely access to quality care and services. (Note: AHCCCS conducts an operational review [OR] to assess each Contractor's compliance with AHCCCS' contract standards, a minimum of one time during each three-year contract period. The CYE 2014 review was the second year of a new three-year review cycle.)
- ◆ Section 7 (Performance Improvement Project Performance)—A presentation of each Contractor's results for its AHCCCS-selected and required performance improvement project (PIP) for the ALTCS and DES/DDD Contractors, and HSAG's associated findings and recommendations.

Performance measurement rates for CYE 2013 have been calculated, but the data were under review at the time this report was written. CYE 2013 and 2014 performance measurement rates, as well as the associated findings and recommendations, will be included in the annual 2015–2016 EQR technical report.

## Overview of the 2014–2015 External Review

During contract year (CY) 2014–2015, AHCCCS contracted with three ALTCS Medicaid managed care Contractors and with DES/DDD.

Below are the three ALTCS Contractors and their abbreviations that are used throughout this report:

- ◆ Bridgeway Health Solutions (BHS)
- ◆ Mercy Care Plan (MCP)
- ◆ UnitedHealthcare Community Plan (UHCCP)

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

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

### **Organizational Assessment and Structure Standards**

AHCCCS conducted an organizational assessment and structural review of the Contractors' performance for three ALTCS EPD Contractors. AHCCCS conducted a focused OR for DES/DDD in early CYE 2014, and the results of this OR were reported in the previous EQR annual report. AHCCCS reviewed the EPD Contractors' performance on approximately 131 compliance standards. Based on AHCCCS' review findings and assessment of the degree to which the Contractor complied with the standards, AHCCCS assigned the applicable performance designation to the Contractor's performance:

- ◆ Standards scored as 90 through 100 percent compliant were designated as Full Compliance.
- ◆ Standards scored as 75 through 89 percent compliant were designated as Substantial Compliance.
- ◆ Standards scored as 50 through 74 percent compliant were designated as Partial Compliance.
- ◆ Standards scored as 0 through 49 percent compliant were designated as Non Compliance.

If a standard was not applicable to a Contractor, AHCCCS noted this using an N/A designation. When AHCCCS evaluated performance for a standard as less than fully compliant or provided a recommendation worded as "The Contractor must" or "The Contractor should," the Contractor was required to develop a corrective action plan (CAP), submit it to AHCCCS for review and approval, and implement the corrective actions.

### **Findings**

Figure 1-1 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of 12 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 1-1—Categorized Levels of Compliance With Technical Standards for ALTCS EPD Contractors<sup>1-1</sup>

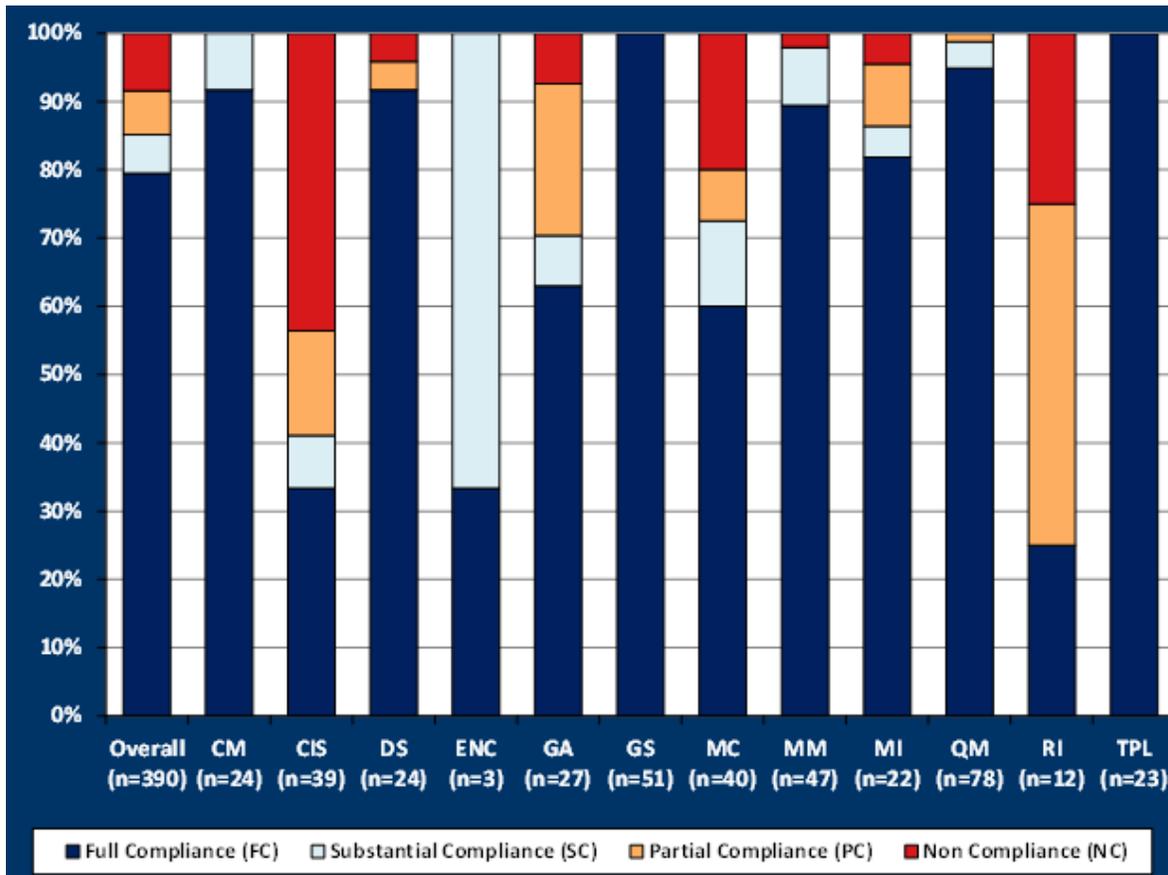


Figure 1-1 shows that the three Contractors were in full compliance for 79.5 percent of the 390 reviewed standards (left-most bar, labeled “Overall”), with varied performance across 10 of the 12 categories of standards. The Contractors’ strongest performance was for the standards associated with the Grievance Systems and Third-Party Liability categories, as AHCCCS scored all Contractors as fully compliant for all related standards in these categories. Strong performance was also demonstrated in the Case Management, Delivery Systems, and Quality Management categories, as more than 90.0 percent of the related standards in each of these categories were scored as fully compliant. Of the 12 categories of standards, the Reinsurance category showed the lowest percentage of standards in full compliance (25.0 percent). Two other categories (Claims and Information Systems, and Encounters) had less than 50.0 percent of the reviewed standards in full compliance. Results from these three categories suggest targeted opportunities for improvement. Each of the three EPD Contractors had at least two categories in which all related standards were scored as fully compliant. One Contractor, Mercy Care Plan, had seven of the 12 categories scored as fully compliant.

<sup>1-1</sup> The compliance categories are abbreviated as follows: CM=Case Management, CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

A comparison of the CAPs across compliance categories highlights areas for quality improvement activities for the ALTCS Contractors as a group. Table 1-1 presents the number and proportion of CAPs required within and across the 12 categories for the compliance standards reviewed for CYE 2014.

Table 1-1—Corrective Action Plans by Category for ALTCS EPD Contractors				
Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Case Management*	24	0	0.0%	0.0%
Claims and Information Systems	39	26	66.7%	33.8%
Delivery Systems	24	2	8.3%	2.6%
Encounters	3	2	66.7%	2.6%
General Administration	27	10	37.0%	13.0%
Grievance Systems**	51	0	0.0%	0.0%
Maternal and Child Health and EPSDT**	40	16	40.0%	20.8%
Medical Management	47	5	10.6%	6.5%
Member Information*	22	2	9.1%	2.6%
Quality Management***	78	5	6.4%	6.5%
Reinsurance	12	9	75.0%	11.7%
Third-Party Liability	23	0	0.0%	0.0%
<b>Overall</b>	<b>390</b>	<b>77</b>	<b>19.7%</b>	<b>100%</b>
* Though standards in these categories were less than fully compliant, AHCCCS did not require the Contractor(s) to develop CAPs for selected standards within these categories.				
** Though selected standards in these categories were fully compliant, AHCCCS provided recommendations to the Contractor(s). The Contractors were not required to develop CAPs for these standards.				
*** CAPs were required for selected standards within this category, although the corresponding standards were scored in full compliance.				

Table 1-1 shows that the Contractors were required to develop CAPs for 19.7 percent of the standards reviewed during CYE 2014. The largest number of required CAPs (26) was in the Claims and Information Systems category. Overall, the Contractors were required to develop at least one CAP for standards in nine of the 12 categories. However, CAPs were not required for any standards in the Case Management, Grievance Systems, or Third-Party Liability categories. The largest percentage of CAPs relative to the number of standards in a category was in the Reinsurance category (75.0 percent), though this percentage may be affected by the relatively low number of standards in the category.

### Conclusions

The three ALTCS EDP Contractors were in full compliance for 79.5 percent of the 390 reviewed standards. Performance varied widely among the three Contractors, with AHCCCS requiring the Contractors to submit CAPs for a variety of topics. The number of CAPs ranged from 19 for UHCCP to 34 for BHS. Only one Contractor, BHS, received full compliance for less than 80 percent of its standards. Overall, AHCCCS required the ALTCS EPD Contractors to submit 26

CAPs (66.7 percent of possible category standards) for the standards associated with the Claims and Information Systems category.

With 85.1 percent of standards in full or substantial compliance and 8.5 percent in noncompliance, AHCCCS' CYE 2014 ALTCS EPD OR identified generally positive results. Most of the CAPs were related to monitoring, reporting, and communications processes. If the Contractors continue to improve in these areas, they should be able to achieve full or nearly full compliance for all standards in AHCCCS' next cycle of operational reviews.

## Recommendations

The intent of the OR is to evaluate a Contractor's performance on and compliance with AHCCCS' standards related to access, structure and operations, and measurement and improvement. Overall, the Claims and Information Systems, Maternal and Child Health and EPSDT, and General Administration categories showed the largest proportional opportunities for improvement, as 67.5 percent of the total CAPs required by AHCCCS were related to these categories.

Based on AHCCCS' review of ALTCS EPD Contractor performance in CYE 2014 and the associated opportunities for improvement identified as a result of the OR, HSAG recommends the following:

- ◆ ALTCS EPD Contractors should conduct internal reviews of operational systems to identify barriers that affect their compliance with AHCCCS standards. Specifically, Contractors should cross-reference existing policies and procedures with AHCCCS requirements and ensure, at a minimum, that they are in alignment with both the intent and content of AHCCCS standards.
- ◆ Contractors should evaluate their current monitoring programs and activities. When deficiencies are noted, the Contractors should take steps to either develop new procedures and review mechanisms or augment existing ones. In many cases, Contractors can apply lessons learned from improving performance for one category of standards to other categories. Specifically, Contractors can look to CAPs completed from earlier ORs to determine best practices specific to their organization for identifying and correcting deficient standards, and monitoring the subsequent compliance.
- ◆ All Contractors should review their Reinsurance policies and bring them into compliance with the relevant standards, as each of the ALTCS EPD Contractors was required to develop and implement a CAP for three of the four standards associated with this category. Specifically, Contractors should work with their respective provider networks and information systems personnel to improve the processing and auditing procedures for reinsurance cases and overpayments. Similarly, all Contractors should assess their policies and procedures pertaining to the Claims and Information Systems standards, as each of the ALTCS EPD Contractors was required to develop and implement at least seven CAPs among the 13 standards associated with this category.

## **Performance Improvement Projects (PIPs)**

HSAG received documentation from AHCCCS regarding the ALTCS EPD Contractors' and DES/DDD's self-reported performance on an AHCCCS-mandated PIP. In CYE 2011, AHCCCS began the baseline measurement of a PIP, *Inpatient Readmission within 30 Days*, for all lines of business. This PIP focuses on decreasing the number of inpatient readmissions for any cause within 30 days of the initial hospitalization. Because the goal of the PIP is to lower the number of readmissions, a lower rate by a Contractor is indicative of better performance.

## **Findings**

During CYE 2014, the *Inpatient Readmissions within 30 Days* PIP was in the second remeasurement phase, and the PIP was closed by AHCCCS. AHCCCS' decision to close this PIP resulted from national and state-specific factors that have contributed to declining readmission rates. As a result of this mid-cycle closure, AHCCCS opted not to generate official measurements and instead relied on Contractor-generated rates submitted to AHCCCS in the Contractors' annual PIP reports. Due to disparate measurement periods, source data, and calculation methods among DES/DDD and the ALTCS EPD Contractors, it is not possible to reliably compare Contractors' self-reported performance on the *Inpatient Readmissions within 30 Days* PIP.

## **Conclusions**

The *Inpatient Readmissions within 30 Days* PIP for the ALTCS EPD Contractors and the DES/DDD Contractor was closed mid-cycle by AHCCCS, and performance results for this PIP were limited to the Contractors' final PIP reports submitted to AHCCCS. Comparative results among the Contractors were not available due to the disparate measurement periods, source data, and calculation methods among the four Contractors.

## **Recommendations**

As AHCCCS will continue to measure performance on this topic through future performance measure validation activities, HSAG recommends that the Contractors continue to monitor the outcomes associated with the reported interventions to reduce inpatient readmissions. Since Contractor-specific strengths and opportunities could not be reliably identified from the data provided, HSAG recommends that AHCCCS fully validate Contractors' PIP submissions for inclusion in future annual EQR reports.

## **Overall Findings, Conclusions, and Recommendations**

### **Organizational Assessment and Structure Standards**

The three ALTCS EDP Contractors were in full compliance for 79.5 percent of the 390 reviewed standards. Performance varied widely among the three Contractors, with AHCCCS requiring the Contractors to submit CAPs for a variety of topics. The number of CAPs ranged from 19 for UHCCP to 34 for BHS. With 85.1 percent of standards in full or substantial compliance and 8.5 percent in noncompliance, AHCCCS' CYE 2014 ALTCS EPD OR identified generally positive results. Most of the CAPs were related to monitoring, reporting, and communications processes;

and specific recommendations addressed standards in the Claims and Information Systems, Maternal and Child Health and EPSDT, and General Administration categories.

### **Performance Improvement Projects**

Since official PIP performance results were not calculated by AHCCCS, strong conclusions have not been identified regarding the strengths and opportunities to improve Contractor performance. However, Contractors should continue to monitor and evaluate the effectiveness of existing interventions on this topic in support of AHCCCS' anticipated performance measure validation activities concerning inpatient readmissions.

### **Conclusions**

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

This section of the report includes a brief history of the Arizona Health Care Cost Containment System (AHCCCS) Medicaid managed care programs and a description of AHCCCS' Quality Assessment and Performance Improvement (QAPI) strategy. The description of the QAPI strategy summarizes AHCCCS':

- ◆ Quality strategy goals and objectives.
- ◆ Operational performance standards used to evaluate Contractor performance in complying with Medicaid managed care act regulations and State contract requirements.
- ◆ Requirements and targets AHCCCS used to evaluate Contractor performance on AHCCCS-selected measures and to evaluate the validity of and improvements achieved through the Contractors' AHCCCS-required PIPs.

### History of the AHCCCS Medicaid Managed Care Program

AHCCCS has operated throughout its 33-year history as a pioneer and recognized, respected leader in developing and managing innovative, quality, and cost-effective Medicaid managed care programs. AHCCCS' model for delivering services has always been one that emphasizes and promotes the goal of providing timely member access to quality health care and preventive services.

AHCCCS operates under a federal 1115 Research and Demonstration Waiver that allows for the operation of a total managed care model that mainstreams members and allows them to select their providers. AHCCCS was the first statewide Medicaid managed care system in the nation and has operated under its waiver since 1982 when it began its Acute Care program. In December 1988 AHCCCS added the ALTCS program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and physically disabled (EPD) populations. In October 1990 AHCCCS began coverage of comprehensive behavioral health services for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals.

AHCCCS contracts with private and public managed care organizations (MCOs) and two prepaid inpatient health plans (PIHPs) to provide services to its members statewide. The two PIHPs are contracted to provide a defined and limited scope of services (i.e., one provides behavioral health services and the other provides children's rehabilitation services). Within the AHCCCS program, the MCOs and the PIHPs are called "Contractors."

### AHCCCS' Strategic Plan

AHCCCS Strategic Plan State Fiscal Years 2015–2019 described the Agency's Vision, Mission, and Guiding Principles:<sup>2-1</sup>

<sup>2-1</sup> AHCCCS Strategic Plan 2015–2019, December 2014. Available at: <http://www.azahcccs.gov/reporting/PoliciesPlans/strategicplan.aspx>. Accessed on: April 28, 2015.

- ◆ AHCCCS Vision: Shaping tomorrow's managed health care...from today's experience, quality, and innovation.
- ◆ AHCCCS Mission: Reaching across Arizona to provide comprehensive quality health care to those in need.
- ◆ Guiding Principles:
  - A Strategic Plan is the result of a collaborative process and reflects informed planning efforts by the Executive Management Team.
  - AHCCCS continues to pursue multiple long-term strategies already in place that can effectively bend the cost curve including system alignment and integration, payment modernization, tribal care coordination, program integrity, health information technology, and continuous quality improvement initiatives.
  - Success is only possible through the retention and recruitment of high quality staff.
  - Program integrity is an essential component of all operational departments and when supported by transparency, promotes efficiency and accountability in the management and delivery of services.
  - AHCCCS must continue to engage stakeholders regarding strategic opportunities.

The six focus areas of the strategic plan are: (1) delivery system alignment and integration, (2) payment modernization, (3) tribal care coordination initiative, (4) program integrity, (5) health information technology, and (6) quality assessment and performance improvement strategy.

AHCCCS Strategic Goals and related Strategies are as follows:

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

- ◆ Increase transparency by providing relevant financial and quality information.
- ◆ Implement and maintain shared savings requirements for all ALTCS and Acute Care Contractors excluding Children's Rehabilitative Services (CRS), Comprehensive Medical and Dental Program (CMDP), and the Regional Behavioral Health Authority (RBHA).
- ◆ Modernize hospital payments to better align incentives, increase efficiency and improve the quality of care provided to members.
- ◆ Establish robust Payment Modernization stakeholder input opportunities.
- ◆ Achieve the Program Integrity Plan goals that improve Third Party Liability (TPL) Coordination of Benefits (COB), and Fraud and Abuse programs.

**AHCCCS must pursue continuous quality improvement.**

- ◆ Continue to promote and evaluate access to care.
- ◆ Continue to improve health outcomes for the integrated populations (CRS and serious mental illness [SMI]).
- ◆ Achieve statistically significant improvements on Contractor PIPs.
- ◆ Achieve statistically significant improvements on quality performance measures.
- ◆ Leverage American Indian care management program to improve health outcomes.

**AHCCCS must reduce the systematic fragmentation that exists in healthcare delivery to develop an integrated system of healthcare.**

- ◆ Align and integrate the model for individuals with SMI and Dual-eligible members.
- ◆ Pursue Care Coordination opportunities in System.
- ◆ Leverage Health Integration Technology (HIT) investments to create more data flow in healthcare delivery system.
- ◆ Build analytics into actionable solutions.
- ◆ Build a web-based system (Health-e-Arizona Plus) in accordance with federal timelines and requirements that improve the accuracy and efficiency of the eligibility determination process for Medicaid and Children's Health Insurance Program (CHIP).

**AHCCCS must maintain core organizational capacity and workforce planning that effectively serves AHCCCS operations.**

- ◆ Pursue continued deployment of electronic solutions to reduce healthcare administrative burden.
- ◆ Continue to manage workforce environment, promoting activities that support employee engagement and retention; and address potential gaps in the organization's knowledge base due to retirements and other staff departures.
- ◆ Strengthen system-wide security and compliance with privacy regulations related to all information/data by evaluating, analyzing and addressing potential security risks.
- ◆ Maintain Information Technology (IT) network infrastructure, including server-based applications, ensuring business continuity.

## **AHCCCS Quality Strategy**

The U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR 438.200 and 438.202 implement Section 1932(c)(1) of the Medicaid managed care act, defining certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their members. The written strategy must describe the standards that a state and its contracted MCOs and PIHPs must meet. The Medicaid state agency must, in part:

- ◆ Conduct periodic reviews to examine the scope and content of its quality strategy and evaluate the strategy's effectiveness.
- ◆ Ensure compliance with standards established by the state that are consistent with federal Medicaid managed care regulations.
- ◆ Update the strategy periodically, as needed.
- ◆ Submit to CMS a copy of its initial strategy, a copy of the revised strategy whenever significant changes have occurred in the program, and regular reports describing the implementation and effectiveness of the strategy.

AHCCCS has had a formal QAPI plan in place since 1994, established and submitted an initial quality strategy to CMS in 2003, and has continued to update and submit revisions of the strategy as needed to CMS. AHCCCS' QAPI strategy was last revised in October 2012. AHCCCS administration oversees the overall effectiveness of its QAPI strategy with several divisions/offices within the agency sharing management responsibilities. For specific initiatives and issues, AHCCCS frequently involves other internal and/or external collaborations/participants.

### **Quality Strategy Scope, Goals, and Objectives**

As mentioned earlier, AHCCCS' vision statement is, "Shaping tomorrow's managed health care from today's experience, quality, and innovation." Its mission statement is, "Reaching across Arizona to provide comprehensive, quality health care to those in need."

AHCCCS uses a workgroup model for considering and deciding whether to add new clinical or non-clinical projects for enhancing the well-being of its members. The first step is to review the current components of AHCCCS' quality initiatives and examine the various processes in place to develop, review, and revise quality measures. Following the review, the workgroup reviews AHCCCS' materials that define and illustrate the agency's focus on quality, its approach to quality improvement, and existing quality measurement initiatives and processes. AHCCCS is also diligent in identifying and incorporating opportunities to improve care coordination through designing new or enhancing current projects and programs that include more than one aspect of a member's healthcare needs.

The specific components of AHCCCS' Quality Strategy include, but are not limited to, activities such as:

- ◆ Facilitating stakeholder involvement through venues such as collaborative relationships with sister agencies, such as the Arizona Department of Health Services and the Arizona Department of Economic Security; task forces, such as the Fetal Alcohol Spectrum Disorder Task Force; and agencies dedicated to specific issues, such as the Behavioral Health Children's Executive Committee.
- ◆ Developing and accessing the quality and appropriateness of member care and services, including identifying priority areas for improvement; establishing realistic outcome-based performance measures; identifying, collecting, and assessing relevant data; providing incentives for excellence; imposing sanctions for poor performance, and sharing best practices.
- ◆ Including medical quality assessment and quality improvement requirements in AHCCCS contracts (e.g., including all federally required elements in contracts and monitoring related performance).
- ◆ Regularly monitoring and evaluating Contractor compliance and performance by conducting desk- and on-site operational reviews; reviewing required Contractor deliverables; and reviewing, analyzing, and validating required Contractor performance measures and PIP results.
- ◆ Maintaining an information system that supports initial and ongoing operations and review of the established quality strategy through the use of an automated statewide managed care data system that supports the processing, reporting, research, and project needs of AHCCCS and the Contractors.

- ◆ Reviewing, revising, and beginning new projects in any given area of the quality strategy, such as identifying needs for new projects or initiatives based on information from performance results, stakeholder input, and new mandates.
- ◆ Involving the public, such as the State Medicaid Advisory Committee, physicians, and others associated with the medical community at large, and other State agencies.
- ◆ Frequently evaluating the quality strategy to ensure that it remains aligned with new federal and State regulations/mandates, programs, funding, technologies, and opportunities for improvement.

### ***Operational Performance Standards***

At least every three years, AHCCCS reviews Contractor performance in complying with standards in a number of performance areas to ensure Contractor compliance with Medicaid managed care act requirements and AHCCCS contract standards. AHCCCS conducts ORs and reviews Contractor deliverables to meet the requirements of the Medicaid managed care regulations (42 CFR 438.364). AHCCCS also conducts the reviews to determine the extent to which each Contractor complied with other federal and State regulations as well as AHCCCS contract requirements and policies. As part of the ORs, AHCCCS staff review Contractor progress in implementing recommendations made during prior ORs and determine each Contractor's compliance with its own policies and procedures.

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

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

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

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

### ***Performance Improvement Project Requirements and Targets***

AHCCCS' QAPI strategy described the agency's requirements and processes to ensure that Contractors conduct PIPs, which the QAPI defined as "a planned process of data gathering, evaluation, and analysis to design and implement interventions or activities that are anticipated to

have a positive outcome”—i.e., to improve the quality of care and service delivery. AHCCCS encourages its Contractors to conduct PIPs for topics that they select (e.g., increasing screening of blood lead levels for children, improving timeliness of prenatal care.). However, AHCCCS also selects PIPs that the Contractors must conduct.

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

## 3. Description of EQR Activities

### Mandatory Activities

As permitted by CMS and described in Section 1, Executive Summary, AHCCCS performed the functions associated with the three CMS mandatory activities for its ALTCS EPD and DES/DDD Contractors and contracted with HSAG to perform the third mandatory activity as noted below:

- ◆ Validate Contractor PIP (as described in further detail in Section 7 of this report, AHCCCS elected to close the Contractor PIP mid-cycle and therefore did not validate the PIP).
- ◆ Validate Contractor performance measures—Performance measurement rates for CYE 2013 have been calculated, but the data were under review at the time this report was written. CYE 2013 and 2014 performance measurement rates, as well as the associated findings and recommendations, will be included in the annual 2015–2016 EQR technical report.
- ◆ Review Contractor performance in complying with the AHCCCS contract requirements and the federal Medicaid managed care regulations cited at 42 CFR 438.358—Review performed by AHCCCS.

### 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 AHCCCS conducted.

### Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

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

AHCCCS uses the information to assess the effectiveness of its current goals and related strategies and to provide a road map for potential changes and new goals and strategies.

### AHCCCS Quality Initiatives

AHCCCS continued to demonstrate innovative, collaborative approaches to managing costs while improving quality of systems, care, and services. Its documentation, including the Quarterly Quality Assurance/Monitoring Activity Reports, 2015–2019 Strategic Plan, and October 2012 Quality Assessment and Performance Improvement (QAPI) Strategy provided compelling evidence of AHCCCS’ vision and leadership in identifying and proactively pursuing opportunities to improve access to, and the quality and timeliness of, care and services; and member health outcomes.

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

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

Some of the key accomplishments AHCCCS highlighted in its quality plan include the following:

- ◆ Made significant progress pursuing long-term strategies to bend the healthcare cost curve while improving quality outcomes and care coordination, including such strategies as:
  - Continued emphasis on care coordination and other opportunities to keep costs down.
  - System alignment and integration for three unique populations (seriously mentally ill, children’s rehabilitation services, and dual-eligible members).
- ◆ Payment modernization— Conducted demonstrations with Contractors and providers in support of payment models designed to improve alignment with incentives.
- ◆ Exchange—Addressed Medicaid coordination, including extensive analysis of its IT infrastructure and efforts to move toward developing a state exchange and Medicaid expansion.
- ◆ Following CMS approval for the Medicaid Health Integration Technology (HIT) Plan, continued processing payments to eligible hospitals and providers and continued to serve on the Health-e Connection Board and the Health Information Network of Arizona Board. AHCCCS also entered into an agreement with the Health Information Network of Arizona (HINAz) to begin using its Health Information Exchange (HIE) services.

- ◆ Healthcare reform modernization—Participated with other state government agencies in developing the necessary infrastructure to manage a State Insurance Exchange while also pursuing opportunities to ensure coordination of care between the Medicaid program and those plans that participate in the exchange in order to manage utilization and transition of care.
- ◆ Worked collaboratively with the Arizona Association of Health Plans (AZAHP) representing the organizations that contract with AHCCCS to create a new Credentialing Alliance (CA) aimed at making the credentialing and recredentialing process easier for providers through eliminating duplication of efforts and reducing administrative burdens. Prior to establishing the CA, providers had to apply for credentials with each Contractor, whereas with the CA, providers need only apply for credentialing/recredentialing once and their status is accepted by all AHCCCS Contractors.

### **Selecting and Initiating New Quality Improvement Initiatives**

AHCCCS further enhanced its quality and performance improvement approach in working with Contractors by selecting and initiating new quality improvement initiatives. AHCCCS has established an objective, systematic process for identifying priority areas for improvement and selecting new performance measures and PIPs. This process involves a review of data from both internal and external sources, while also taking into account factors such as the prevalence of a particular condition and population affected, the resources required by both AHCCCS and Contractors to conduct studies and effect improvement, and whether the areas are current priorities of CMS or State leadership and/or can be combined with existing initiatives. AHCCCS also seeks Contractor input in prioritizing areas for improvement.

In selecting and initiating new quality improvement initiatives, AHCCCS:

- ◆ Identified priority areas for improvement.
- ◆ Established realistic, outcome-based performance measures.
- ◆ Identified, collected, and assessed relevant data.
- ◆ Provided incentives for excellence and imposed financial sanctions for poor performance.
- ◆ Shared best practices with, and provided technical assistance to, the Contractors.
- ◆ Included relevant, associated requirements in its contracts.
- ◆ Regularly monitored and evaluated Contractor compliance and performance.
- ◆ Maintained an information system that supported initial and ongoing operations and review of AHCCCS' quality strategy.
- ◆ Conducted frequent evaluation of the initiatives' progress and results.

### **Collaboration/Initiatives**

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

- ◆ Center for Medicaid and CHIP Services (CMCS) Maternal and Infant Health Initiative: Postpartum Care Action Learning Series: The AHCCCS Clinical Quality Management (CQM) Unit applied and was selected to participate in this initiative. This initiative involves a rapid-cycle improvement project aimed at increasing the rate of postpartum visits as well as enhancing the family planning content discussed during those visits. As part of this initiative, AHCCCS CQM has formed an Arizona team which includes a pilot site, health plan representatives, and an obstetrician.
- ◆ Center for Health Care Strategies—Oral Health Initiative: The focus of this seven-state collaborative is twofold: to increase the rate of preventive dental care for children under the age of 21 and to increase the sealant rate for children ages 6–9. AHCCCS has formed a collaborative workgroup to drive these improvements across the State; all AHCCCS Contractors have agreed to share data and implement interventions relevant to this initiative.
- ◆ Arizona Department of Health Services Immunization Program: AHCCCS continues to collaborate with the Arizona Department of Health Services (ADHS) to ensure efficient and effective administration and oversight of the federal Vaccines for Children (VFC) Program. VFC Program representatives provide education to Contractors, regular notifications to AHCCCS regarding vaccine-related trends and issues, and updates regarding the Arizona State Immunization Information System (ASIIS).
- ◆ Genetic Testing Work Group: AHCCCS is collaborating with its Contractors to determine the appropriate genetic testing processes for AHCCCS members when medically necessary.
- ◆ Nutrition: AHCCCS facilitated a member nutrition work group which included efforts around coverage for adults and individuals with special healthcare needs, regardless of age. The goal is to expand access to nutrition services for members and is supported by AHCCCS Contractors.
- ◆ Arizona and Maricopa County Asthma Coalitions: AHCCCS is collaborating with ADHS, the Department of Economic Security (DES), community agencies, and organizations to identify and provide quality improvement resources to Contractors that can be used to support optimal health outcomes among members with asthma and other respiratory diseases.
- ◆ Tobacco Cessation: AHCCCS is collaborating with the ADHS Bureau of Tobacco and Chronic Disease to monitor the utilization of smoking cessation drugs and nicotine replacement therapy programs. Members are encouraged to participate in the smoking support cessation groups offered by ADHS.
- ◆ Arizona Early Intervention Program (AzeIP): AHCCCS collaborates with AzeIP, a program that is administered by DES. The program seeks to facilitate early intervention services for children under 3 years of age to ensure they receive timely access and availability of services.
- ◆ Arizona Health-e Connection/Arizona Regional Extension Center: Arizona Health-e Connection (AzHeC) is a public-private community agency geared toward promotion of and provider support for electronic health record (EHR) integration into the healthcare system. AzHeC is a key partner with AHCCCS in promoting the use of health information technology (HIT) as well as Arizona's health information exchange (HIE). As a subset of AzHeC, the Arizona Regional Extension Center (REC) provides technical assistance and support to Medicare and Medicaid eligible professionals who are working to adopt, implement, or upgrade (AIU) an EHR in their practice and/or achieve Meaningful Use in order to receive monetary payments through state (Medicaid) and national (Medicare) EHR incentive programs. The long-term goal is to be able

to use this technology for quality improvement purposes and to improve outcomes for AHCCCS members.

### ***Continuing or New AHCCCS Actions and Collaborative Initiatives to Improve Performance for the ALTCS EPD and DES/DDD Contractors***

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

- ◆ Agency with Choice: AHCCCS has developed and implemented a new member-directed option—Agency with Choice. This option is available to ALTCS members who prefer to reside in their own home. The member and provider agency enter into a formal partnership agreement that allows the provider agency to act as the legal employer of the Direct Care Worker and the member serves as the day-to-day managing employer. AHCCCS is planning to develop and implement a case manager refresher training program to ensure case managers are able to support members in making informed choices about the member-directed option, as well as a provider assessment tool to help providers and Contractors assess whether or not the provider agency is fulfilling its roles and responsibilities. AHCCCS is also developing performance indicators for Contractors.
- ◆ Direct Care Workforce Development: AHCCCS participates in a work group that studies the issues of the direct care workforce and provides recommendations regarding potential strategies to improve the workforce. In CYE 2013, AHCCCS and its Contractors initiated audits of the Approved Direct Care Worker Training and Testing Programs to ensure the programs were in compliance with AHCCCS standards. In addition, AHCCCS has developed an online database to serve as a tool to support the portability of Direct Care Worker testing records from one employer to another employer. AHCCCS is also in the process of developing quality of care measures that may be used to assess the impact of the new competency and training standards pertaining to member satisfaction, hospitalization re-admittance, and incident reports.
- ◆ Arizona Dementia Coalition: AHCCCS collaborates with this partnership composed of the thought leaders in the treatment of dementia. The group discusses barriers and interventions to reducing the use of antipsychotics in nursing homes. Fifty nursing homes across the State have agreed to participate in this work. AHCCCS and its Contractors provide de-identified data related to this initiative and work with stakeholders to develop effective interventions.
- ◆ Injury Prevention Advisory Council: AHCCCS participates in an internal work group led by ADHS, in cooperation with the Centers for Disease Control, to develop injury surveillance and control processes. The work group has developed the Arizona Injury Surveillance and Prevention Plan.
- ◆ A demonstration grant for Testing Experience and Functional Assessment Tools (TEFT) is designed to test quality measurement tools and demonstrate e-health in Medicaid long term care services and supports. AHCCCS was awarded the TEFT grant funding on April 1, 2014. The funding will conclude on March 31, 2018, with year one designated to plan and complete work plans outlining all components, which will map the implementation phase for Years two through four. AHCCCS was awarded \$343,000 for the first year and will be eligible to receive a non-competitive grant award up to a total of \$3.5 million for years two through four. The

purpose of the TEFT grant is to support states in furthering adult quality measurement activities under section 2701 of the Patient Protection and Affordable Care Act. The TEFT grant advances the development of two national, rigorously tested tools that can be used across all beneficiaries using Community-Based Long Term Services and Supports (CB-LTSS), an area in need of national measures. Additionally, the grant offers funding and technical support to demonstrate the use of a Personal Health Record (PHR) and test new electronic standards for interoperability among long term services and supports data.

## 5. Contractor Best and Emerging Practices

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

### Bridgeway Health Solutions (BHS)

- ◆ **Transition Care Program:** BHS developed a Transition of Care program, which includes a post-discharge assessment within 72 hours of discharge, communication with a PCP once the member is discharged from the hospital, and assistance with scheduling an appointment with the member's PCP within 7–10 days of discharge.
- ◆ **Member Advisory Council:** BHS's Member Advisory Council was implemented during 2007 to participate in providing input on policy and programs and to promote a collaborative effort to enhance the service delivery system in local communities while maintaining a member focus. The purpose of the council is to help facilitate the quality and effectiveness of medical, behavioral, skilled nursing facility, and home and community-based services (HCBS) delivered to BHS members, and provide a forum for providers and members to have a "meaningful voice" in the development of BHS's delivery model. The Member/Provider Advisory Council is a service-based council reporting through the Quality Management/Performance Improvement Committee and meets quarterly.
- ◆ **Prior Authorization Processes:** BHS has made several changes in its prior authorization process to improve utilization. For example, BHS has begun to require prior authorization for Quantitative Drug Testing for Drugs of Abuse or Molecular Diagnostic Testing and Specialty Radiation Services. Although it was determined that utilization of these tests is not high, the costs are very high when they are utilized. In addition, BHS adopted the CPT/HCPCS code-driven Durable Medical Equipment (DME) prior authorization requirement. This list is reviewed annually, and certain codes are added or removed.
- ◆ **Care Coordination/Case Management Teams:** BHS uses Care Coordination/Case Management Teams that are composed of a nurse case manager (NCM), program coordinator (PC), and LTC case manager. This approach allows non-medical personnel to perform the nonclinical-based health service coordination and clerical functions and permits the nurse case manager to focus on the more complex and clinically based service coordination needs. Identification of members is through direct referral and Impact Pro, BHS's predictive modeling tool. Specific triggers alert the medical management team to conduct a more in-depth assessment to determine if clinical case management is indicated. In addition, BHS has a nurse transplant coordinator and has also identified a nurse to monitor members with hepatitis C who are taking high-cost medications.
- ◆ **Partnership to Improve Dementia Care:** BHS collaborates with stakeholders in the Partnership to Improve Dementia Care. BHS has five participating staff members involved in meetings and trainings to support the initiative, including the medical director, vice president of case management, consulting psychiatrist, and behavioral health coordinators. Staff members at INSPIRIS, a healthcare management company, held two trainings for their prescribing staff on

the initiative and the importance of gradual dose reductions. INSPIRIS also reviewed involved members, coordinated with psychiatric prescribers, and provided quarterly updates to BHS regarding antipsychotic medication reduction trials.

## **Mercy Care Plan (MCP)**

- ◆ **Health Risk Assessment:** MCP distributes a health risk assessment (HRA) tool to all new members who are age 1 or older. Surveys are mailed within two weeks of enrollment to new members (or the parents/guardians of new members under the age of 18). Members are identified through an automated data extraction and validation process. The type of survey mailed depends on the age of the member. Members over the age of 18 receive a survey with items appropriate for adults. Members under the age of 18 receive a survey with items appropriate for a child. A self-addressed stamped envelope is enclosed for the member to use when returning the assessment. A toll-free phone number is available for members to call the ICM department if they have questions regarding the survey.
- ◆ **Case Management Services:** MCP provides case management services to ALTCS members. MCP case managers assess all members to determine needed placement and long-term care services. Case managers regularly conduct on-site visits with members to monitor and assess their needs and to evaluate the quality of services provided by any service providers. A case manager initiates contact with each member to identify new or ongoing unmet needs. The information gathered guides the case manager to assist members in accessing appropriate and timely care which includes medical and preventive health services, behavioral health services, and social services. Case managers then work to coordinate access to the identified services, and promote member understanding and involvement in personal health management. Manager continues follow-up after discharge to help prevent an avoidable readmission.
- ◆ **MCP is actively participating in the AzAHP ERx Workgroup,** which is a group of plan representatives who have come together to collaborate to increase the rate of e-prescribing (ERx) within the AHCCCS program and the State of Arizona. As part of the AzAHP ERx Workgroup, MCP will use data mining to identify opportunities, and then complete member and provider education and targeted provider assistance to increase ERx. The opportunities identified will vary in terms of need, scope, and impact. The work group will prioritize the opportunities and use its combined resources as well as outside resources (such as AzHeC) when necessary. The goal is to realize a 20 percent increase per plan in this first year of the initiative while identifying and planning for years two and three (longer term) opportunities. MCP does not propose any payment incentive or disincentive relating to ERx in this first year of the initiative. However, MCP will provide plan-specific incentives to encourage ERx in its patient-centered medical homes (PCMHs) and Arizona Care Network (ACN) providers. Improvements in ERx will be one of MCP's performance measures for 2015 with targets and rewards varying by practice based on baseline and actual practice performance.

## **UnitedHealthcare LTC (UHCCP)**

- ◆ **Post-hospital Assessment:** UHCCP LTC case managers complete an on-site post-hospital assessment (PHA) within two days of notification that a member has been discharged from an

inpatient stay. This assessment is completed for both dual and non-dual members living at home in the community or in an assisted living facility. The assessment includes evaluation of the reason the member was hospitalized; review of discharge instructions and orders; identification of status of follow-up care including assistance with making appointments for any specialist appointments and/or PCP follow-up appointment; assistance with instructions for labs, therapies, or DME needs; evaluation of the member's understanding of those orders or instructions; medication changes including member understanding of the reason for a medication change; review of triggers associated with warning signs for exacerbation of existing or new conditions; review of advance directive status; and an evaluation of current services and the adequacy of those services to meet the member's current needs.

- ◆ Preventative Care Program: UHCCP LTC's Preventive Care Program is an outreach program serving UnitedHealthcare Community Plan's long-term care members. Staff develops partnerships with community and state agencies for health promotion on a community-wide scale. Through these partnerships, multiple resources are linked to enhance member and provider educational efforts. These resources may also be used to coordinate services and/or to identify additional means of contact for hard-to-reach members.
- ◆ UnitedHealthcare LTC found that primary care physicians (PCPs) were continuing nursing orders after the member had his or her needs met, as a result of monitoring authorization patterns and researching member-specific authorizations. To improve this situation, UnitedHealthcare LTC established a role for a nurse case manager to manage all nursing orders and the authorization of and coordination of services. The nurse contacts the PCP directly, discusses the member's situation, and confirms the reason for the service with the PCP. She also obtains the home health agency (HHA) documentation to reconcile it with the discussion with the PCP. In many cases UnitedHealthcare LTC has found that the PCP was just responding to the HHA request without probing for additional member information.
- ◆ UnitedHealthcare LTC implemented a shared savings program during CYE 2014, involving five skilled nursing facilities, two assisted living centers, and three home and community-based service (HCBS) providers. Participating providers represented both urban and rural membership. The focus of the program was geared toward reducing emergency room utilization, inpatient admissions and readmissions, and increased member compliance with obtaining diabetic preventive health screenings and influenza vaccinations. Providers had the opportunity to select the identified quality and utilization goals on which they wanted to focus. Monthly joint operations committee meetings were conducted with each provider. Attendees for the meetings included the provider staff and UnitedHealthcare LTC network, case management and quality staff, and health plan medical directors. During these meetings, both progress toward goals and a review of barriers and solutions to identified issues were reviewed. Many positive outcomes were realized with this program.

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

- ◆ DES/DDD's chief medical officer, along with the health care services administrator, chair a quarterly health plan meeting with each of the health plans to review and evaluate performance of delegated activities. The Quality Management representative is in attendance. Health plans

are required to submit data on quality and utilization review activities prior to each meeting, and any problems or trends noted are discussed with the health plan representatives during these meetings. A follow-up letter, reviewing the data presented, is then forwarded to the health plan when trends are identified or concerns are noted. Any trend development will be addressed during the meeting and reviewed in the follow-up letter.

- ◆ DES/DDD will monitor, through the annual operational review, the subcontracted health plans as well as the DBHS, when applicable, to ensure a process has been established to ensure that a “best effort” attempt has been made to conduct an initial health assessment of each member’s healthcare needs, including follow-up on unsuccessful attempts to contact a member within 90 days of the effective date of enrollment. The division will further monitor to assure that the health plan has a process in place to use health assessment results to identify individuals with special healthcare needs and to coordinate care.
- ◆ DES/DDD’s Incident Management System (IMS) is central to the determination of the level of severity of quality of care issues and is essential to the Quality Management Committees and the care concern resolution process. The computerized IMS database provides a platform for (a) the reporting and input of incidents, (b) tracking the notification of key personnel and agencies, (c) the assignment of personnel to fact-find incidents, and (d) the tracking of incidents to closure. The IMS is also critical for incident trending and analysis.
- ◆ DES/DDD’s ALTCS specialists and Quality Assurance staff assist with review and monitoring of long-term care services requirements within each district. Staff members conduct monitoring reviews of residential group home placements, day program settings, transportation agencies, adult/child developmental homes, and home and community-based services (HCBS) in conjunction with the DDD Central Office monitors and OLCR. Staff members have experience in providing services to members, having been support coordinators, program monitors, licensed practical nurses, or direct care staff. They also have training in incident management, ALTCS requirements, support coordination, care concern resolution, fact finding, and other training topics that support quality improvement.
- ◆ DES/DDD’s Health Care Acquired Conditions Reporting and Monitoring policy and procedure is intended to improve the administration of a systematic process of identification, reporting, and analysis of health care-acquired conditions (HCACs). The health plans are required to identify and report HCACs for DDD members to Health Care Services (HCS). HCS reviews the reported inpatient acute admissions tracking for potential cases of HCAC independently of each health plan. The division under HCS also tracks and case manages pressure ulcer incidents that are evaluated as potential HCACs.
- ◆ DES/DDD has begun to evaluate emergency department (ED) “super utilizers” and make efforts to improve the utilization of services and quality of care for these members. DES/DDD has used different approaches to improve this area. A Clinical Staffing meeting is chaired by the chief medical officer, where most of the super utilizer cases are presented usually by both the district nurse and support coordinator. The medical director has made home visits to several members where questionable competency was noted during the clinical staffing meetings. Some cases have resulted in care conferences with the individual health plans or behavioral health providers to ensure resolution of issues. Staffing meetings on-site with the members and managed risk agreements have been successful in working on members’ unmet needs.

## 6. Organizational Assessment and Structure Performance

According to 42 CFR 438.358, which describes activities related to external quality reviews, a state Medicaid agency, its agent that is not an MCO or PIHP, or an EQRO must conduct a review within a three-year period to determine MCO and PIHP compliance with state standards. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described at 42 CFR 438 that address requirements related to access, structure and operations, and measurement and improvement. AHCCCS meets the requirement by conducting operational reviews (ORs) of its Contractors' performance in complying with federal and AHCCCS' contract requirements, ensuring that it reviews each requirement at least once every three years.

AHCCCS has extensive experience preparing for, conducting, and reporting findings from its reviews of Contractors' performance in complying with federal and AHCCCS requirements. As permitted by 42 CFR 438.258(a), AHCCCS elected to conduct the functions associated with the Medicaid managed care act mandatory compliance review activity. In accordance with, and satisfying, the requirements of 42 CFR 438.364(a)(1-5), AHCCCS then contracted with HSAG as an EQRO, to use the information AHCCCS obtained from its compliance review activities to prepare this 2014–2015 annual external quality review report.

### Conducting the Review

CYE 2013 commenced a new, three-year cycle of ORs, and AHCCCS conducted ORs for all ALTCS contractors during CYE 2014. ORs were most recently conducted for these contractors during CYE 2012. Two contractors offering more than one line of business, Mercy Care Plan and UnitedHealthcare Community Plan, received an OR during CYE 2014 for each line of business; however, only the results pertaining to the ALTCS standards are presented here.

Because of the population served, AHCCCS conducts ORs for the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) annually. AHCCCS completed a full OR for DES/DDD early in CYE 2014, and the results of this OR were reported in the previous external quality review (EQR) annual report.

The CYE 2014 review assessed Contractors' performance in the following categories:

- ◆ Case Management—(8 standards)
- ◆ Claims and Information Systems—(13 standards)
- ◆ Delivery Systems—(8 standards)
- ◆ Encounters—(1 standard)
- ◆ General Administration—(9 standards)
- ◆ Grievance Systems—(17 standards)
- ◆ Maternal and Child Health and EPSDT—(13 standards)
- ◆ Medical Management—(15 scored standards and 1 standard for information only)
- ◆ Member Information—(8 standards)

- ◆ Quality Management—(26 scored standards and 1 standard for information only)
- ◆ Reinsurance—(4 standards)
- ◆ Third-Party Liability—(8 standards)

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

AHCCCS' objectives for conducting the OR were to:

- ◆ Determine if the Contractors satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR).
- ◆ Increase AHCCCS' knowledge of the Contractors' operational encounter processing procedures.
- ◆ Provide technical assistance and identify areas where Contractors can improve, as well as areas of noteworthy performance and accomplishments.
- ◆ Review Contractors' progress in implementing recommendations AHCCCS made during prior ORs.
- ◆ Determine if the Contractors complied with their own policies and evaluate the effectiveness of those policies and procedures.
- ◆ Perform oversight of the Contractor as required by CMS in accordance with AHCCCS' 1115 waiver.
- ◆ Provide information to HSAG as AHCCCS' EQRO to use in preparing this report as described in 42 CFR 438.364.

HSAG designed a summary tool to organize the information AHCCCS presents in the individual Contractor reports documenting each Contractor's performance in complying with the operational standards. Additionally, this summary tool facilitated a comparison of the Contractors' performance.

The summary tool focused on HSAG's analytic objectives, which were to:

- ◆ Determine each Contractor's compliance with standards established by the State to comply with the requirements of the AHCCCS contract and 42 CFR 438.204(g).
- ◆ Analyze data from the review of each Contractor's compliance with the standards, allowing HSAG to draw conclusions as to the quality and timeliness of, and access to, care and services furnished to members by individual Contractors and statewide, across Contractors.
- ◆ Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and across Contractors.

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

While AHCCCS reviews the operational performance of the Contractors throughout the year, it also conducts formal reviews on a schedule that ensures it reviews all applicable CMS and AHCCCS

contract requirements at least once every three years. AHCCCS conducts the ORs consistent with CMS' protocol for EQROs that conduct the reviews.<sup>6-1</sup>

AHCCCS conducted an extensive review of Contractor performance in meeting standards. AHCCCS provided the Contractors with: (1) a detailed description of the contract requirements and expectations for each of the standards that AHCCCS would review, and (2) a list of documents and information that was to be available to AHCCCS for its review during the OR process.

AHCCCS' methodology was consistent across all Contractors and included the following:

- ◆ Review activities that AHCCCS conducted to assess the Contractor's performance, including:
  - Reviewing documents and deliverables the Contractor was required to submit to AHCCCS.
  - Conducting interviews with key Contractor administrative and program staff. Reviews generally required three to four days, depending on the extent of the review.

Activities AHCCCS conducted following the review, including:

- Documenting and compiling the results of its reviews, preparing the draft reports of findings, and issuing the draft reports to the Contractors for their review and comment. In the report, each standard and substandard was individually listed with the applicable performance designation based on AHCCCS' review findings and assessment of the degree to which the Contractor was in compliance with the standards. Performance designations were as follows:
  - Full compliance (FC): 90 percent to 100 percent compliant
  - Substantial compliance (SC): 75 percent to 89 percent compliant
  - Partial compliance (PC): 50 percent to 74 percent compliant
  - Noncompliance (NC): 0 percent to 49 percent compliant
  - Not Applicable (N/A): Standard was not applicable to UHCCP-CRS
  - Information Only (IO): Standard was assessed for information only
- The reports sent to the Contractors also included, when applicable, any AHCCCS recommendations, which began with one of the following three phases:
  - *The Contractor must* .... This statement indicates a critical noncompliant area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
  - *The Contractor should* .... This statement indicates a noncompliant area that must be corrected to be in compliance with the AHCCCS contract but is not critical to the day-to-day operation of the Contractor.
  - *The Contractor should consider* .... This statement is a suggestion by the review team to improve the operations of the Contractor but is not directly related to contract compliance.
- ◆ Reviewing and responding to any Contractor challenges to AHCCCS' draft report findings and, as applicable based on AHCCCS' review of the challenges, revising the draft reports.

<sup>6-1</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: February 26, 2015.

- ◆ Preparing and issuing the final Contractor reports describing the findings, scores, and, as applicable, required Contractor CAPs for each standard AHCCCS reviewed.

AHCCCS' review team members for ALTCS standards included employees of the Division of Health Care Management (DHCM) Acute Care Operations, ALTCS Operations, Reinsurance, Data Analysis and Research, Medical Management and Clinical Quality Management, and the Office of Administrative Legal Services.

AHCCCS' review activities complied with the CMS requirement to assess each Contractor on the extent to which it addressed the recommendations for quality improvement AHCCCS made as a result of its findings from the previous year's review. Fundamental to this process, AHCCCS requires its Contractors to propose formal CAPs, and have the CAPs accepted by AHCCCS, for deficiencies in the Contractor's performance that AHCCCS identified as part of its ongoing monitoring and/or formal annual OR processes.

From its review of the Contractors' CAPs and associated documentation, AHCCCS determines if:

- ◆ The activities and interventions specified in the CAPs could reasonably be anticipated to correct the deficiencies AHCCCS identified during the OR (or other monitoring activity) and bring the Contractor back into compliance with the applicable AHCCCS standards.
- ◆ The documentation demonstrates that the Contractor had implemented the required action(s) and is now in compliance with one or more of the standards requiring a CAP.
- ◆ Additional or revised CAPs or documentation are still required from the Contractor for one or more standards and if the CAP process remains open and continuing.

AHCCCS follows up on each Contractor's implementation of the CAPs and related outcomes during its ongoing monitoring and oversight activities as well as during future ORs. These activities determine whether the corrective actions were effective in bringing the Contractor back into compliance with AHCCCS requirements.

As needed throughout the preparation of this report, AHCCCS clarified any remaining questions regarding the accuracy and completeness of the data and information that HSAG used to prepare this 2014–2015 annual report.

Using the verified results AHCCCS obtained from conducting the ORs, HSAG organized and aggregated the performance data and the required CAPs for each Contractor and across Contractors. HSAG then analyzed the data by performance category (e.g., Quality Management and Delivery Systems) and by each standard within a category.

Based on the analysis, HSAG drew conclusions about the quality and timeliness of, and access to, care and services provided by each Contractor and statewide across ALTCS EPD Contractors. HSAG identified data-driven Contractor performance strengths and, where applicable, opportunities for improvement. When HSAG identified opportunities for improvement, it also provided recommendations to improve the quality and timeliness of, and access to, the care and services Contractors provided to AHCCCS members.

## Contractor-Specific Results

### Bridgeway Health Solutions (BHS)

Bridgeway Health Solutions (BHS) has contracted with AHCCCS since 2006 for the ALTCS EPD population.

### Findings

Figure 6-1 presents the overall compliance results (i.e., the far-left bar, labeled “Overall”) and the results for each of 12 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-1—Categorized Levels of Compliance with Technical Standards for BHS<sup>6-2</sup>

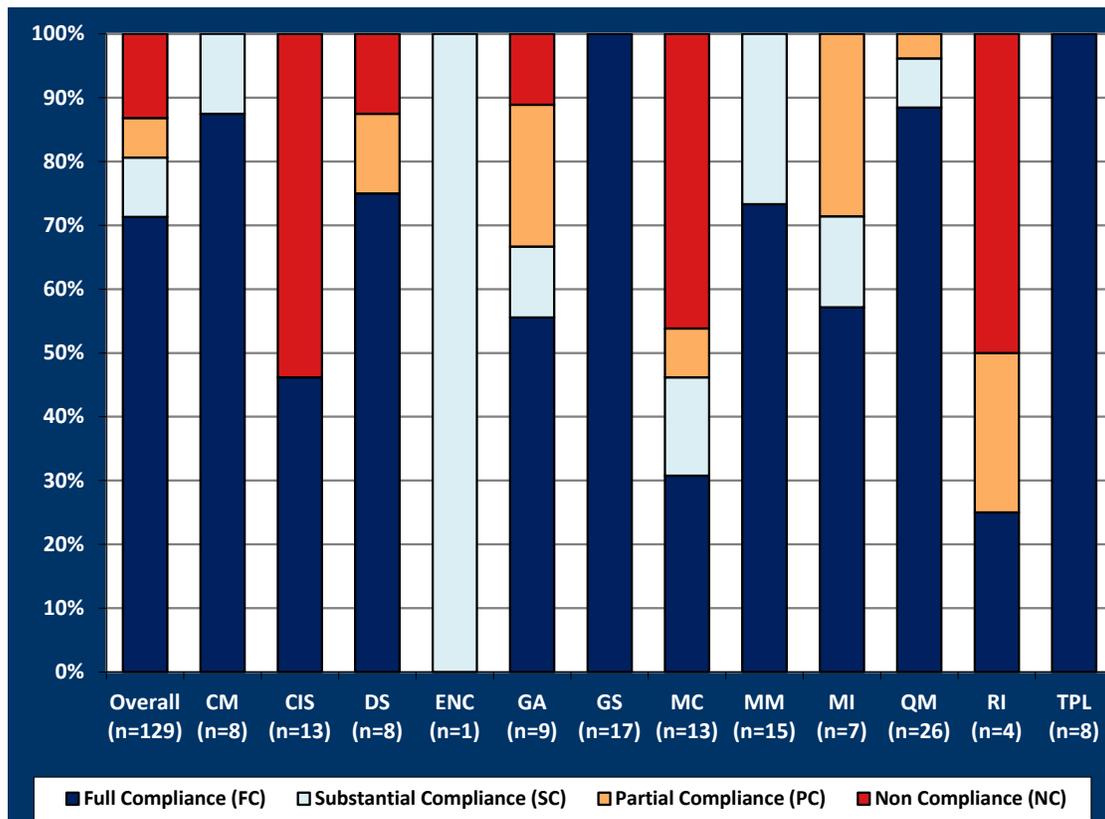


Figure 6-1 shows that BHS was in full compliance for 71.3 percent of the 129 reviewed standards, with a large variation in performance across the categories of standards. The

<sup>6-2</sup> The compliance categories are abbreviated as follows: CM=Case Management, CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

Contractor’s strongest performance was for the standards associated with the Third-Party Liability and Grievance Systems categories. AHCCCS scored these categories fully compliant for all related standards.

Of the 12 categories of standards, the Encounters category showed the lowest percentage of standards in full compliance (0.0 percent). However, the small number of standards within this category (i.e., one) could have influenced this result. BHS had five categories with standards scored as noncompliant (Claims and Information Systems, Delivery Systems, General Administration, Maternal and Child Health and EPSDT, and Reinsurance). Categories with less than 60.0 percent of the reviewed standards in full compliance included Member Information (57.1 percent), General Administration (55.6 percent), Claims and Information Systems (46.2 percent), Maternal and Child Health and EPSDT (30.8 percent), Reinsurance (25.0 percent), and Encounters (0.0 percent). Results for these categories suggest significant opportunities for improvement.

**CAPs**

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop and implement a CAP. Prior to implementation, Contractors submit their proposed CAPs to AHCCCS for review and approval. A Contractor may also be required to enact a CAP for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard, even if the overall standard is scored as fully compliant. Table 6-1 presents the number and proportion of CAPs required from BHS within and across the categories for compliance standards reviewed in CYE 2014.

<b>Category</b>	<b>Total # of Standards</b>	<b>Number of CAPs</b>	<b>% of Category Standards</b>	<b>% of Total CAPs</b>
Case Management*	8	0	0.0%	0.0%
Claims and Information Systems	13	7	53.9%	20.6%
Delivery Systems	8	2	25.0%	5.9%
Encounters	1	1	100.0%	2.9%
General Administration	9	4	44.4%	11.8%
Grievance Systems	17	0	0.0%	0.00%
Maternal and Child Health and EPSDT	13	9	69.2%	26.5%
Medical Management	15	4	26.7%	11.8%
Member Information*	7	1	14.3%	2.9%
Quality Management	26	3	11.5%	8.8%
Reinsurance	4	3	75.0%	8.8%
Third-Party Liability	8	0	0.0%	0.00%
<b>Overall</b>	<b>129</b>	<b>34</b>	<b>26.4%</b>	<b>100.0%</b>
* Though standards in these categories were less than fully compliant, AHCCCS did not require the Contractor to develop CAPs for one Case Management standard and two Member Information standards.				

Table 6-1 shows that the Contractor was required to develop CAPs for 26.4 percent of the standards reviewed during CYE 2014. BHS was required to develop at least one CAP for standards in nine of the 12 categories. However, CAPs were not required for the Case Management, Grievance Systems, or Third-Party Liability categories. The largest percentage of required CAPs was in the Encounters category; however, the small number of standards within this category (i.e., one) could have influenced this result. In addition to the Encounters category, the largest percentages of CAPs relative to the number of standards in a category were in the Reinsurance (75.0 percent), Maternal and Child Health and EPSDT (69.2 percent), and Claims and Information Systems (53.9 percent) categories.

## Strengths

BHS was in full compliance for all standards within three categories (Case Management, Grievance Systems, and Third-Party Liability), and the Contractor was not required to develop CAPs for standards in these categories. Quality Management was also considered a strength with 88.5 percent of the assessed standards scored as fully compliant.

## Opportunities for Improvement and Recommendations

The OR findings for BHS demonstrated significant opportunities for improvement, as 34 of the standards reviewed (26.4 percent) remained less than fully compliant with AHCCCS' required policies and procedures and required corrective action. The Contractor was required to develop a CAP for at least one standard in nine of the 12 categories, and five or more CAPs in two categories. Among the nine categories in which BHS was required to develop a CAP, 47.1 percent of the CAPs were clustered among two categories: Maternal and Child Health and EPSDT (nine CAPs) and Claims and Information Systems (seven CAPs), suggesting focused areas for improvement. As of May 2014, AHCCCS determined that corrective actions were completed and the CAPs were closed for four of the standards (11.8 percent).

In the report generated from the Contactor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

### ◆ **Claims and Information Systems:**

#### **Open Corrective Actions as of May 2014**

- The Contractor must ensure its remittance advices include an adequate description of all denials and adjustments, sufficient reasons for these denials and adjustments, clear delineation of the application of Coordination of Benefits, the amount paid, and accurate instructions for the submission of claim disputes and corrected claims.
- The Contractor must have AHCCCS-compliant policies and procedures for the recoupment of overpayments and adjustments for underpayments.
- The Contractor must pay applicable interest on all claims, including overturned claims disputes.
- The Contractor must ensure it pays overturned claims disputes within 15 days of the date of decision.

- The Contractor must have and document a process to train internal and subcontractor claims staff on processing claims specific to AHCCCS claims, and include nationally recognized payment methodologies such as National Correct Coding Initiative (NCCI), Multiple Procedure/Surgical Reductions, and Global Day Evaluation and Management (E & M) Bundling standards.
- The Contractor must have a process and documented procedures to accept and integrate evidence of provider registration data provided by AHCCCS into its Claims and Information Systems.
- The Contractor must ensure that its system contains correct contracted rates, and it has a process to correctly reimburse out-of-network providers in the absence of a written, negotiated rate.

◆ **Delivery Systems:**

**Open Corrective Actions as of May 2014**

- The Contractor must utilize its provider call resolution time frames when assessing staffing needs.
- The Contractor must have a mechanism to monitor appointment standards more frequently for those providers who appear on the 1800 report or who have exceeded their contracted capacity for the ALTCS/EPD line of business. The Contractor must have a process to monitor, on an on-going basis, the number of members assigned to each PCP and the PCP's total capacity (including the 1800 report, the Provider Affiliation Transmission report, and geo-mapping) for the ALTCS/EPD line of business. The Contractor must have a process in place to adjust (reduce or close) a PCP's panel when a PCP is noncompliant with AHCCCS appointment availability and wait time standards and the noncompliance is not resolved through other actions such as a corrective action plan for the ALTCS/EPD line of business.

◆ **Encounters:**

**Completed Corrective Actions as of May 2014**

- The Contractor must ensure encounters are complete, accurate, and timely, and ensure omitted and inaccurate encounters are submitted and corrected.

◆ **General Administration:**

**Open Corrective Actions as of May 2014**

- The Contractor must include reporting for acts of suspected fraud or abuse that were resolved internally but involved AHCCCS funds, Contractors or subcontractors in its processes.
- The Contractor must ensure that documentation of audit findings, including deficiencies and implementation of corrective action are tracked and documented appropriately. The

Contractor should consider adding auditing/corrective action activity to its QMPI as a standing agenda item.

- The Contractor must revise its policies to reflect that information collected regarding ownership and control of its fiscal agents, including administrative subcontractors, includes all the required information as outlined in this standard (name, address, date of birth, social security number, tax identification number of corporation with ownership or control interest, etc.)
- The Contractor must revise its policies and procedures to include that appropriate committee review and discussion takes place for policies and procedures.

◆ **Maternal and Child Health and EPSDT:**

**Open Corrective Actions as of May 2014**

- The Contractor must have an ongoing process to coordinate referrals of high-risk members to appropriate service providers to ensure that services are received that includes revising the plan of care as appropriate. The Contractor should consider utilizing the policies and procedures it utilized for its prior Acute Care line of business with AHCCCS.
- The Contractor must implement a process to monitor whether pregnant members obtain initial prenatal care appointments within the prescribed time frames according to trimester or risk. The Contractor must implement a process to monitor whether pregnant members obtain return visits in accordance with the American College of Obstetricians and Gynecologists (ACOG) standards. The Contractor should utilize the policies and procedures it utilized for its prior Acute Care line of business with AHCCCS.
- The Contractor must implement a process to ensure that both male and female members who wish to use family planning services are informed of what services are covered and how to access family planning services. The Contractor must have a process to monitor medical necessity for sterilizations of members younger than 21 years of age.
- The Contractor must implement provider and member outreach activities to increase EPSDT/Well Child participation rates. The Contractor must provide targeted outreach to members who miss/no-show for the EPSDT or dental appointments.
- The Contractor must distribute outreach material to inform members of the importance of EPSDT services that includes the topics of childhood obesity and the dangers of lead exposure.
- The Contractor must demonstrate evidence of monitoring EPSDT providers for participation in the Vaccines for Children (VFC) program including entering immunizations given to children in the ASIIS system. The Contractor must have a process for reassigning members to a new PCP when their PCP is no longer participating in the VFC program.
- The Contractor must develop and implement policies and procedures to coordinate care with community organizations and federal and state programs including Women, Infants, and Children (WIC), VFC, ASIIS, and the Head Start programs.
- The Contractor must have a process to inform providers about the Arizona Early Intervention (AZEIP) program including the need for providers to request authorization for medically necessary early intervention services from the Contractor. The Contractor must

have a process to coordinate care with AzEIP utilizing the AHCCCS/AzEIP procedure. The Contractor must monitor, evaluate, and implement interventions, as needed, aimed at reducing the number of members on a wait list for services.

- The Contractor must implement a process for transitioning a child (who is receiving nutritional therapy) to or from another Contractor, or another program. The Contractor must have a process for monitoring and implementing referrals for underweight/overweight members. The Contractor must monitor provider compliance in implementing interventions with members identified as overweight, including education and/or nutrition referral.

◆ **Medical Management:**

**Completed Corrective Actions as of May 2014**

- The Contractor should consider implementing methods to increase timeliness of concurrent reviews in accordance with the Concurrent Review Policy.
- The Contractor should consider providing policies and procedures that identify members with special healthcare needs, assure direct access to specialists, and monitor the utilization.
- The Contractor should consider including information regarding the right of the member to have services continue during the appeal process and the circumstances under which the member may be required to pay for these services.

**Open Corrective Actions as of May 2014**

- The Contractor must ensure early and appropriate discharge planning is conducted with a follow-up process to ensure all post-discharge needs are met in accordance with the new proactive discharge requirements.

◆ **Member Information:**

**Open Corrective Actions as of May 2014**

- The Contractor must develop a policy and procedure and/or a desk-level reference guide and ensure its Transportation and Prior Authorization staff has access to, and utilizes, appropriate mapping services when scheduling appointments and/or referring members to services or service providers.

◆ **Quality Management:**

**Open Corrective Actions as of May 2014**

- The Contractor should include in the credentialing process providers who are not licensed or certified, and review the performance improvement and monitoring of those providers that are being recredentialed.
- The Contractor must have policies, procedures, and audit tool requirements for PCP, Obstetric, and Behavioral Health (BH) practitioners.

- The Contractor must address and complete all elements on its audit tool.
- ◆ **Reinsurance:**

#### **Open Corrective Actions as of May 2014**

- The Contractor must develop policies and procedures for processing transplant reinsurance cases.
- The Contractor must have a process for auditing all types of reinsurance cases.
- The Contractor must develop policies and procedures for notification and processing of reinsurance overpayments.

#### **Summary**

BHS had widespread variation in its CYE 2014 OR results. Of the 129 standards reviewed, 92 were scored as fully compliant (71.3 percent). Three of the 12 categories (Case Management, Grievance Systems, and Third-Party Liability) had all respective standards scored as fully compliant, and BHS was not required to develop CAPs for any of the standards associated with these categories. Among the nine remaining categories, the Encounters, Reinsurance, Maternal and Child Health and EPSDT, and Claims and Information Systems categories represented the greatest opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

**Mercy Care Plan (MCP)**

Mercy Care Plan (MCP) has contracted with AHCCCS since 2000 for the ALTCS EPD population. AHCCCS conducted the OR in CYE 2014, concurrent with the OR for MCP’s Acute Care line of business.

**Findings**

Figure 6-2 presents the overall compliance results (i.e., the far-left bar, labeled “Overall”) and the results for each of 12 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

**Figure 6-2—Categorized Levels of Compliance with Technical Standards for MCP<sup>6-3</sup>**

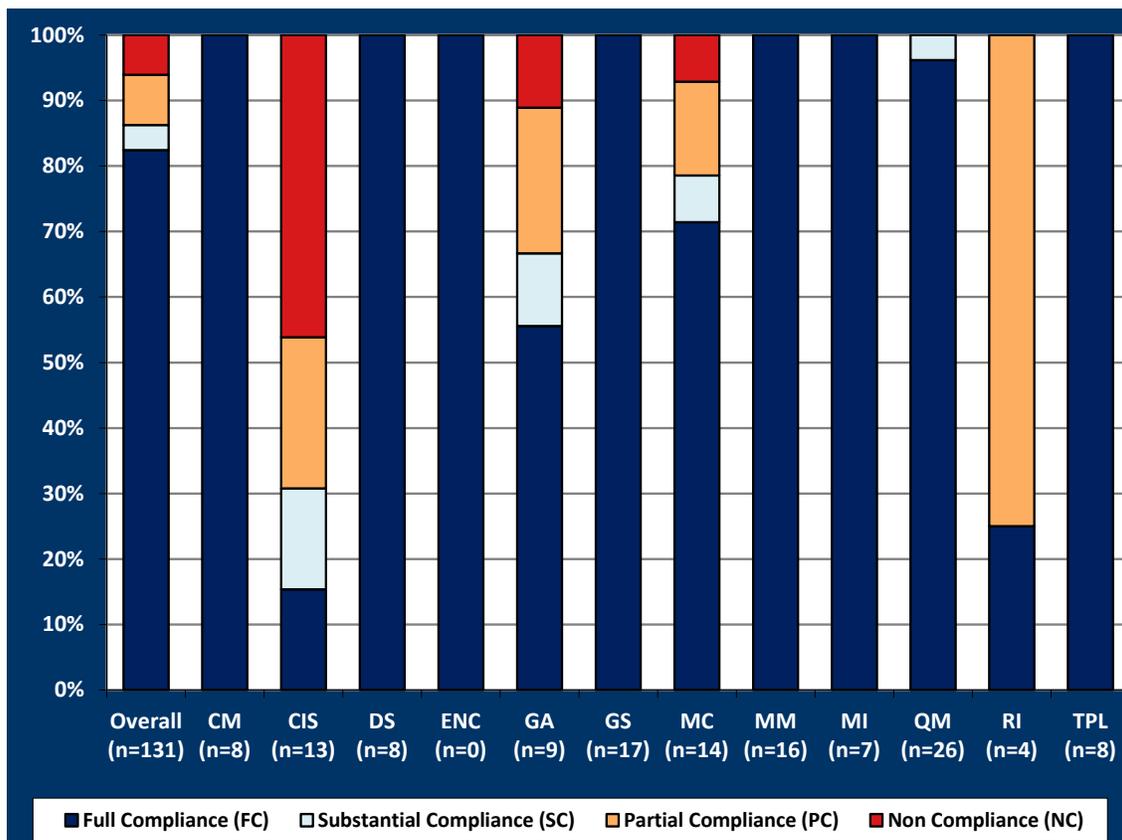


Figure 6-2 shows that MCP was in full compliance for 108 of the 131 reviewed standards (82.4 percent), with some variation in performance across the 12 categories of standards. The

<sup>6-3</sup> The compliance categories are abbreviated as follows: CM=Case Management, CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

Contractor’s strongest performance was for the standards associated with the Encounters, Delivery Systems, Case Management, Medical Management, Member Information, Third-Party Liability and Grievance Systems categories. AHCCCS scored all standards associated with these categories as fully compliant.

Of the 12 categories of standards, the Claims and Information Systems category showed the lowest percentage of standards in full compliance (15.4 percent). MCP had three categories with standards scored as noncompliant (Claims and Information Systems, General Administration, and Maternal and Child Health and EPSDT). Categories with less than 80.0 percent of the reviewed standards in full compliance included Maternal and Child Health and EPSDT (71.4 percent), General Administration (55.6 percent), Reinsurance (25.0 percent), and Claims and Information Systems (15.4 percent). Results for these categories suggest focused opportunities for improvement.

### CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop and implement a CAP. Prior to implementation, Contractors submit their proposed CAPs to AHCCCS for review and approval. A Contractor may also be required to enact a CAP for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard, even if the overall standard is scored as fully compliant. Table 6-2 presents the number and proportion of CAPs required from MCP within and across the categories for compliance standards reviewed during CYE 2014.

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Case Management	8	0	0.0%	0.0%
Claims and Information Systems	13	11	84.6%	45.8%
Delivery Systems	8	0	0.0%	0.0%
Encounters	1	0	0.0%	0.0%
General Administration	9	4	44.4%	16.7%
Grievance Systems*	17	0	0.0%	0.0%
Maternal and Child Health and EPSDT	14	4	28.6%	16.7%
Medical Management	16	0	0.0%	0.0%
Member Information	7	0	0.0%	0.0%
Quality Management**	26	2	7.7%	8.3%
Reinsurance	4	3	75.0%	12.5%
Third-Party Liability	8	0	0.0%	0.0%
<b>Overall</b>	<b>131</b>	<b>24</b>	<b>18.3%</b>	<b>100%</b>
* Though one standard in this category was fully compliant, AHCCCS provided a recommendation to the Contractor. The Contractor was not required to develop a CAP for the standard.				
** CAPs were required for selected standards within this category, although the corresponding standards were scored in full compliance.				

Table 6-2 shows that the Contractor was required to develop CAPs for 18.3 percent of the standards reviewed during CYE 2014. Three categories shared the largest number of required CAPs (19): Claims and Information Systems, General Administration, and Maternal and Child Health and EPSDT. MCP was required to develop at least one CAP for standards in five of the 12 categories. However, CAPs were not required for any standards in the Case Management, Delivery Systems, Encounters, Grievance Systems, Medical Management, Member Information, and Third-Party Liability categories. The largest percentages of CAPs relative to the number of standards in a category were in the Claims and Information Systems (84.6 percent), Reinsurance (75.0 percent), and General Administration (44.4 percent) categories.

## Strengths

MCP was in full compliance for all standards within seven categories (Case Management, Delivery Systems, Encounters, Grievance Systems, Medical Management, Member Information, and Third-Party Liability), and the Contractor was not required to develop CAPs for standards in these categories. Grievance Systems and Quality Management were recognized as strengths for the Contractor's program. MCP was not required to develop any CAPs for the 17 standards in the Grievance Systems category, and was required to develop only two CAPs for the 26 standards in the Quality Management category.

## Opportunities for Improvement and Recommendations

The OR findings for MCP demonstrated important opportunities for improvement, as 24 of the standards reviewed (18.3 percent) remained less than fully compliant with AHCCCS' required policies and procedures or required corrective actions. The Contractor was required to develop at least one CAP for standards in five of the 12 categories. MCP was required to develop 11 CAPs for the standards associated with the Claims and Information Systems category. MCP was required to develop four CAPs for the associated standards in each of two categories (General Administration and Maternal and Child Health and EPSDT), and these categories suggest targeted areas for improvement. As of January 2015, AHCCCS determined that corrective actions were completed and the CAPs were closed for seven of the standards (29.2 percent).

In the report generated from the Contactor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

### ◆ Claims and Information Systems:

#### Completed Corrective Actions as of January 2015

- The Contractor must have AHCCCS-compliant policies and procedures for the recoupment of overpayments and the adjustment of underpayments.

#### Open Corrective Actions as of January 2015

- The Contractor must ensure its remittance advice includes an adequate description of all denials and adjustments, sufficient reasons for these denials and adjustments, reflects the

accurate amount billed, and reflects the correct application of coordination of benefits and copays. Furthermore, the Contractor must ensure its system appropriately applies denial reasons to claims being denied for maximum benefits exceeded.

- The Contractor's claims payment system must edit for primary insurance coverage based on AHCCCS-supplied TPL information.
- The Contractor must pay interest on all non-hospital claims paid more than 45 days after the date of receipt of the clean submission at the rate of 10 percent per annum (calculated daily). The interest is prorated on a daily basis and must be paid by the Contractor at the time the clean claim is paid. The Contractor must pay interest on clean claims for licensed skilled nursing facilities, assisted living ALTCS, or home and community-based providers for authorized services provided to members that are not paid within 30 calendar days after the claim is received, at the rate of 1 percent per month from the date the claim is submitted. The Contractor must also ensure that its policies align with AHCCCS requirements. For all hospital claims the Contractor must pay interest at the rate of 1 percent per month for each month or portion of a month following the 60th day of receipt of the clean claim until the date of payment. The Contractor must also ensure that all claims, including Medicaid claims submitted for dual SNP members, contain an accurate received date. The Contractor must pay interest on all claim disputes as appropriate based on the date of the receipt of the original clean submission (not the claim dispute).
- The Contractor must ensure it accurately applies quick pay discounts on all hospital claims paid within 30 days of receipt of the clean claim. The Contractor must also ensure that all claims, including Medicaid claims submitted for dual SNP members, contain an accurate received date.
- The Contractor must process overturned claim disputes in a manner consistent with the claim dispute decision within 15 business days of the decision.
- The Contractor must have a claims processing manual that clearly includes the AHCCCS requirements for claims processing for all AHCCCS lines of business appropriate to the Contractor. The Contractor must have a process in place to train internal and/or subcontractor claims processing staff on the processing of claims specific to the AHCCCS lines of business. The Contractor's claims processing system must include nationally recognized methodologies to correctly pay claims including but not limited to Multiple Procedure/Surgical Reductions and Global Day E & M Bundling standards.
- The Contractor must ensure it has procedures in place to accept and integrate the eligibility and enrollment information provided by AHCCCS.
- The Contractor must ensure it accepts and integrates evidence of provider registration data provided by AHCCCS into its Claims and Information Systems and ensure denials clearly and correctly reflect the appropriate reasons for the denials.
- The Contractor must ensure its claims system has an automated process to identify resubmitted claims, and links all adjustments of a claim with the original claim.
- The Contractor must ensure its policies contain provisions for auditing at least once every five years in addition to any time a contract change is initiated, it accurately pays providers according to contracted rates, and in the absence of a written negotiated rate it accurately pays out-of-network providers.

◆ **General Administration:**

**Completed Corrective Actions as of January 2015**

- The Contractor must ensure the operational records/files are maintained for a period of five years.

**Open Corrective Actions as of January 2015**

- The Contractor must ensure that its pre-payment editing process includes member eligibility, covered services, excessive or unusual services for sex or age, duplication of services, prior authorization, invalid procedure codes, and duplicate claims. The Contractor must ensure that discussion of audit findings, including deficiencies and any implementation of corrective action where appropriate, is documented.
- The Contractor must collect required information for all persons with an ownership or controlling interest in the Contractor and its fiscal agents and determine, on a monthly basis, whether such individuals have been convicted of a criminal offense related to any program under Medicare, Medicaid, or the Title XX services program.
- The Contractor must ensure that it reviews all policies and procedures annually.

◆ **Grievance System:**

*Note:* Although MCP was not required to submit a CAP for one of the standards in this category, AHCCCS provided a recommendation to the Contractor. This standard is not included in the count of CAPs required from MCP by AHCCCS.

- The Contractor must update its Policy 3000.67 to include the missing definition and correct the Request for Expedited Hearing information to read: “The request for hearing must be received within thirty (30) days from the receipt of the appeal resolution.”

◆ **Maternal and Child Health and EPSDT**

**Open Corrective Actions as of January 2015**

- The Contractor must provide documentation demonstrating its process to monitor whether ALTCS pregnant members obtain return visits in accordance with ACOG standards.
- The Contractor must implement a process to identify postpartum depression and refer members to the appropriate healthcare providers, and provide documentation that verifies the implementation of this process.
- The Contractor must ensure that physicians and other practitioners are documenting in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services. The Contractor must have a process to monitor the medical necessity for sterilizations of members under 21 years of age.
- The Contractor should monitor provider compliance in implementing interventions with members identified as overweight, such as education and/or nutrition referrals.

◆ **Quality Management**

**Completed Corrective Actions as of January 2015**

- The Contractor must participate in appropriate community initiatives and maintain documentation of its participation.
- The Credentialing Committee decision should be documented in the provider files as indicated on the Contractor's form. The Contractor must include AHCCCS Medical Policy Manual (AMPM) Chapter 950 requirements for transportation and behavioral health residential providers. These requirements should also be reflected in the Contractor's policy.

◆ **Reinsurance**

**Completed Corrective Actions as of January 2015**

- The Contractor must include procedures to ensure services were encountered correctly.
- The Contractor must add a process to utilize its quarterly encounter void log to verify the status of the associated reinsurance encounters were processed correctly and follow the timely encounter process timeline.
- The Contractor must develop a process ensuring that it follows its procedure of monitoring the appropriateness of the reinsurance revenue received against paid claims.

**Summary**

MCP had generally positive CYE 2014 OR results. Of the 131 standards reviewed, 108 were scored as fully compliant (82.4 percent). Seven of the 12 categories (Case Management, Delivery Systems, Encounters, Grievance Systems, Medical Management, Member Information, and Third-Party Liability) had all respective standards scored as fully compliant, and MCP was not required to develop CAPs for any of the standards associated with these categories. Among the five remaining categories, the Claims and Information Systems and Reinsurance categories presented the greatest opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

**UnitedHealthcare Community Plan (UHCCP)**

UnitedHealthcare Community Plan (UHCCP) has contracted with AHCCCS since 1989 for the ALTCS EPD population, though the plan was previously referred to as Evercare Select (ES). AHCCCS conducted the OR in CYE 2014, concurrent with the OR for UHCCP’s Acute Care and Children’s Rehabilitative Services lines of business.

**Findings**

Figure 6-3 presents the overall compliance results (i.e., the far-left bar, labeled “Overall”) and the results for each of 12 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

**Figure 6-3—Categorized Levels of Compliance with Technical Standards for UHCCP<sup>6-4</sup>**

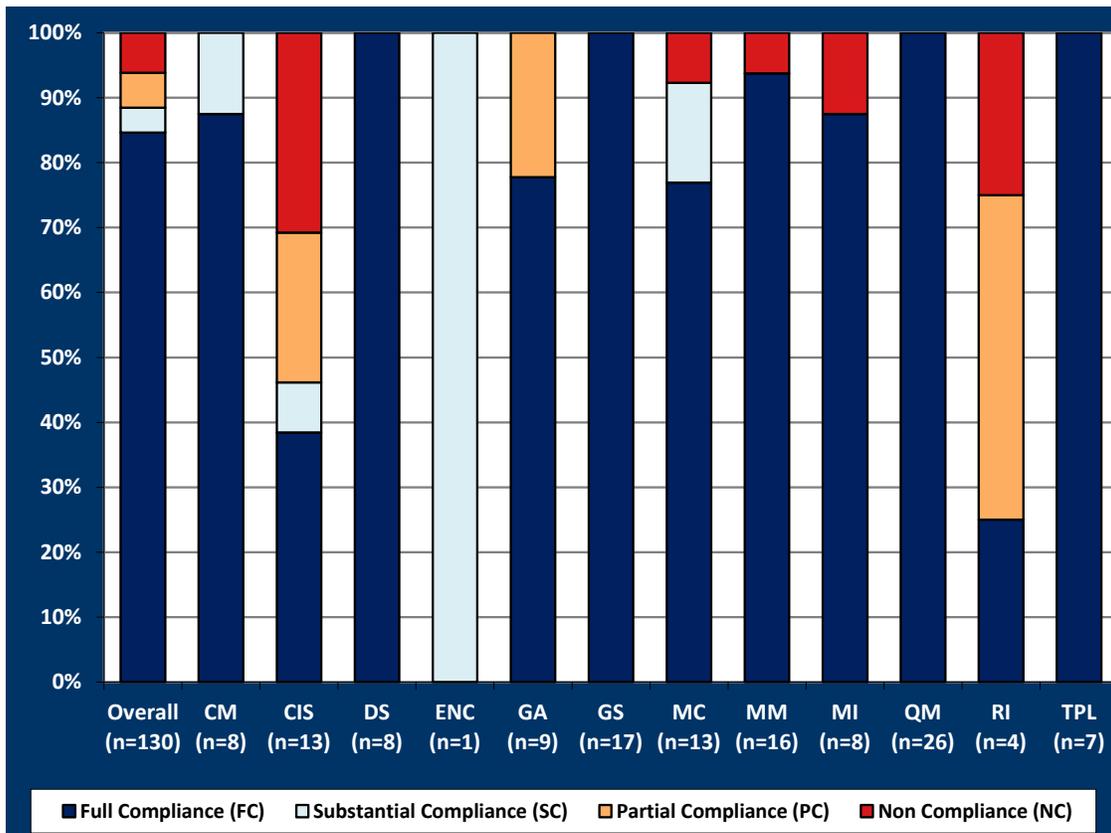


Figure 6-3 shows that UHCCP was in full compliance for 84.6 percent of the 130 reviewed standards, with a large variation in performance across the categories of standards. The Contractor’s

<sup>6-4</sup> The compliance categories are abbreviated as follows: CM=Case Management, CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

strongest performance was for the standards associated with the Delivery Systems, Grievance Systems, Quality Management, and Third-Party Liability categories. AHCCCS scored all related standards in these categories as fully compliant.

Of the 12 categories of standards, the Encounters and Reinsurance categories showed the lowest percentage of standards in full compliance. However, the small number of standards in the Encounters category (i.e., one) could have influenced this result. UHCCP had five categories with standards scored as noncompliant (Claims and Information Systems, Maternal and Child Health and EPSDT, Medical Management, Member Information, and Reinsurance). Categories with less than 80 percent of the reviewed standards in full compliance included General Administration (77.8 percent), Maternal and Child Health and EPSDT (76.9 percent), Claims and Information Systems (38.5 percent), Reinsurance (25.0 percent), and Encounters (0.0 percent). Results for these categories suggest significant opportunities for improvement.

### CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop and implement a CAP. Prior to implementation, Contractors submit their proposed CAPs to AHCCCS for review and approval. A Contractor may also be required to enact a CAP for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard, even if the overall standard is scored as fully compliant. Table 6-3 presents the number and proportion of CAPs required from UHCCP within and across the categories for compliance standards reviewed during CYE 2014.

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Case Management*	8	0	0.00%	0.00%
Claims and Information Systems	13	8	61.5%	42.1%
Delivery Systems	8	0	0.0%	0.0%
Encounters	1	1	100.0%	5.3%
General Administration	9	2	22.2%	10.5%
Grievance Systems	17	0	0.0%	0.0%
Maternal and Child Health and EPSDT**	13	3	23.1%	15.8%
Medical Management	16	1	6.3%	5.3%
Member Information	8	1	12.5%	5.3%
Quality Management	26	0	0.0%	0.0%
Reinsurance	4	3	75.0%	15.8%
Third-Party Liability	7	0	0.0%	0.0%
<b>Overall</b>	<b>130</b>	<b>19</b>	<b>14.6%</b>	<b>100%</b>
* Though one standard in this category was less than fully compliant, AHCCCS did not require the Contractor to develop a CAP for the standard.				
** Though one standard in this category was fully compliant, AHCCCS provided a recommendation to the Contractor. The Contractor was not required to develop a CAP for the standard.				

Table 6-3 shows that the Contractor was required to develop CAPs for 14.6 percent of the standards reviewed during CYE 2014. UHCCP was required to develop at least one CAP for standards in seven of the 12 categories. Three categories shared the largest number of required CAPs (14): Claims and Information Systems, Maternal and Child Health and EPSDT, and Reinsurance. However, CAPs were not required for any of the standards in the Case Management, Delivery Systems, Grievance Systems, Quality Management, and Third-Party Liability categories. The largest percentage of required CAPS was in the Encounters category; however, the small number of standards within this category (i.e., one) could have influenced this result. In addition to the Encounters category, the largest percentages of CAPs relative to the number of standards in a category were in the Reinsurance (75.0 percent) and Claims and Information Systems (61.5 percent) categories.

### Strengths

UHCCP was in full compliance for all standards within five categories (Case Management, Delivery Systems, Grievance Systems, Quality Management, and Third-Party Liability), and the Contractor was not required to develop CAPs for standards in these categories. Quality Management and Medical Management were recognized as strengths for the Contractor's program. UHCCP was not required to develop CAPs for any of the 26 standards in the Quality Management category, and was only required to develop a CAP for one of the 16 standards in the Medical Management category.

### Opportunities for Improvement and Recommendations

The OR findings for UHCCP demonstrated significant opportunities for improvement, as 19 of the standards reviewed (14.6 percent) remained less than fully compliant with AHCCCS' required policies and procedures or required corrective action. The Contractor was required to develop at least one CAP for standards in seven of the 12 categories. Within these seven categories, 73.7 percent of CAPs were clustered among standards in three categories: Claims and Information Systems (eight CAPs), Maternal and Child Health and EPSDT (three CAPs), and Reinsurance (three CAPs). As of January 2015, AHCCCS determined that corrective actions were completed and the CAPs were closed for 13 of the standards (68.4 percent).

In the report generated from the Contactor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

#### ◆ **Claims and Information Systems:**

##### **Completed Corrective Actions as of January 2015**

- The Contractor must ensure its staff is able to direct providers/billers to information regarding claim submission.
- The Contractor must have a process in place to train internal and/or subcontractor claims processing staff on the processing of claims specific to the AHCCCS lines of business and provide periodic refresher/update material as appropriate.

- The Contractor must ensure it has appropriate policies and procedures in place for the reimbursement of services provided during the Prior Period Coverage period.

#### **Open Corrective Actions as of January 2015**

- The Contractor must ensure its remittance advice reflects the accurate amount billed, correct application of coordination of benefits and copays, information on provider rights for claim disputes, and instructions for submitting claim disputes and corrected claims.
- The Contractor should ensure that its claims payment system edits for primary insurance coverage based on AHCCCS-supplied TPL information.
- The Contractor must pay applicable interest on all claims, including overturned claims disputes. The Contractor must accept and accurately integrate evidence of provider registration data provided by AHCCCS into its Claims and Information Systems. In the absence of a written negotiated rate, the Contractor must reimburse out-of-network providers pursuant to ARS §36-2903, 2904, and 2905.01

#### ◆ **Encounters:**

##### **Open Corrective Actions as of January 2015**

- The Contractor must ensure encounters are complete, accurate, and timely, and ensure omitted and inaccurate encounters are submitted and corrected.

#### ◆ **General Administration:**

##### **Completed Corrective Actions as of January 2015**

- The Contractor must ensure that all policies and procedures have been reviewed annually.

##### **Open Corrective Actions as of January 2015**

- The Contractor must ensure that it performs regular audits of the organization to mitigate fraud and abuse.

#### ◆ **Maternal and Child Health and EPSDT:**

*Note:* Although UHCCP was not required to submit a CAP for one of the standards in this category, AHCCCS provided a recommendation to the Contractor. This standard is not included in the count of CAPs required from UHCCP by AHCCCS.

##### **Completed Corrective Actions as of January 2015**

- The Contractor should distribute informative outreach material to educate members on the importance of EPSDT services, including the dangers of lead exposure.

- The Contractor must implement a process to coordinate with AzEIP utilizing the AHCCCS/AzEIP procedure.
  - Documents should be updated to reflect the current requirements described in the AHCCCS Medical Policy Manual (AMPM), Chapter 400.
  - The Contractor must develop and implement a process for transitioning a child (who is receiving nutritional therapy) to or from another Contractor, or another service program (i.e., WIC). The Contractor must develop and implement a process of monitoring and implementing referrals for underweight members. The Contractor must develop and implement a process of monitoring provider compliance in implementing interventions with members identified as overweight, including education and/or nutrition referrals.
- ◆ **Medical Management:**
- Completed Corrective Actions as of January 2015**
- The Contractor must provide medical home services to members.
- ◆ **Member Information:**
- Completed Corrective Actions as of January 2015**
- The Contractor must provide evidence that its member services representatives are trained on how to appropriately identify, document, refer, and respond to member inquiries and grievances. The Contractor must provide proof that phone inquiries are monitored for department policy accuracy.
- ◆ **Reinsurance:**
- Completed Corrective Actions as of January 2015**
- The Contractor must include procedures to ensure services were encountered correctly.
  - The Contractor must add a process to utilize its quarterly encounter void log to verify that the status of the associated reinsurance encounters were processed correctly and follow the timely encounter process. The Contractor must produce a monthly overpayment report to be sent to the reinsurance unit for both open and closed contract years. The Contractor's current written processes must be updated with these new processes.
  - The Contractor should follow the process for monitoring the appropriateness of the reinsurance revenue received against paid claims data.

## Summary

UHCCP had widespread variation in its CYE 2014 OR results. Of the 130 standards reviewed, 110 were scored as fully compliant (84.6 percent). Four of the 12 categories had all respective standards scored as fully compliant, and UHCCP was not required to develop CAPs for any of the standards associated with five categories: Case Management, Delivery Systems, Grievance Systems, Quality

Management, and Third-Party Liability. Among the seven remaining categories, the Encounters, Reinsurance, and Claims and Information Systems categories presented the greatest opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

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

CYE 2013 began a three-year cycle of ORs, and within this cycle, AHCCCS conducted an OR for DES/DDD early in CYE 2014. The results of the CYE 2014 OR were reported in the CYE 2013 external quality review report. AHCCCS’ subsequent OR-related activities during CYE 2014 were limited to oversight of the 72 CAPs resulting from the CYE 2014 OR findings. Specifically, AHCCCS accepted and closed 48 CAPs submitted by DES/DDD during CYE 2014. These CAPs address recommendations for all standards reported as less than fully compliant during the CYE 2013 OR. Table 6-4 presents the number and proportion of CAPs required from DES/DDD within and across the categories for compliance standards, as well as the number and percentage of CAPs closed during CYE 2014.

<b>Category</b>	<b>Total # of Standards</b>	<b>Number of CAPs</b>	<b>% of Category Standards</b>	<b>% of Total CAPs</b>	<b>Number of CAPs Closed</b>	<b>% of CAPs Closed</b>
Case Management	8	1	12.5%	1.4%	1	100%
Claims and Information Systems	13	10	76.9%	13.9%	5	50.0%
Delivery Systems	8	6	75.0%	8.3%	1	16.7%
Encounters	1	0	0.0%	0.0%	0	N/A
General Administration	9	7	77.8%	9.7%	0	0.0%
Grievance Systems	17	1	5.9%	1.4%	1	100%
Maternal and Child Health and EPSDT	14	12	85.7%	16.7%	9	75.0%
Medical Management	16	12	75.0%	16.7%	11	91.7%
Member Information	8	6	75.0%	8.3%	5	83.3%
Quality Management	25	11	44.0%	15.3%	9	81.8%
Reinsurance	4	3	75.0%	4.2%	3	100%
Third-Party Liability	8	3	37.5%	4.2%	3	100%
<b>Overall</b>	<b>131</b>	<b>72</b>	<b>54.9%</b>	<b>100%</b>	<b>48</b>	<b>66.7%</b>

Table 6-4 shows that the Contractor was required to develop CAPs for 54.9 percent of the standards reviewed in CYE 2014, and AHCCCS closed 48 (66.7 percent) of the CAPs during CYE 2014. All CAPs within the Case Management, Grievance Systems, Reinsurance, and Third-Party Liability categories were closed. Of the seven categories with open CAPs, AHCCCS closed 75.0 percent or fewer of the CAPs in four of the categories (Maternal and Child Health and EPSDT, Claims and Information Systems, Delivery Systems, and General Administration) based on DES/DDD’s corrective actions. Results from these categories suggest targeted opportunities for improvement.

## Strengths

DES/DDD closed 48 of the 72 CAPs required by AHCCCS following the CYE 2014 OR. The Contractor's strongest performance was for the standards associated with the Case Management, Grievance Systems, Reinsurance, and Third-Party Liability categories. AHCCCS closed all CAPs required for standards in these categories.

## Opportunities for Improvement and Recommendations

The OR findings for DES/DDD demonstrated targeted opportunities for improvement, as seven of the 12 categories showed open CAPs following the CYE 2014 OR. The Contractor was required to develop seven CAPs for the standards associated with the General Administration category, and AHCCCS determined that none of these CAPs could be closed. Additionally, DES/DDD was required to develop six CAPs for the Delivery Systems category, and AHCCCS determined that one CAP could be closed based on the Contractor's corrective actions.

## Summary

OR-related activities for DES/DDD during CYE 2014 were limited to oversight of the 72 CAPs resulting from the CYE 2014 OR findings, and the Contractor completed 66.7 percent of the CAPs required by AHCCCS. The Case Management, Grievance Systems, Reinsurance, and Third-Party Liability categories were strengths for the Contractor's program, as all required CAPs were completed. General Administration, Delivery Systems, and Claims and Information Systems presented the greatest opportunities for improvement, as these categories had the largest number of open CAPs.

**Comparative Results for ALTCS EPD Contractors**

The following section presents a comparative analysis of the performance results from AHCCCS’ OR for the three ALTCS EPD Contractors. Findings are provided on the proportion of the aggregate Contractors’ compliance standards assessed at each level of compliance. A comparison of the percentage of reviewed compliance standards requiring a CAP is also presented for all Contractors combined.

**Findings**

Figure 6-4 presents the overall compliance results (i.e., the far-left bar, labeled “Overall”) and the results for each of 12 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

**Figure 6-4—Categorized Levels of Compliance with Technical Standards for ALTCS EPD Contractors<sup>6-5</sup>**

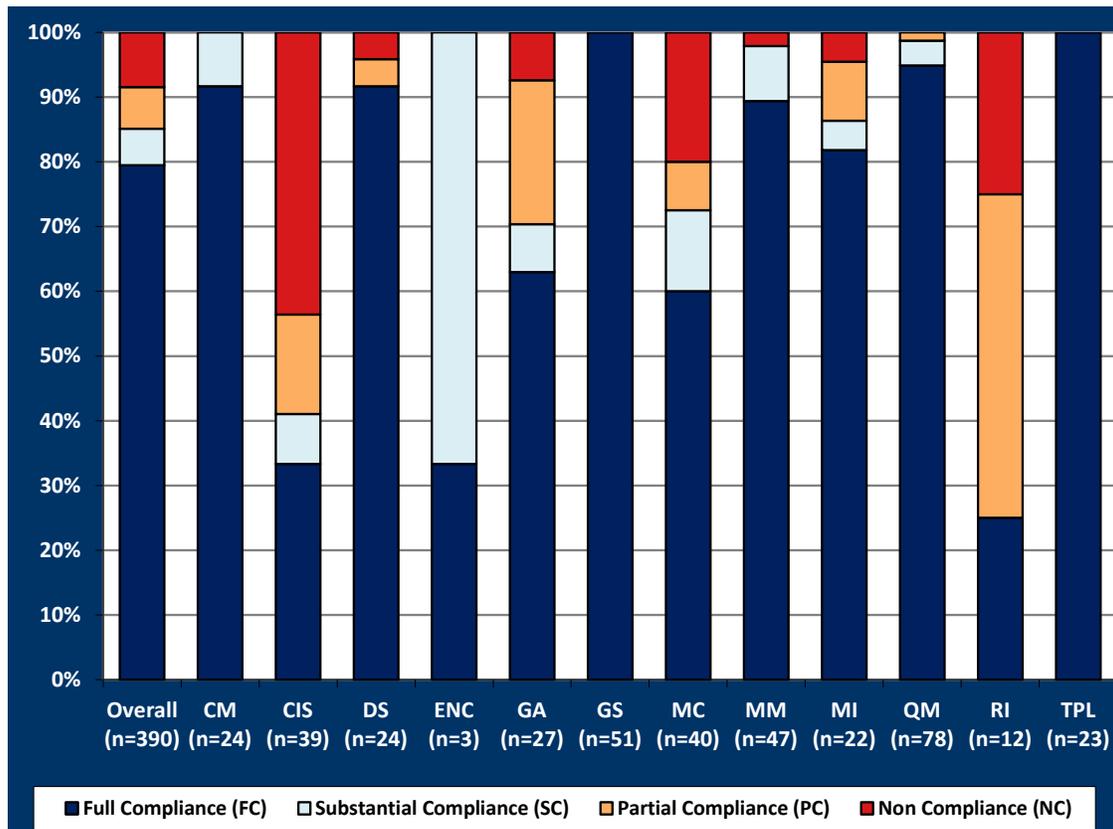


Figure 6-4 shows that the three Contractors were in full compliance for 79.5 percent of the 390 reviewed standards (left-most bar, labeled “Overall”), with varied performance across 10 of the 12

<sup>6-5</sup> The compliance categories are abbreviated as follows: CM=Case Management, CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

categories of standards. The Contractors’ strongest performance was for the standards associated with the Grievance Systems and Third-Party Liability categories, as AHCCCS scored all Contractors fully compliant for all related standards in these categories. Strong performance was also demonstrated in the Case Management, Delivery Systems, and Quality Management categories, as more than 90.0 percent of the related standards in each of these categories were scored as fully compliant.

Of the 12 categories of standards, the Reinsurance category showed the lowest percentage of standards in full compliance (25.0 percent). Two other categories, Claims and Information Systems and Encounters, had less than 50.0 percent of the reviewed standards in full compliance. Results from these three categories suggest targeted opportunities for improvement.

Each of the three EPD Contractors had at least two categories in which all related standards were scored as fully compliant. One Contractor, Mercy Care Plan, had no standards scored as noncompliant and standards for seven of the 12 categories scored as fully compliant.

**CAPs**

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop and implement a CAP. Prior to implementation, proposed CAPs are submitted to AHCCCS for review and approval. A Contractor may also be required to enact a CAP for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard, even if the overall standard is scored as fully compliant. Table 6-5 presents the number and proportion of CAPs required within and across the categories for compliance standards reviewed during CYE 2014.

<b>Table 6-5—Corrective Action Plans by Category for ALTCS EPD Contractors</b>				
<b>Category</b>	<b>Total # of Standards</b>	<b>Number of CAPs</b>	<b>% of Category Standards</b>	<b>% of Total CAPs</b>
Case Management*	24	0	0.0%	0.0%
Claims and Information Systems	39	26	66.7%	33.8%
Delivery Systems	24	2	8.3%	2.6%
Encounters	3	2	66.7%	2.6%
General Administration	27	10	37.0%	13.0%
Grievance Systems**	51	0	0.0%	0.0%
Maternal and Child Health and EPSDT**	40	16	40.0%	20.8%
Medical Management	47	5	10.6%	6.5%
Member Information*	22	2	9.1%	2.6%
Quality Management***	78	5	6.4%	6.5%
Reinsurance	12	9	75.0%	11.7%
Third-Party Liability	23	0	0.0%	0.0%
<b>Overall</b>	<b>390</b>	<b>77</b>	<b>19.7%</b>	<b>100%</b>
* Though standards in these categories were less than fully compliant, AHCCCS did not require the Contractor(s) to develop CAPs for selected standards within these categories.				

Table 6-5—Corrective Action Plans by Category for ALTCS EPD Contractors				
Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
** Though selected standards in these categories were fully compliant, AHCCCS provided recommendations to the Contractor(s). The Contractors were not required to develop CAPs for these standards. *** CAPs were required for selected standards within this category, although the corresponding standards were scored in full compliance.				

Table 6-5 shows that the Contractors were required to develop CAPs for 19.7 percent of the standards reviewed during CYE 2014. The largest number of required CAPs (26) was in the Claims and Information Systems category. Overall, the Contractors were required to develop at least one CAP for standards in nine of the 12 categories. However, CAPs were not required for any standards in the Case Management, Grievance Systems, or Third-Party Liability categories. The largest percentage of CAPs relative to the number of standards in a category was in the Reinsurance category (75.0 percent), though this percentage may be affected by the relatively low number of standards in the category.

### Strengths

Each of the three Contractors had at least two categories (Grievance Systems and Third-Party Liability) in which all related standards were scored as fully compliant. Additionally, none of the EPD Contractors were required to develop CAPs for standards in the Case Management category. Overall, UHCCP had 84.6 percent of the reviewed standards in full compliance.

### Opportunities for Improvement and Recommendations

Performance varied widely among the three Contractors, with AHCCCS requiring the Contractors to submit CAPs for a variety of topics. The number of CAPs ranged from a low of 19 for UHCCP to a high of 37 for BHS. Only one Contractor, BHS, received full compliance for less than 80 percent of its standards. Overall, AHCCCS required the ALTCS EPD Contractors to submit 26 CAPs (66.7 percent of possible category standards) for the standards associated with the Claims and Information Systems category. Overall, the Claims and Information Systems, Maternal and Child Health and EPSDT, and General Administration categories showed the largest proportional opportunities for improvement, as 67.5 percent of the total CAPs required by AHCCCS were related to these categories.

BHS showed the greatest opportunity for improvement from its CYE 2014 OR, with AHCCCS requiring the Contractor to submit 34 CAPs for the 129 reviewed standards (26.4 percent). With only 71.3 percent of the reviewed standards in full compliance, opportunities for improvement are widespread for this Contractor.

When comparing performance among the Contractors for individual standards, there were nine standards for which at least two of the three eligible Contractors were required to submit a CAP. All three Contractors were required to submit a CAP for three individual standards: Claims and Information Systems Standard 2, Claims and Information Systems Standard 5, and Claims and Information Systems Standard 10. Table 6-6 below details the overall performance of the nine standards for which at least two of the three eligible Contractors were required to submit a CAP.

**Table 6-6—Selected Levels of Compliance By Standard for ALTCS EPD Contractors**

Category and Standard	Eligible Contractors	Fully Compliant Contractors		Substantially Compliant Contractors		Partially Compliant Contractors		Non-Compliant Contractors	
		#	%	#	%	#	%	#	%
Claims and Information Systems 2	3	0	0.0%	0	0.0%	0	0.0%	3	100%
Claims and Information Systems 5	3	0	0.0%	0	0.0%	0	0.0%	3	100%
Claims and Information Systems 8	3	0	0.0%	0	0.0%	1	33.3%	2	66.7%
Claims and Information Systems 10	3	0	0.0%	0	0.0%	0	0.0%	3	100%
Claims and Information Systems 13	3	0	0.0%	1	33.3%	0	0.0%	2	66.7%
General Administration 9	3	0	0.0%	0	0.0%	3	100%	0	0.0%
Maternal and Child Health and EPSDT 13	3	0	0.0%	1	33.3%	0	0.0%	2	66.7%
Reinsurance 2	3	0	0.0%	0	0.0%	3	100%	0	0.0%
Reinsurance 3	3	0	0.0%	0	0.0%	1	33.3%	2	66.7%

Though the categories of standards provide a valuable framework for assessing overall performance, comparing Contractor performance among selected individual standards allows for a focused examination of the Contractors’ opportunities for improvement. Additionally, the standards identified in Table 6-6 illuminate opportunities for AHCCCS to provide additional oversight and potential technical assistance to Contractors.

Opportunities for improvement generated by the OR, as well as required CAPS, identify areas within the structural operations of each Contractor that require significant attention and improvement. All of the Contractors were required to develop CAPs that could be resolved by ensuring that their policies and protocols contain all AHCCCS-required elements and associated time frames (e.g., notice of action letters to members and service determination notices) and that Contractors’ staff monitor compliance with these requirements. Deficiencies in coordination of care also directly impact access to care and the timeliness and quality of care provided to members by the three Contractors.

Based on AHCCCS’ review of ALTCS EPD Contractor performance in CYE 2014 and the associated opportunities for improvement identified as a result of the OR, HSAG recommends the following:

- ◆ ALTCS EPD Contractors should conduct internal reviews of operational systems to identify barriers that impact their compliance with AHCCCS standards. Specifically, Contractors should cross-reference existing policies and procedures with AHCCCS requirements and ensure, at a minimum, that they are in alignment with both the intent and content of AHCCCS standards.

- ◆ Contractors should evaluate their current monitoring programs and activities. When deficiencies are noted, the Contractors should take steps to either develop new procedures and review mechanisms or augment existing ones. In many cases, Contractors can apply lessons learned from improving performance for one category of standards to other categories. Specifically, Contractors can look to CAPs completed from earlier ORs to determine best practices specific to their organization for identifying and correcting deficient standards, and monitoring the subsequent compliance.
- ◆ All Contractors should review their Reinsurance policies and bring them into compliance with the relevant standards, as each of the ALTCS EPD Contractors was required to develop and implement a CAP for three of the four standards associated with this category. Specifically, Contractors should work with their respective provider networks and information systems personnel to improve the processing and auditing procedures for reinsurance cases and overpayments. Similarly, all Contractors should assess their policies and procedures pertaining to the Claims and Information Systems standards, as each of the ALTCS EPD Contractors was required to develop and implement at least seven CAPs among the 13 standards associated with this category.

## Summary

With 85.1 percent of standards in full or substantial compliance and 8.5 percent in noncompliance, AHCCCS' CYE 2014 ALTCS EPD OR found generally positive results. Most of the CAPs were related to monitoring, reporting, and communications processes. If the Contractors continue to improve in these areas, they should be able to achieve full or nearly full compliance for all standards in AHCCCS' next cycle of operational reviews.

## 7. Performance Improvement Project Performance

In accordance with 42 CFR 438.240(d), AHCCCS requires Contractors to have a QAPI program that (1) includes ongoing programs of PIPs designed to achieve favorable effects on health outcomes and member satisfaction, and (2) focuses on clinical and/or nonclinical areas that involve the following:

- ◆ Measuring performance using objective quality indicators
- ◆ Implementing system interventions to achieve improvement in quality
- ◆ Evaluating the effectiveness of interventions
- ◆ Planning and initiating activities for increasing and sustaining improvement

42 CFR 438.240(d) also requires each PIP to be completed in a reasonable period to allow information on the success of PIPs in the aggregate to produce new information on quality of care each year.

One of the three EQR-related activities mandated by the federal Medicaid managed care requirements and described at 42 CFR 438.358(b)(1) is the annual validation of MCO and PIHP PIPs that are required by a state and are underway during the preceding 12 months. The requirement at 42 CFR 438.358(a) allows a state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory and optional EQR-related activities.

AHCCCS typically conducts the functions associated with the mandatory Medicaid managed care act activity of validating its Contractors' PIPs. However, AHCCCS opted to close the PIP—*Inpatient Readmissions within 30 Days*—and instead rely on the Contractors' reported performance measurements going forward to monitor performance. This decision was made as a result of national and state-specific factors that have contributed to declining readmission rates (a positive outcome), as well as the fact that several improvement interventions have since been institutionalized by AHCCCS and its Contractors, namely:

- ◆ Adoption of the HEDIS measure *Readmission within 30 Days* as a contract-required performance measure, allowing for continued focus on the topic by Contractors.
- ◆ Inclusion of this measure in the payment withhold formula. This readmission measure is one of six measures that Acute Care Contractors are held accountable for annually as part of payment reform.
- ◆ Alignment with shared savings arrangements. Shared savings arrangements are now contractually mandated with increasing requirements annually. AHCCCS expects that Contractors' care efforts will focus on providing care in the most appropriate yet least expensive setting and that use of higher levels of care/more expensive settings and resulting outcomes will be better managed.
- ◆ In addition, CMS has made readmission a central focus by limiting instances where readmissions would be a reimbursable expense.

Because the Contractor-reported results on *Inpatient Readmissions within 30 Days* were not validated due to AHCCCS' closure of this PIP, HSAG is presenting the results and improvement

activities as reported by the Contractors, but is unable to assess strengths and weaknesses or provide an evaluation of findings because the results have not been validated.

To replace this PIP topic, AHCCCS has required all lines of business, including ALTCS Contractors, to initiate a new PIP focused on increasing the number of prescribers electronically prescribing medications and increasing the number of prescriptions submitted electronically. CYE 2014 was the baseline year for this PIP, and further details regarding the PIP methodology were not available at the time of this annual report but will be reported in subsequent years.

## Contractor-Specific Results

AHCCCS provided its CYE 2014 Contractor PIP reports for three ALTCS EPD Contractors and for DES/DDD to HSAG. The three ALTCS EPD Contractors for which data were provided were Bridgeway Health Solutions (BHS), Mercy Care Plan (MCP), and UnitedHealthcare Community Plan (UHCCP). The PIP conducted during CYE 2014 for the ALTCS EPD Contractors and for DES/DDD was *Inpatient Readmissions within 30 Days*, which focused on decreasing the number of inpatient readmissions for any cause within 30 days of the initial hospitalization. Because the goal of the PIP was to lower the number of readmissions, a lower rate by a Contractor indicates better performance.

During CYE 2014, the *Inpatient Readmissions within 30 Days* PIP was in the second remeasurement phase, and the PIP was closed by AHCCCS. Contractors used baseline data collected during the CYE 2011 measurement period to implement strategies to decrease the number of inpatient hospitalization readmissions among Medicaid members beginning in CYE 2012. It is expected that Contractor education efforts during and beyond the CYE 2012 intervention period will result in a smaller percentage of ALTCS members requiring readmission within 30 days of a discharge from an inpatient hospitalization.

This section includes Contractors' PIP remeasurement results as submitted to AHCCCS by the Contractors, along with specific activities and interventions during the measurement period from October 1, 2013, through September 30, 2014. Because data presented below were supplied by the Contractors, results may differ from the PIP baseline rates reported in the previous 2012–2013 annual EQR report. Also, because the results were not validated by AHCCCS, an assessment of Contractors' strengths and weaknesses could not be performed.

### **Bridgeway Health Solutions (BHS)**

Table 7-1 presents the *Inpatient Readmissions within 30 Days* PIP results reported to AHCCCS by BHS. BHS noted in its PIP report that these results were generated from the Contractor's HEDIS reporting data software, using the HEDIS technical specifications for tracking readmissions.

**Table 7-1—Inpatient Readmissions within 30 Days PIP Results for BHS**

PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2011, to Sept. 30, 2012 <sup>A</sup>	Remeasurement Period 2 Oct. 1, 2012, to Sept. 30, 2013	Relative Percent Change From Baseline <sup>B</sup>
Percentage of members with an inpatient readmission within 30 days	17.5%	17.1%	11.3%	NA

<sup>A</sup> Though AHCCCS indicated that CYE 2012 was the intervention year for this PIP, BHS reported data from this time period as Remeasurement Period 1 and data from CYE 2013 as Remeasurement Period 2.

<sup>B</sup> HSAG opted to present this result as NA because the Contractor noted that different calculation methodologies were used for the baseline rate and remeasurement rate.

Table 7-1 shows BHS’s self-reported *Inpatient Readmissions within 30 Days* PIP results for the baseline period and two remeasurement periods. In spite of the difference in calculation methodologies, BHS attributed the improvement in its inpatient readmission rate to its internal Transition of Care program developed in June 2013. Under the Transition of Care program, medical case managers completed outreach telephone calls to members discharged to community settings (e.g., the member’s residence or an assisted living facility). BHS reported that the case managers assisted members in addressing common issues that could result in readmission to the hospital, such as:

- ◆ Relaying hospital information to members’ PCPs, to ensure the PCP would have all pertinent medical information from the hospital prior to the member’s follow-up visit.
- ◆ Assisting members in scheduling follow-up visits with the member’s PCP
- ◆ Conducting follow-up calls to members to ensure they visited their PCP for follow-up care.

### **Mercy Care Plan (MCP)**

Table 7-2 presents the *Inpatient Readmissions within 30 Days* PIP results reported to AHCCCS by MCP. MCP noted in its PIP report that these results were generated from the Contractor’s internal data using the AHCCCS *Inpatient Readmissions within 30 Days* PIP methodology.

**Table 7-2—Inpatient Readmissions within 30 Days PIP Results for MCP**

PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2012, to Sept. 30, 2013	Remeasurement Period 2 Oct. 1, 2013, to Sept. 30, 2014	Relative Percent Change From Baseline <sup>A</sup>
Percentage of members with an inpatient readmission within 30 days	26.7%	24.5%	14.5%	-45.7%

<sup>A</sup> The relative percent change from baseline was calculated by HSAG using Contractor-supplied PIP results and was not validated by AHCCCS.

Table 7-2 shows MCP’s self-reported *Inpatient Readmissions within 30 Days* PIP rate decreased 45.7 percent, from 26.7 percent during the baseline period to 14.5 percent during the second remeasurement period. A lower rate for this PIP indicates better performance. MCP attributed the improvement in its inpatient readmission rate to the following interventions:

- ◆ The Contractor established partnerships with additional hospital and provider groups.
- ◆ The Contractor established a process to conduct a Readmission Intervention Assessment (RIA). Under this process, the Contractor contacts the member and/or the member’s family at the time the member is admitted to the hospital and offers resource assistance during the hospital discharge process. Following the member’s discharge from the hospital, the Contractor contacts the member to ensure appropriate follow-up actions have or will occur (e.g., scheduling follow-up appointments and coordinating transportation, if needed).
- ◆ The Contractor implemented a PCP/Specialist Initiative, in which members are encouraged to see their provider at least quarterly.
- ◆ Time during the Contractor’s monthly Inter-Disciplinary Team meetings is used to identify members who have been readmitted twice within the previous 90 days.
- ◆ MCP contracts with Optum to provide PCP care in nursing home settings, with the goal of maintaining members’ medical stability and encouraging admissions to skilled nursing facilities rather than inpatient hospitals.
- ◆ Beginning in January 2015, MCP began contracting with PopHealthCare to provide in-home care and care in assisted living communities.

MCP reported that these interventions address member education and self-management, care coordination, discharge planning, and removal of barriers to service access, especially for home health and durable medical equipment.

**UnitedHealthcare Community Plan (UHCCP)**

Table 7-3 presents the *Inpatient Readmissions within 30 Days* PIP reported to AHCCCS by UHCCP. UHCCP noted in its PIP report that these results were generated from the Contractor’s HEDIS reporting data software, using the HEDIS technical specifications for the *Inpatient Utilization* measure. UHCCP did not specify which year of HEDIS technical specifications was used when calculating the Remeasurement Period 1 rate.

**Table 7-3—Inpatient Readmissions within 30 Days PIP Results for UHCCP**

PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2012, to Sept. 30, 2013	Remeasurement Period 2 Oct. 1, 2013, to Sept. 30, 2014 <sup>A</sup>	Relative Percent Change From Baseline <sup>B</sup>
Percentage of members with an inpatient readmission within 30 days	19.1%	15.9%	NR	NA

<sup>A</sup> UHCCP did not report a rate for Remeasurement Period 2.

<sup>B</sup> HSAG opted to present this result as NA because the Contractor noted that different calculation methodologies were used for the baseline rate and the remeasurement rate.

Table 7-3 shows UHCCP’s self-reported *Inpatient Readmissions within 30 Days* PIP results for the baseline period and one remeasurement period. UHCCP did not report any new interventions during CYE 2014. Further, UHCCP’s PIP report did not include the Contractor’s assessment of how the interventions contributed to the decreased readmission rate.

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

Table 7-4 presents the *Inpatient Readmissions within 30 Days* PIP results reported to AHCCCS by DES/DDD. DES/DDD’s PIP report did not provide details of the specifications used to calculate the rates reported below.

**Table 7-4—Inpatient Readmissions within 30 Days PIP Results for DES/DDD**

PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2012, to Sept. 30, 2013	Remeasurement Period 2 Oct. 1, 2013, to Sept. 30, 2014 <sup>A</sup>	Relative Percent Change From Baseline <sup>B</sup>
Percentage of members with an inpatient readmission within 30 days	15.4%	13.9%	NR	-9.6%

<sup>A</sup> DES/DDD did not report a rate for Remeasurement Period 2.

<sup>B</sup> The relative percent change from baseline was calculated by HSAG using Contractor-supplied PIP results and was not validated by AHCCCS.

Table 7-4 shows DES/DDD’s self-reported *Inpatient Readmissions within 30 Days* PIP rate decreased 9.6 percent, from 15.4 percent during the baseline period to 13.9 percent during the first remeasurement period. A lower rate for this PIP indicates better performance. The Contractor noted that the rates include all DES/DDD members, and this lack of exclusions probably resulted in higher rates (i.e., worse performance) than expected under the AHCCCS PIP methodology. DES/DDD reported the initiation of one new intervention during CYE 2014, a quarterly Medical Management meeting in which a multidisciplinary team reviews the number of admissions, annualized admissions, length of hospital stay, and readmissions within 30 days for each health plan. DES/DDD acknowledged that interventions unrelated to DES/DDD’s efforts contributed to the improved readmission rate among its members, and cited the following interventions as having a positive effect on its performance on this PIP:

- ◆ The Contractor reported that the statewide “No Place Like Home” initiative to reduce hospital readmissions has provided a wealth of informative materials that are used and shared between hospitals, home health agencies, and community agencies.
- ◆ The Contractor noted that health plans are engaging community models of home health care to address chronic medical conditions.
- ◆ DES/DDD reported that health plan newsletters, performance measures, and medical home initiatives have been used to educate providers on the importance of decreasing inappropriate readmissions within 30 days. However, the Contractor did not identify whether it has provided any such educational outreach to its providers.

**Comparative Results for ALTCS EPD Contractors**

**Findings**

Due to the disparate measurement periods, lack of validation of source data, and variable calculation methods among the ALTCS EPD Contractors and the DES/DDD Contractor, it is not

possible to reliably compare Contractors' self-reported performance on the *Inpatient Readmissions within 30 Days* PIP.

### **Strengths**

No strengths in Contractor performance have been identified because the data reported by the Contractors were not comparable and were not validated by AHCCCS.

### **Opportunities for Improvement and Recommendations**

AHCCCS has closed this PIP, but will continue to measure performance on this topic through future performance measure reporting and validation activities. HSAG recommends that the Contractors continue to monitor the outcomes associated with the reported interventions. As Contractor-specific strengths and opportunities could not be reliably identified from the data provided, HSAG recommends that AHCCCS fully validate Contractors' PIP submissions for inclusion in future annual EQR reports.

### **Summary**

The *Inpatient Readmissions within 30 Days* PIP for the ALTCS EPD Contractors and the DES/DDD Contractor was closed mid-cycle by AHCCCS, and performance results for this PIP were limited to the Contractors' final PIP reports submitted to AHCCCS. As such, evaluations of individual Contractor results and comparative results across Contractors were not able to be performed.