

Arizona Health Care Cost Containment System



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

**Behavioral Health Services**

*June 2018*



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## 1. Executive Summary

The Code of Federal Regulations (CFR) at 42 CFR §438.364<sup>1-1</sup> requires that states use an external quality review organization (EQRO) to prepare an annual technical report that describes how data from activities conducted for Medicaid managed care organizations (MCOs), in accordance with the CFR, were aggregated and analyzed. The annual technical report also draws conclusions about the quality of, timeliness of, and access to healthcare services that managed care organizations provide.

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

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

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

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

In Arizona, behavioral health has historically been a carved-out benefit separately managed by Regional Behavioral Health Authorities (RBHAs), also referred to as Contractors. Related to this structure, for an individual with a serious mental illness to obtain care, up to four different healthcare systems might be necessary: the Arizona Health Care Cost Containment System (AHCCCS) acute health plan, for physical health services; the RBHA Contractors, for behavioral health services; Medicare, for persons with a serious mental illness (SMI) who are dually eligible for both Medicaid and Medicare; and Medicare Part D, for medications. Navigating the complex healthcare system was one of the greatest barriers to obtaining medically necessary healthcare. For Arizonans with SMI, obtaining needed healthcare was challenging and further complicated by concerns around poor medication management and stigma, sometimes causing individuals to forgo physical healthcare. Many persons with SMI also experience co-morbidities; therefore, management of chronic diseases like diabetes or hypertension has also been poor among that population.<sup>1-2</sup>

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

<sup>1-2</sup> Arizona Health Care Cost Containment System. Behavioral Health Integration. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html>. Accessed on: Jan 29, 2018.

To help address these issues, AHCCCS collaborated with behavioral health partners to create a more streamlined system that reduced barriers to care for members and increased accountability of the RBHA Contractors for managing the “whole health” of persons with SMI.<sup>1-3</sup>

To be eligible for SMI services in Arizona, persons must have a specific SMI diagnosis and a functional impairment related to the diagnosis. SMI diagnoses include the following disorders: psychotic, bipolar, obsessive-compulsive, depressive, mood, anxiety, post-traumatic stress, dissociative, and personality.<sup>1-4</sup>

On April 1, 2014, approximately 17,000 members with SMI in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their behavioral and physical healthcare needs.<sup>1-5</sup> On October 1, 2015, this model was launched statewide through contracts with Health Choice Integrated Care (HCIC) in Northern Arizona and Cenpatico Integrated Care (CIC) in Southern Arizona. Members residing in the following counties began receiving physical and behavioral health services from CIC beginning October 1, 2015: Cochise, Greenlee, La Paz, Pima, Pinal, Yuma, Santa Cruz, Graham, and ZIP Codes 85542 and 85192. Members residing in the following counties began receiving physical and behavioral health services from Health Choice Integrated Care beginning October 1, 2015: Apache, Coconino, Mohave, Navajo, Yavapai, and Gila (excepting ZIP Codes 85542 and 85192).

In addition, as part of the 2015 legislative session, Governor Ducey proposed and the Arizona Legislature approved an administrative simplification effort that brought together the AHCCCS program with its longstanding partner, the Division of Behavioral Health Services (DBHS), within the Arizona Department of Health Services (ADHS). Historically, ADHS/DBHS served as AHCCCS’ contracted managed care organization (MCO) for the provision of behavioral health services to AHCCCS members. In turn, ADHS/DBHS contracted with RBHAs, which provided behavioral health benefits for members. Through Governor Ducey’s Administrative Simplification Initiative, DBHS merged with AHCCCS and the RBHAs became AHCCCS-contracted MCOs for administration of behavioral health benefits. The administrative simplification for DBHS and AHCCCS was completed on July 1, 2016.

Effective October 1, 2018, AHCCCS will implement the AHCCCS Complete Care contracts that were awarded to seven integrated MCOs, The AHCCCS Complete Care contracts will allow AHCCCS to coordinate the provision of physical and behavioral healthcare services to 1.5 million Medicaid members.<sup>1-6</sup> The contracts are awarded in the following geographic service areas (GSAs):

- Central GSA (Maricopa, Gila and Pinal counties, excluding zip codes 85542, 85192, and 85550): Banner-University Family Care Plan, Care1st Health Plan Arizona, Health Choice Arizona (Steward

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<sup>1-3</sup> Ibid.

<sup>1-4</sup> Arizona Health Care Cost Containment System. SMI Determination Process. October 20, 2016. Available at: <https://www.azahcccs.gov/AmericanIndians/Downloads/Handouts/CrisisResponseSMIDeterminationProcess102016.pdf>. Accessed on: Jan 29, 2018.

<sup>1-5</sup> Arizona Health Care Cost Containment System. Behavioral Health Integration. Available at: <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html>. Accessed on: May 14, 2018.

<sup>1-6</sup> Arizona Health Care Cost Containment System. AHCCCS Awards Contracts to Managed Care Organizations to Provide AHCCCS Complete Care Integrated Services Effective Oct. 1, 2018. Available at: <https://www.azahcccs.gov/shared/News/PressRelease/AHCCCSAwardsContractstoManagedCareOrganizations.html>. Accessed on: May 14, 2018.

Health Choice Arizona), Health Net Access, Magellan Complete Care of Arizona, Mercy Care, and United Healthcare Community Plan.

- South GSA (Pima, Cochise, Graham, Greenlee, La Paz, Santa Cruz, and Yuma Counties, including zip codes 85542, 85192, and 85550): Banner-University Family Care Plan, Health Net Access, and in Pima County only, United Healthcare Community Plan.
- North GSA (Mohave, Coconino, Apache, Navajo, and Yavapai Counties): Care1st Health Plan Arizona, Health Choice Arizona (Steward Health Choice Arizona).

AHCCCS' integrated healthcare delivery benefits members by aligning all physical and behavioral health services under a single plan. With one plan, one provider network, and one payer, healthcare providers are better able to coordinate care and members can more easily navigate the system, both of which ultimately improve health outcomes. AHCCCS members in every Arizona County will have a choice of health plans.

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

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

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

To meet the requirements set forth in 42 CFR §438.364, as the EQRO, HSAG must use the information AHCCCS obtained to prepare and to provide to AHCCCS EQR results in an annual, detailed technical report that summarizes findings on the quality, timeliness, and access to healthcare services, to include:

- A description of how data from the activities were aggregated and analyzed.
- For each activity:
  - Objectives.
  - Technical method of data collection and analysis.
  - Description of the data obtained.
  - Conclusions drawn from the data.

- An assessment of the Contractor's strengths and weaknesses for the quality of, timeliness of, and access to care.
- Recommendations for improving the quality of care furnished by the Contractor including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality, timeliness, and access to healthcare services rendered to Medicaid members.
- Methodologically appropriate comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities (described in §438.310[c][2]), consistent with guidance included in the EQR protocols.
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

HSAG has prepared the annual technical report for AHCCCS for 14 consecutive years. The report complies with all requirements set forth at 42 CFR §438.364.

This executive summary includes an overview of AHCCCS' CYE 2017 EQR activities as provided to HSAG and a high-level summary of the results. The results include a description of HSAG's findings with respect to performance by the RBHA Contractors in complying with the AHCCCS contract requirements and the applicable federal 42 CFR §438 requirements for each activity. In addition, this executive summary includes an assessment of each RBHA Contractor's strengths and weaknesses related to the quality of, timeliness of, and access to healthcare services and HSAG's recommendations for improving the quality of services.

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

- Section 2—An overview of the history of the AHCCCS program.
- Section 3—A description of the contract year ending (CYE) 2016 and CYE 2017 EQR activities.
- Section 4—An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care program and those initiatives specific to the behavioral health program for CYE 2017.
- Section 5—An overview of the RBHA Contractors' best and emerging practices for CYE 2017.
- Section 6 (Organizational Assessment and Structure Performance)—An overview of the new AHCCCS methodology for the organizational review (OR). (AHCCCS began a new OR in contract year ending [CYE] 2017 [review period October 1, 2016, through September 30, 2017] to assess each RBHA Contractor's compliance with AHCCCS' contract standards.) In 2017, CIC underwent a focused OR in January and Mercy Maricopa Integrated Care (MMIC) underwent a comprehensive OR in July.
- Section 7 (Performance Measure Performance)—A presentation of rates for AHCCCS-selected performance measures for one RBHA Contractor and HSAG's associated findings and recommendations for CYE 2016.
- Section 8 (Performance Improvement Project Performance)—A presentation of Contractor-specific PIP results for Mercy Maricopa Integrated Care (MMIC) as well as HSAG's associated findings and recommendations for CYE 2016.

- Section 9 (Consumer Assessment of Healthcare Providers and Systems [CAHPS®])<sup>1-7</sup>—A presentation of Contractor-specific CAHPS results for MMIC as well as HSAG’s associated findings and recommendations for CYE 2017.

## Overview of the CYE 2017 External Review

During the review period, AHCCCS contracted with the RBHA Contractors listed below to provide services to members enrolled in the AHCCCS Behavioral Health Medicaid managed care program.

The RBHA Contractors and associated abbreviations used throughout this report are listed below:

- Mercy Maricopa Integrated Care (MMIC)
- Cenpatico Integrated Care (CIC)
- Health Choice Integrated Care (HCIC)

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

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

### *Organizational Assessment and Structure Standards*

AHCCCS conducted a comprehensive OR for MMIC and a focused OR for CIC during CYE 2017. Between CYE 2016 and CYE 2017, AHCCCS monitored the progress of all RBHA Contractors in implementing their CAPs for the recommendations from the CYE 2016 OR review cycle. HCIC and CIC had not undergone the scheduled comprehensive OR during CYE 2017; therefore, no documentation has been submitted to HSAG for this reporting period.

The CYE 2017 comprehensive OR (which includes CYE 2016 and CYE 2017 activities) for MMIC was organized into 10 standard areas. Each standard area consisted of several elements designed to measure the MMIC's performance and compliance. The following 10 standard areas and coinciding numbers of elements are used throughout the report:

- Corporate Compliance (CC), five elements
- Claims and Information Systems (CIS), 12 elements
- Delivery Systems (DS), 14 elements
- General Administration (GA), three elements
- Grievance Systems (GS), 17 elements

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<sup>1-7</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).



- Adult; Early and Periodic Screening, Diagnostic and Treatment (EPSDT); and Maternal Child Health (MCH), 12 elements
- Medical Management (MM), 27 elements
- Member Information (MI), nine elements
- Quality Management (QM), 25 elements
- Third Party Liability (TPL), seven elements

For the CYE 2017 focused OR for CIC, AHCCCS reviewed specific standards in the following categories, as indicated following.

- Claims and Information Systems (CIS), four elements
- Delivery Systems (DS), three elements
- Adult; Early and Periodic Screening, Diagnostic and Treatment (EPSDT); and Maternal Child Health (MCH), seven elements
- Medical Management (MM), 17 elements
- Quality Management (QM), 16 elements

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

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

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

RBHA Contractors are required to complete a CAP for any standard for which the total score is less than 95 percent. In addition, when AHCCCS evaluated performance for a standard as less than fully compliant or made a recommendation worded as "The Contractor must" or "The Contractor should," the RBHA Contractor was required to develop a CAP, submit it to AHCCCS for review and approval, and implement the corrective actions once approved.

## Findings

In Section 6 (Organizational Assessment and Structure Performance) of this report, HSAG includes details for each RBHA Contractor's performance related to the standards measured in the OR. Based on the data and considering that each standard contained numerous elements, HSAG conducted an analysis

of the scores for each standard area. The following table summarizes outcomes of the comprehensive review conducted by AHCCCS related to MMIC’s scores in the applicable standard areas during the comprehensive OR. Table 1-1 details the total number of elements scored for each standard; the standard area scores; and the total number, if any, of required corrective actions for each standard.

**Table 1-1—Standard Areas and Compliance Scores for MMIC**

Standard Area	Total Number of Elements Scored	Standard Area Score	Required Corrective Actions
Corporate Compliance	5	83%	2
Claims and Information Systems	12	99%	1
Delivery Systems	14	96%	2
General Administration	3	100%	0
Grievance Systems	17	100%	0
Adult, EPSDT, and Maternal Child Health	12	94%	1
Medical Management	27	95%	5
Member Information	9	100%	0
Quality Management	25	98%	2
Third Party Liability	7	100%	0

Standards with greatest opportunity for improvement were the CC, MCH, and MM standards. For the CC and MCH standards, MMIC scored below 95 percent. Though MMIC scored at 95 percent for the MM standard, AHCCCS required five CAPs. The strongest performances were in GA, GS, MI, and TPL, for all of which MMIC received 100 percent standard area scores and had no CAPs assigned.

The following table summarizes the outcome of the focused review conducted by AHCCCS related to CIC’s scores in the applicable standard areas reviewed during the focused OR. Table 1-2 details the total number of elements scored for each standard; the standard area scores; and the total number, if any, of required corrective actions for each standard.

**Table 1-2—Standard Areas and Compliance Scores for CIC**

Standard Area	Total Number of Elements Scored	Standard Area Score	Required Corrective Actions
Claims and Information Systems	4	82%	2
Delivery Systems	3	100%	0
Adult, EPSDT, and Maternal Child Health	7	28%	7
Medical Management	17	83%	7
Quality Management	16	90%	4

Table 1-2 preceding details that, overall, CIC was at or above the 95 percent compliance threshold for one standard (DS) reviewed. Based on the number of required corrective actions, standards with greatest opportunity for improvement were the MCH and MM standards. For the CIS, MCH, MM, and QM standards, CIC scored below 95 percent. The strongest performance was in the DS standard, for which CIC received a 100 percent standard area score and no CAPs were assigned.

## Conclusions

AHCCCS conducted a comprehensive OR on MMIC during CYE 2017, reviewing 10 standards. Additionally, AHCCCS conducted a focused OR on CIC during CYE 2017, reviewing five standards.

Overall results for one RBHA Contractor (MMIC) for CYE 2017 were positive. During MMIC's comprehensive review, MMIC scored at or above the 95 percent compliance threshold in eight of the 10 standard areas (CIS, DS, GA, GS, MM, MI, QM, and TPL). MMIC was required to complete the highest number of corrective actions (five CAPs) for the MM standard and the lowest number of required corrective actions (one CAP each) for the CIS and MCH standards.

During CIC's focused review, CIC scored at or above the 95 percent compliance threshold in one standard area (DS), which received a standard area score of 100 percent with no CAPs required. CIC received the lowest compliance score (28 percent) for the MCH standard. CIC's standard areas with highest number of CAPs required were MCH and MM (seven CAPs for the two standards combined).

## Recommendations

Based on AHCCCS' review of RBHA Contractor performance conducted in CYE 2017 (for the CYE 2016 review period) and associated opportunities for improvement identified as a result of the comprehensive (MMIC) and focused (CIC) ORs, HSAG recommends the following:

- RBHA Contractors should conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations. Specifically, RBHA Contractors should cross-reference existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements and ensure, at a minimum, alignment with both the intent and content of AHCCCS standards, State rules, and federal regulations. For example, for the MCH standard, CIC could develop a document that describes its maternity care program, including all requirements mandated by AHCCCS.
- RBHA Contractors should assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes. When deficiencies are noted, the RBHA Contractors should develop mechanisms to address such areas and enhance existing procedures. In addition, RBHA Contractors should implement periodic assessments of those elements reviewed by AHCCCS for which the RBHA Contractor was found deficient.
- RBHA Contractors should apply lessons learned from improving performance for one category of standards to other categories. For example, RBHA Contractors should look at CAPs completed from previous ORs to determine best practices specific to their organizations to identify and correct policies, procedures, and practices so as to address deficient standards and monitor subsequent

compliance. Further, RBHA Contractors should use opportunities to address and discuss issues identified during ORs.

- RBHA Contractors should implement control systems to address specific findings in the MCH standard related to the women’s preventive care services to ensure that services are provided in accordance with the AHCCCS Medical Policy Manual.
- AHCCCS should concentrate improvement efforts on the MCH standard as both RBHA Contractors scored below the 95 percent compliance threshold. For example, AHCCCS should consider distributing technical assistance documents to the RBHA Contractors and holding in-person meetings with RBHA Contractors regarding this standard. In particular, AHCCCS might want to meet with CIC to determine what issues the RBHA Contractor has in implementing these requirements.
- AHCCCS should consider using the quarterly meetings with RBHA Contractors as forums in which to share lessons learned from both the State and RBHA Contractor perspectives. For example, for the MM standard, CIC did not meet the AHCCCS performance threshold and was required to submit seven corrective actions, while MMIC was required to submit five corrective actions. AHCCCS should present identified best practices regarding care coordination and case management, post-discharge telephone calls, and enrollment transition information (ETI) documentation issues as these areas were problematic for both RBHA Contractors.

### Performance Measures

AHCCCS collected data and reported RBHA Contractor rates for a set of seven performance measures for the general mental health/ substance abuse (GMH/SA) Aggregate population and 17 performance measure rates for the RBHA Contractors serving the SMI population. Rates without an established MPS are found in the “Performance Measure Performance” section of this report.

### GMH/SA Aggregate Findings

Table 1-3 presents the following information for each measure indicator for the GMH/SA Aggregate: CYE 2016 performance and the AHCCCS MPS.

**Table 1-3—GMH/SA Aggregate—Performance Measure Results**

Performance Measure	CYE 2016 Performance	Minimum Performance Standard
<i>Follow-Up After Hospitalization for Mental Illness</i>		
<i>7-Day Follow-Up</i>	51.5%	50.0%
<i>30-Day Follow-Up</i>	69.0%	70.0%

For CYE 2016, the GMH/SA Aggregate exceeded the MPS for one measure rate (*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*) and fell below the MPS for the other measure rate (*Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*).

### Conclusions

For CYE 2016, both *Follow-Up After Hospitalization for Mental Illness* measure rates were close to the MPS, with the *7-Day Follow-Up* rate exceeding the MPS by only 1.5 percentage points and the *30-Day Follow-Up* rate falling below the MPS by only 1 percentage point.

### Recommendations

With both measure rates being close to the MPS for CYE 2016, efforts should be focused on increasing follow-up visits for members after hospitalization for mental illness.

### RBHA Integrated SMI Aggregate Findings

Table 1-4 presents the following information for each measure indicator for the RBHA Integrated SMI Aggregate: CYE 2016 performance and the AHCCCS MPS. Although, CYE 2016 was the second reporting year for the SMI population after the transition, only one year of data could be reported because prior year results included only one of the three RBHA Integrated SMI Contractors (MMIC).

**Table 1-4—RBHA Integrated SMI Aggregate—Performance Measure Results**

Performance Measure	CYE 2016 Performance	Minimum Performance Standard
<b><i>Adults’ Access to Preventive/Ambulatory Health Services</i></b>		
<i>Total</i>	92.8%	75.0%
<b><i>Annual Monitoring for Patients on Persistent Medications</i></b>		
<i>Total</i>	91.4%	75.0%
<b><i>Breast Cancer Screening</i></b>		
<i>Breast Cancer Screening</i>	35.5%	50.0%
<b><i>Cervical Cancer Screening</i></b>		
<i>Cervical Cancer Screening</i>	22.5%	64.0%
<b><i>Chlamydia Screening in Women</i></b>		
<i>Total</i>	54.9%	63.0%
<b><i>Follow-Up After Hospitalization for Mental Illness</i></b>		
<i>7-Day Follow-Up</i>	74.4%	50.0%
<i>30-Day Follow-Up</i>	87.4%	70.0%

The RBHA Integrated SMI Aggregate exceeded the MPS for four measure rates (*Adults’ Access to Preventive/Ambulatory Care; Annual Monitoring for Patients on Persistent Medications—Total; and Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up*).

### Conclusions

The RBHA Integrated SMI Aggregate exhibited strength for *Adults’ Access to Preventive/Ambulatory Care; Annual Monitoring for Patients on Persistent Medications—Total; and Follow-Up After*

*Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*, exceeding the MPS by 17.8, 16.4, 24.4, and 17.4 percentage points, respectively. Conversely, the RBHA Integrated SMI Aggregate exhibited low performance related to screenings for women, with the rates for *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Chlamydia Screening in Women—Total* falling below the MPS by 14.5, 41.5, and 8.1 percentage points, respectively.

## Recommendations

With all three rates falling below the MPSs, efforts should be focused on increasing compliance with recommended screenings for women.

## Performance Improvement Projects (PIPs)

In CYE 2015 (October 1, 2014, through September 30, 2015), AHCCCS implemented a new PIP, *E-Prescribing*, for all lines of business. The baseline measurement period included CYE 2014 (data from October 1, 2013 through September 30, 2014), to be followed by two remeasurement periods: Remeasurement 1 period in CYE 2016 (October 1, 2015, through September 30, 2016), and Remeasurement 2 period in CYE 2017 (October 1, 2016, through September 30, 2017). Upon initiation of the *E-Prescribing* PIP, all behavioral health services were provided under DBHS, an AHCCCS Contractor. However, behavioral health services for the GMH/SA and SMI populations within Maricopa County transitioned to MMIC effective April 1, 2014. GMH/SA and SMI members outside Maricopa County transitioned to either CIC or HCIC effective October 1, 2015. Therefore, the RBHA Contractors' PIP measurement periods differ from those of all other lines of business. CYE 2015 was an intervention year for MMIC's GMH/SA member population; therefore, the CYE 2016 annual report included CYE 2014 baseline measurement data for MMIC's GMH/SA member population. Thus, this annual report will include for CIC: CYE 2016 baseline rates, qualitative analysis, and interventions for the GMH/SA and integrated members; and will include for HCIC: CYE 2016 baseline rates, qualitative analysis, and interventions for the GMH/SA and integrated members.

AHCCCS implemented the *E-Prescribing* PIP to improve preventable errors in communicating a medication between a prescriber and a pharmacy. Research found that clinicians make fewer errors using an electronic system than with handwritten prescriptions.<sup>1-8</sup> AHCCCS found that sending electronic prescriptions can reduce mistakes related to medication types, dosages, and member information and that electronic prescribing assists pharmacies in identifying potential problems related to medication management as well as potential reactions that members may encounter, especially for those taking multiple medications.

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

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

## Findings

This was the baseline reporting period for the *E-Prescribing* PIP; therefore, comparisons could not be made between rates for each indicator. HSAG recommends that all RBHA Contractors continually monitor the PIP rates to determine whether or not interventions are successful prior to the first remeasurement of the PIP.

### **Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Statewide Mercy Maricopa Integrated Care (MMIC)**

The CAHPS Health Plan Surveys are standardized survey instruments that measure members’ satisfaction with their healthcare. During 2016–2017, HSAG administered the *CAHPS 5.0 Adult Medicaid Health Plan Survey* with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental set to adult Medicaid members (who met age and enrollment criteria) served by MMIC.<sup>1-9</sup> The CAHPS survey was administered using a statewide sampling methodology and followed standard survey administration protocols, in accordance with National Committee for Quality Assurance (NCQA) specifications. These standard protocols promote the comparability of resulting CAHPS data.

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

## Findings

Table 1-5 presents the 2016 CAHPS survey statewide results for MMIC. The table displays the following information for each CAHPS survey measure: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings).<sup>1-10,1-11</sup>

**Table 1-5—Adult CAHPS Results for Mercy Maricopa Integrated Care**

Measure	2016 Top-Box Rate	Three-Point Mean	Star Rating
<b>Global Ratings</b>			
<i>Rating of Health Plan</i>	49.7%	2.28	★
<i>Rating of All Health Care</i>	43.5%	2.21	★

<sup>1-9</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

<sup>1-10</sup> NCQA national averages for the adult Medicaid population were used for comparative purposes. Given the potential differences in the demographics of these populations, caution should be exercised when interpreting these results.

<sup>1-11</sup> NCQA’s benchmarks and thresholds for the adult Medicaid population were used to derive the overall member satisfaction ratings (i.e., star ratings); therefore, caution should be exercised when interpreting these results.

Measure	2016 Top-Box Rate	Three-Point Mean	Star Rating
<i>Rating of Personal Doctor</i>	56.1%	2.40	★
<i>Rating of Specialist Seen Most Often</i>	57.8%	2.42	★
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	82.9%	2.32	★★
<i>Getting Care Quickly</i>	81.1%	2.31	★
<i>How Well Doctors Communicate</i>	85.8%	2.46	★
<i>Customer Service</i>	87.3%	2.43	★
<i>Shared Decision Making</i>	75.9%	NA	NA
<b>Individual Item Measures</b>			
<i>Coordination of Care</i>	73.6%	2.15	★
<i>Health Promotion and Education</i>	71.5%	NA	NA
★★★★★ 90th or Above   ★★★★★ 75th-89th   ★★★ 50th-74th   ★★ 25th-49th   ★ Below 25th Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average. Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average. NA indicates that results are not available for the CAHPS measure.			

### Conclusions

Based on evaluation of MMIC’s overall member satisfaction ratings (i.e., star ratings), priority assignments were determined for each CAHPS measure. The priority assignments are grouped into four main categories for quality improvement (QI): top, high, moderate, and low priority; and are based on results of the NCQA comparisons. Table 1-6 shows how the priority assignments were determined for MMIC for each CAHPS measure.

**Table 1-6—Derivation of Priority Assignments**

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

Based on evaluation of MMIC’s overall member satisfaction ratings for the adult Medicaid population, the measures identified as areas of top priority are the specific areas that should be targeted for QI initiatives. For MMIC, the top priority areas identified for QI were *Rating of Health Plan*, *Rating of All*



*Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Coordination of Care.*

## Recommendations

Based on MMIC's overall performance on the CAHPS survey measures, recommendations for improvement were identified. These recommendations include best practices and other proven strategies that may be used or adapted by the program to target improvement in the areas of *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Coordination of Care.*

To improve overall performance on the CAHPS measures, MMIC should consider the following general recommendations in the context of its operation and QI activities:

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

## Overall Findings, Recommendations, and Conclusions

AHCCCS has completed a strategic plan for SFY 2017–2022 that includes goals related to long-term strategies that bend the cost curve while improving member outcomes, the pursuit of continuous quality improvement, and the reduction of fragmentation through an integrated healthcare system. The results of the three mandatory activities relative to RBHA Contractor performance support these goals. AHCCCS has a comprehensive system to monitor and improve the timeliness of, access to, and quality of care that RBHA Contractors provide to Medicaid members. All RBHA Contractors are working toward improving the delivery of services and quality of care provided to their members. MMIC demonstrated improvement in nearly all areas in the comprehensive OR; however, in the focused OR, CIC continued to experience difficulties. Overall, the RBHA Contractors' performance measure rates demonstrate positive performance, with several performance measure rates performing above the MPSs. However, the performance measure rates related to women's screening measures fell below the MPS,

demonstrating opportunities for improvement. GMH/SA demonstrated positive performance, with the rates for *Follow-Up After Hospitalization for Mental Illness* exceeding the MPS or falling just short of the MPS. AHCCCS has selected a mandatory PIP, *E-Prescribing*, for all lines of business which, to increase patient safety, measures the number of providers who write electronic prescriptions and the number of prescriptions submitted electronically. Most RBHA Contractors have employed significant interventions to improve the results of this PIP. AHCCCS could benefit from conducting a root cause analysis of CAHPS measures that have been identified as low performing to identify potential causes for lower member satisfaction in these areas and to devise possible solutions.

### Organizational Assessment and Structure Standards

AHCCCS conducted a comprehensive OR on MMIC during CYE 2017, reviewing 10 standards. Additionally, AHCCCS conducted a focused OR on CIC during CYE 2017, reviewing five standards.

Overall results for one RBHA Contractor (MMIC) for CYE 2017 were positive. MMIC scored at or above the 95 percent compliance threshold for eight of ten standard areas reviewed during the comprehensive review of 131 elements and was required to complete 13 CAPs total. During CIC's focused review of 47 elements, CIC scored at or above the 95 percent compliance threshold for only one standard area and was required to complete 20 CAPs.

### Performance Measures

Overall, performance for the RBHA Contractors serving the SMI and GMH/SA populations varied across all three areas of **quality**, **access**, and **timeliness**. Across all three areas, the performance measure rates for *Follow-Up After Hospitalization for Mental Illness* demonstrated positive performance for both the GMH/SA and SMI population while the RBHA Integrated SMI Aggregate exceeded the MPS for both measure indicators and the GMH/SA Aggregate only exceeded the MPS for the *7-Day Follow-Up* measure rate. Additionally, the RBHA Integrated SMI Aggregate exhibited mixed performance in the **quality** area, with the measure rate for *Annual Monitoring for Patients on Persistent Medications—Total* exceeding the MPS, while the rates for *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Chlamydia Screening in Women—Total* fell below the MPSs. The RBHA Integrated SMI Aggregate demonstrated positive performance in the **access** area, exceeding the MPS for the *Adults' Access to Preventive/Ambulatory Health Services* performance measure rate.

The remaining measure rates for the RBHA Contractors are utilization rates and should be monitored for informational purposes.

### Performance Improvement Projects

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

This was the baseline reporting period for the *E-Prescribing* PIP; therefore, no comparable findings were noted. The RBHA Contractors did, however, implement solid interventions. In addition, because

this was the baseline measurement period, strong conclusions have not been identified regarding the strengths and opportunities for the RBHA Contractors' performance improvement.

HSAG recommends the following:

- The RBHA Contractors should continue to monitor and evaluate the effectiveness of interventions for this PIP.

In addition, HSAG recommends that AHCCCS consider the following:

- Require the RBHA Contractors to have more than one PIP. AHCCCS now requires the *E-Prescribing* PIP; however, AHCCCS could require the RBHA Contractors to expand to one additional PIP to improve outcomes of one of the lower-scoring performance measures.
- Establish a standing agenda item for the RBHA quarterly meetings, that RBHA Contractors share PIP results, including successes and lessons learned. Improvement strategies and interventions that were successful and resulted in sustained improvement should be considered for system-wide implementation.

### Consumer Assessment of Healthcare Providers and Systems (CAHPS)

HSAG identified the following CAHPS measures that could benefit from quality improvement activities for MMIC: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Coordination of Care*. HSAG recommends that AHCCCS share the survey results with MMIC and other stakeholders, as appropriate, and use quality improvement tools and processes to improve member satisfaction. The MMIC should consider the following general recommendations in the context of its operation and QI activities:

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

### Conclusions

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

This section of the report includes a brief history of the Arizona Health Care Cost Containment System (AHCCCS) Medicaid managed care programs and a description of AHCCCS' Strategic Plan for State Fiscal Years 2017–2022 (Strategic Plan). The description of the Strategic Plan includes the four goals:

- AHCCCS must pursue and implement long-term strategies that bend the cost curve while improving member health outcomes.
- AHCCCS must pursue continuous quality improvement.
- AHCCCS must reduce fragmentation driving toward an integrated healthcare system.
- AHCCCS must maintain core organizational capacity and workforce planning that effectively serves AHCCCS operations.

### AHCCCS Medicaid Managed Care Program History

AHCCCS is the single state Medicaid agency for Arizona. AHCCCS operates under the authority of the federal Research and Demonstration 1115 Waiver, which has allowed for the operation of a total managed care model since 1982. AHCCCS uses State, federal, and county funds to administer healthcare programs to the State's acute, long-term care, children, and behavioral health Medicaid members.

AHCCCS has an allocated budget of approximately \$11.4 billion to administer its programs, coordinating services through its Contractors and delivering care for 1.9 million individuals and families in Arizona through a provider network of over 60,000 healthcare providers.

AHCCCS' Acute Care program was incorporated from its inception in 1982. In 1988, AHCCCS added the Arizona Long Term Care System (ALTCS) program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and physically disabled (EPD) populations. In October 1990, AHCCCS began coverage of comprehensive behavioral health services for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals. The Children's Health Insurance Program (CHIP) was incorporated in Arizona in 1998 and is known as KidsCare. In 2009, due to a persistently severe budget shortfall, a freeze was placed on enrollment in KidsCare. In 2016, Governor Ducey signed Senate Bill 1457 into law, ending the enrollment freeze on the KidsCare program. Children who qualify for this program receive care through AHCCCS Contractors.

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

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

## AHCCCS' Strategic Plan

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

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

The plan offers four overarching goals:

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

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

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<sup>2-1</sup> AHCCCS Strategic Plan State Fiscal Years 2017-2022 Available at: [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan\\_17-22.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_17-22.pdf). Accessed on: January 17, 2018.

- Modernize hospital payments to better align incentives, increase efficiency, and improve the quality of care provided to members.
- Achieve the Program Integrity Plan goals that improve Third Party Liability (TPL), Coordination of Benefits (COB), and Fraud and Abuse programs. As part of the initiatives to bend the cost curve and ensure overall fiduciary oversight, AHCCCS continues to dedicate significant resources to Program Integrity efforts.
- Reduce administrative burden on providers while expanding access to care.

## **2. AHCCCS must pursue continuous quality improvement.**

- Achieve statistically significant improvements on Contractor Performance Improvement Projects (PIPs). For example, AHCCCS Contractors are expected to conduct PIPs in clinical care and non-clinical areas that are anticipated to have a favorable impact on health outcome and member satisfaction.
- Achieve and maintain improvement on quality performance measures.
- Leverage American Indian care management program to improve health outcomes.
- Increase transparency in health plan performance to inform members when selecting a health plan. AHCCCS continues to grow and strengthen its quality structure by incorporating the latest national standards and regional trends. In addition, AHCCCS is working on improving and updating the Health Plan scorecard to provide accurate and timely information to its members.

## **3. AHCCCS must reduce fragmentation driving towards an integrated healthcare system.**

- Establish a system of integrated care organizations that serves all AHCCCS members. The following are integration models AHCCCS is currently implementing:
  - CRS—Previously 17,000 children with complex medical needs were served by three different payers. These included an acute plan, RBHA and CRS plan. These members are now served by a single Integrated Contractor.
  - During 2014 and 2015, almost 40,000 individuals with Serious Mental Illness were transitioned to a single organization that was responsible for all services.
  - Currently, 80,000 dual eligible members receive integrated general mental health and substance abuse services.
  - In 2016, the requirements for Tribal Regional Behavioral Health Authority (TRBHA) contractors were streamlined to enhance and create integration and care coordination opportunities for members served by the TRBHAs.
  - In 2016, AHCCCS had approximately 48 percent of the dual eligible member population aligned, which is the highest percentage ever.
- Establish policies and programs to support integrated providers. For example, the structure of AHCCCS is transforming towards integrated care delivery systems with better alignment of incentives that seeks to efficiently improve health outcomes.
- Leverage health information technology (HIT) investments to create more data flow in the healthcare delivery system. AHCCCS devoted significant resources to integrate health information



across providers and now it has a fully functioning Health Information Exchange to facilitate the coordination of information for all the delivery systems.

- Develop a strategy to strengthen the availability of behavioral health resources within the integrated delivery system. AHCCCS is planning on offering fully integrated services to all its members by 2019.
- Develop comprehensive strategy to curb opioid abuse and dependency.
- Improve access for individuals transitioning out of the justice system.

#### **4. AHCCCS must maintain core organizational capacity, infrastructure, and workforce planning that effectively serve its operations.**

- Pursue continued deployment of electronic solutions to reduce health care administrative burden. In addition, define strategies to make data available and reliable for decision-making processes.
- Continue to manage the workforce environment, promoting activities that support employee engagement and retention; and address potential gaps in the organization's knowledge base due to retirements and other staff departures.
- Strengthen system-wide security and compliance with privacy regulations related to all information and data by evaluating, analyzing, and addressing potential security risks.
- Improve and maintain information technology (IT) infrastructure, including server based applications, ensuring business continuity.
- Continue work and effort around implementation of the Arizona management system.

### **AHCCCS Quality Strategy**

The U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.200 and §438.340 implement Section 1932(c)(1) of the Medicaid managed care act, which defines certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of healthcare services offered to their members. The written strategy must describe the standards that a state and its contracted MCOs and PIHPs must meet. The Medicaid state agency quality strategy must include all of the following:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs as well as examples of evidence-based clinical practice guidelines required by the State.
- The State's goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of each population that the State serves.
- A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP; the performance improvement projects to be implemented, including any interventions that the State proposes to improve access, quality, or timeliness of care.



- Arrangements for annual, external independent reviews of the quality outcome and timeliness of and access to, the covered services.
- A description of the State’s transition of care policy.
- The State’s plan to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status, to the extent practicable.
- Appropriate use of intermediate sanctions for MCOs.
- A description of how the State will assess the performance and quality outcomes achieved by each primary care case management (PCCM) entity.
- The mechanisms implemented by the State to comply with requirements relating to the identification of persons who need long-term services and supports or persons with special healthcare needs.
- Information relating to non-duplication of EQR activities.
- The State’s definition of “significant change” related to instances in which significant changes are made to the quality strategy or occur in the State Medicaid program.

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

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

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

AHCCCS operates from a well-established objective and systematic process in identifying priority areas for improvement and selecting new Contractor-required performance measures and PIPs. The process involves a review of internal and external data sources. AHCCCS also considers the prevalence of 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.





## ***Operational Performance Standards***

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

For CYE 2015, because of the administrative simplification and merger of ADHS/DBHS and AHCCCS, an operational review was not conducted for the RBHAs.

In CYE 2016, for the RBHAs, ORs were scheduled to occur between July 2017 and October 2017. Cenpatico Integrated Care (CIC) underwent a focused OR in January 2017; however, this did not fall within the CYE 2016 (current reporting period) time frame. Therefore, no documentation has been submitted for this reporting period.

## ***Performance Measure Requirements and Targets***

AHCCCS establishes performance measures based on the CMS Core Measure sets and the National Committee for Quality Assurance (NCQA) HEDIS measures as well as on measures unique to Arizona's Medicaid program. AHCCCS establishes minimum performance standards and goals for each performance measure based on national standards such as the NCQA National Medicaid means, whenever possible.

AHCCCS has been a leader in developing, implementing, and holding Contractors accountable to performance measurements. AHCCCS' consistent approach for performance expectations has resulted in performance measures with rates closer to the NCQA HEDIS national Medicaid mean. AHCCCS made the decision to transition to measures found in the CMS Core Measure Sets that provide a better opportunity to shift the systems toward indicators of health outcomes, access to care, and member satisfaction.

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

AHCCCS requires that RBHAs conduct PIPs, which AHCCCS defines 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 RBHAs to conduct PIPs for topics that they select. However, AHCCCS also selects PIPs that the RBHAs must conduct.

For the AHCCCS-mandated PIPs, AHCCCS and the RBHAs measure performance for at least two years after the RBHA 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 RBHAs to demonstrate improvement, and then sustain the improvement over at least one subsequent remeasurement cycle to ensure institutionalization of the interventions. AHCCCS requires RBHAs to submit reports evaluating their data and interventions and propose new or revised interventions, if necessary.

## 3. Description of EQR Activities

### Mandatory Activities

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

- Validate Contractor PIP—validation performed by AHCCCS.
- Validate Contractor performance measures. (The validation of performance measures was only conducted for Mercy Maricopa Integrated Care.)
- Summary and findings of Contractor’s performance in complying with the AHCCCS’ contract requirements and the federal Medicaid managed care regulations cited at 42 CFR §438.358—Review performed by AHCCCS. (The Operational Review was not completed for the RBHAs.)

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

### Optional Activities

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

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

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

### AHCCCS Quality Initiatives

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

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

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

### Key Accomplishments for AHCCCS

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

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

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

- Committed to helping foster families, and in 2016 implemented Jacob’s Law. Through this implementation, AHCCCS has simplified access to needed behavioral health services, improved monitoring systems to ensure timely access to services, and engaged with foster families throughout the process.
- Released a report with recommendations to strengthen the healthcare system’s ability to respond to the needs of members with or at risk for autism spectrum disorder (ASD), including those with co-occurring diagnoses.
- Released a comprehensive report: *Behavioral Health Needs of Children Involved with the Department of Child Safety: Psychotropic Prescribing Update*. This report analyzed psychotropic prescribing for children in Arizona’s foster care system. The report detailed “the percentage of children in foster care receiving psychotropic medications decreased by 26 percent from 2008 to 2014, from 20.3 percent to 14.9 percent respectively. The percentage of children in foster care receiving antipsychotic medication decreased by 43 percent, from 10.9 percent to 6.2 percent.”
- Reopened enrollment for the KidsCare program, providing high quality healthcare coverage for children of working families.
- Restored podiatry services provided by a licensed podiatrist and provided a \$1,000 dental benefit to all members in the ALTCS program.
- Continues to expand the external contract for determinations for persons with serious mental illness (SMI) to all Arizona counties, including several American Indian tribes, to ensure consistency and equity in the determination process.
- Worked with the Arizona Department of Corrections to establish a Justice System Transition program which allows eligible individuals to be enrolled with AHCCCS immediately upon release.
- Continues to pursue long-term strategies to reduce fragmentation in the healthcare delivery system through service integration.
- Experienced a capitation rate increase of 1.7 percent. This is in-line with the previous four-year average of just 2.1 percent. This is well above the Great Recession period where rates averaged a decrease of 4.6 percent and much more sustainable than the 2005 through 2009 period wherein rates averaged a 6.6 percent increase.
- Continued care delivery and payment reform efforts, with a focus on transitioning from paying for the volume of care to the value of care provided. Contracted managed care organizations were required to have an increased percentage of their provider payments in value-based arrangements, in which payments are related to quality outcomes.
- Met most program integrity goals established in its annual plan. AHCCCS worked successfully with prosecutors on 39 different cases resulting in 62 convictions—a program record. AHCCCS recouped over \$1 billion due to coordination of benefits, third party recoveries, and the Office of Inspector General activities, and then began pursuing leveraging private sector expertise on data analyses.
- Registered, validated, and paid 3,600 eligible professionals and 75 acute care and critical access hospitals since the electronic health record program opened in July 2011. These payments total over \$666 million. AHCCCS continues to serve on the Health Current board, the Health Information

Network of Arizona (HINAZ) board, and the Network Leadership Council. In July 2016, AHCCCS became an official participant in the network when the Division of Fee-for-Service Management began receiving information from the network about its patient population.

- Continued to pursue an improved partnership with tribal stakeholders while continuing to engage in strategies that improve the health system for tribal members. AHCCCS conducted eight tribal consultation meetings in 2016. AHCCCS also had over 190 American Indians enrolled in active care coordination by the end of calendar year 2016.
- Conducted a 2016 employee survey the results of which indicated strong, positive feelings among staff. A total of 97 percent of staff value members of their team; 96 percent believe in the AHCCCS mission; 90 percent understand clearly what is expected from them; and 87 percent are proud to be AHCCCS employees. In addition, AHCCCS has achieved a world-class level of employee engagement, with nine engaged employees for every one disengaged employee. This is compared to the statewide average of 2.3 engaged employees for every one disengaged employee.

## Selecting and Initiating New Quality Improvement Initiatives

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

In selecting and initiating new quality improvement initiatives, AHCCCS:

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

## Collaboratives/Initiatives

### *Administrative Simplification and the Integrated Model*

The Division of Behavioral Health Services (DBHS), as part of the Arizona Department of Health Services' (ADHS) transitioned, along with the programs it manages, to AHCCCS, effective July 1, 2016. The behavioral health services were “carved out” benefits administered by DBHS through contracts with the (RBHAs). Not only was this transition part of a more efficient government operation, it also coincides with a large integration effort for the seriously mentally ill population in Arizona. Before the integration of services, a member with an SMI had to coordinate with several healthcare systems to obtain services. As such, the physical health services were provided through the acute health plan; the behavioral health services through the RBHA; and the Medicare system, if the member was also eligible for Medicaid and Medicare; and Medicare Part D for medications.

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

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

Starting on October 1, 2018, AHCCCS proposes, to offer fully integrated contracts to manage behavioral healthcare and physical healthcare services to children (including children with Children's Rehabilitative Services [CRS] eligible conditions) and adult AHCCCS members not determined to have SMI. AHCCCS is also proposing to preserve the RBHAs as a choice option and to provide a mechanism for affiliated contractors to hold a single contract with AHCCCS for non-ALTCS members.

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

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

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

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

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

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

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

### ***Executive Order 2016-06—Prescription of Opioids***

On October 24, 2016, the Governor of Arizona, Douglas Ducey, signed Executive Order 2016-06 to address the opioid crisis affecting the nation and, in particular, the state of Arizona. In this order, the



Governor indicated that Arizona has the ninth highest rate of opioid deaths in the nation, and that approximately 404 people in the state died of prescribed opioid overdoses in 2015. The State presented alarming statistics showing that during 2013 enough prescription pain medications were dispensed to medicate every adult in Arizona around the clock for two weeks.

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

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

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

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

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

### **Targeted Investments Program**

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

AHCCCS in promoting the integration of physical and behavioral healthcare, increasing efficiencies in care delivery and improving health outcomes.

Pursuant to 42 CFR 438.6 (c), the TI Program will fund time-limited, outcomes-based projects aimed at building the necessary infrastructure to create and sustain integrated, high-performing healthcare delivery systems that improve care coordination and drive better health and financial outcomes. The TI projects will support children and adults with behavioral health needs (including children with or at risk for Autism Spectrum Disorder and children engaged in the child welfare system) as well as individuals transitioning from incarceration who are AHCCCS-eligible. The TI program is expected to:

- Reduce fragmentation for both acute and behavioral health programs.
- Increase efficiency in service delivery for behavioral health members.
- Improve health outcomes for the affected populations.

## Other Collaboratives/Initiatives

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

- 2016 United Cerebral Palsy Report: AHCCCS received national recognition for its 2016 United Cerebral Palsy Report as it ranked number one nationally among Medicaid state programs for individuals with individuals with disabilities programs.
- *Behavioral Health Needs of Children Involved with the Department of Child Safety: Psychotropic Prescribing Update*: AHCCCS is revising the Psychiatric and Psychotherapeutic Best Practices for Children Birth Through Five Years of Age guidance document to ensure that the most recent research on appropriate prescribing is provided to providers, children, and families. AHCCCS is also updating tools that provide best practice strategies related to infants and toddlers—including psychotropic prescribing, early childhood mental health intervention, and trauma-informed care. The document content focuses on the most current prescribing practices and psychotherapeutic approaches for use during early childhood, with the recommendation that psychotherapeutic approaches be the preferred method of treatment prior to implementation of psychopharmacologic intervention.
- Recommendations to Office of the Arizona Governor Policy Advisor for Health and Human Services on Autism Spectrum Disorder (ASD): In February 2016, the ASD Advisory Committee (appointed by the Office of the Arizona Governor in spring 2015) publicized a report of recommendations to strengthen the healthcare system's ability to respond to the needs of AHCCCS members with or at-risk for ASD, including those with co-morbid diagnoses. During 2017, two centers of excellence opened in Maricopa County. AHCCCS Complete Care, the new contract for AHCCCS and the Contractors, is addressing the recommendation to integrate care for acute members. In addition, AHCCCS is developing a behavioral intervention policy that addresses this issue.

- **Summary of Activities Designed to Enhance the Credentialing/Rec credentialing Process:** AHCCCS previously worked collaboratively with the Arizona Association of Health Plans (AzAHP), representing the AHCCCS Contractors, to create a credentialing alliance (CA) aimed at making the credentialing and rec credentialing process easier for providers through the elimination of duplicative efforts and reduction of administrative burdens. Prior to establishing the CA, providers had to apply for credentials with each Contractor; with the CA, providers need only apply for credentialing or rec credentialing for approved status to be accepted by all AHCCCS Contractors. During CYE 2016, the credentialing process for primary source verification was implemented. AHCCCS will continue its efforts to enhance the credentialing and rec credentialing process.
- **Summary of Activities Designed to Enhance the Medical Record Review (MRR) Process:** AHCCCS has initiated a statewide workgroup designed to develop a consistent behavioral health chart review tool. The tool will be designed to:
  - Meet CFR and State statutory requirements.
  - Operate according to AHCCCS contractual guidelines.
  - Provide consistency across the state regarding clinical behavioral health practice.
  - Allow for consistency of results in chart analysis and review.
  - Allow for data comparisons across geographic services areas related to consistent measurement of required chart elements.
- **AHCCCS Quarterly Contractors’ Quality Management/Maternal and Child Health Meeting:** To further promote the integration of medical and behavioral health services, targeted education is included within the AHCCCS Quarterly Contractor’s Quality Management/Maternal Child Health Meeting. AHCCCS hosts Community Quality Forums (formerly known as the Quarterly Behavioral Health Quality Meeting) for members, families, and providers to obtain public input on issues related to behavioral health.
- **Clinical Integration:** The Medical Management (MM) unit, which regularly partners with the Quality Management (QM) and MCH/EPSDT units, added a behavioral health coordinator to support efforts for the entire clinical team. The addition of a behavioral health coordinator enhances the ability for clinical considerations, service delivery, and program and contract development to encompass a holistic approach in all aspects of care. AHCCCS continues to hire additional staff with behavioral health expertise from within its workforce.

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

- Required tracking of performance on frequency of diabetic screening for individuals with schizophrenia or bipolar disorder.
  - Tracking performance on prenatal and postnatal timeliness of care, with supplemental training provided to contracted health plan staff relative to physical and behavioral health aspects of perinatal mood disorders.
- **Centers of Excellence:** AHCCCS requires Contractors to identify centers of excellence to improve standards of quality, care, and service. Contractors are required to submit a value-based providers (VBP)/centers of excellence report. The report incorporates the CYE 2017 implementation of one to

two contracts with either the centers of excellence identified in the CYE 2016 executive summary and/or other existing centers of excellence. Contractors identify the centers of excellence under contract in CYE 2017 and, if different from those identified in the CYE 2016 executive summary, include a description as to how these centers were selected. The report includes a thorough description of the Contractors' initiatives to encourage member utilization, goals and outcome measures for the contract year, a description of the monitoring activities throughout the year, an evaluation of the effectiveness of the previous year's initiatives, a summary of lessons learned and any implemented changes, a description of the most significant barriers, any plans to encourage providers that have been determined to offer high value but are not participating in VBP arrangements (if any) to participate in VBP contracts, and a plan for next contract year. (Although this initiative occurred partially outside the review period, it is significant and therefore is included in this report.)

- **Prenatal Exposure to Alcohol and Other Drugs:** AHCCCS and the Contractors, including the RBHAs, participated in the Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs (task force). The task force is composed of representatives from various agencies who work to increase awareness of and address concerns in the community regarding fetal alcohol spectrum disorders. AHCCCS staff members attend the monthly meetings and regularly participate in discussions related to solutions to reduce prenatal exposure to alcohol and other drugs. A strategic plan has been finalized by the task force, and members meet regularly to work on goals and objectives. The task force reviewed and developed publications and toolkits for members and providers. For providers, publications included the *Guidelines for Identifying Substance-Exposed Newborns*, while members' publications included information that related to the exposure and use of all drugs (prescription, opioids, alcohol, etc.) and neonatal abstinence syndrome (NAS). Mercy Care Plan (MCP) and Mercy Maricopa Integrated Care (MMIC) both worked out processes to refer infants with NAS to Southwest Human Development, and MMIC had a perinatal care manager for pregnant members with a designation of SMI. All pregnancies in women with SMI were considered high-risk and were provided integrated care management via MMIC care managers. When additional medical risks to the pregnancy were identified, they were flagged (i.e., substance use or abuse) and a referral was made to Mercy Maricopa Perinatal Care Management for care coordination and support.
- **Involvement of Stakeholders and Community Subject Matter Experts:** Throughout 2017, AHCCCS continually involved stakeholders and community subject matter experts as members of AHCCCS committees, quality meetings, policy workgroups, and advisory councils. Subject matter experts provided technical assistance, guidance, and advisement related to various areas and issues (e.g., special needs populations, consumer advocacy, ASD, early intervention, trauma-informed care, behavioral health system best practices, integrated care).
- **Medical Director Meetings:** AHCCCS involves medical directors from Contractors in quarterly meetings. These meetings are designed to inform medical directors of changes in policy, regulation, billing practices, and current or future system updates. Additionally, these quarterly medical director meetings are designed to provide information on best practices in medical, behavioral care, and/or prescribing practices.
- **ADHS Bureau of the United States Department of Agriculture (USDA) Nutrition Programs:** AHCCCS works with ADHS Bureau of USDA Nutrition Programs on many initiatives ranging from

Contractor education to Women, Infants, and Children promotion and obesity issues. The nutrition coordinators present the most up-to-date information at the AHCCCS Contractor quarterly meetings.

- **Arizona Early Intervention Program:** The Arizona Early Intervention Program (AzEIP), Arizona’s IDEA Part C program, is administered by the Division of Developmental Disabilities. MCH staff in the Clinical Quality Management unit at AHCCCS work with AzEIP to facilitate early intervention services for children younger than 3 years of age who are enrolled with AHCCCS Contractors. These services are closely monitored to ensure timely access and availability of services to members. AHCCCS and AzEIP continue to collaborate and meet regularly to ensure that members receive care in a timely manner. As an ongoing effort to promote care coordination and system clarification, the MCH/EPST manager undertook extensive efforts to create detailed flow charts that outline the process from multiple points of entry and across many different MCO types and member conditions. These flow charts have been promoted at several stakeholder groups, with collaborative feedback. Once the charts undergo a final review, these tools will be made available on the AHCCCS website.
- **The Arizona Partnership for Immunization (TAPI):** Quality management staff attend TAPI Steering Committee meetings and subcommittee meetings concerning community awareness, provider issues, and adult immunizations. TAPI regularly communicates immunization trends and best practices with AHCCCS and its Contractors. TAPI’s Provider Awareness and Adult and Community Awareness committees continue to focus on long-term projects such as updating the TAPI website with the most current information for providers, parents, and the community at large. In addition to the website, TAPI provides vaccination handouts. TAPI has a teen vaccination campaign (Tdap, meningococcal and human papillomavirus [HPV] vaccines) that involves provider education as well as parent and teen outreach. Protect Me with 3, a parent-focused campaign, reminds parents that their children still need them to protect them and to help with healthy decisions. Take Control, a teen campaign, addresses teen vaccinations required to maintain health as teens begin to take control of their lives in the realms of college, driving, and even health decisions.
- **Health Current:** Formerly Arizona Health-e Connection, this non-profit organization is a health information exchange organization (HIO) and is the single statewide Health Information Exchange (HIE). Health Current currently has 347 unique participants, which include hospitals, accountable care organizations, health plans, behavioral health providers, laboratories, ambulatory practices, long-term care providers, and more. (For a complete list of participants, Health Current maintains a count on their website: <https://healthcurrent.org/hie/the-network-participants/>). To improve care coordination, AHCCCS requires all managed care contractors to join the HIE. Health Current electronically shares hospital data with several other out-of-state HIEs through a project called the Patient-Centered Data Home (PCDH). The PCDH project provides the technical and legal agreements to support cross-state data sharing for care coordination. Launched in early 2017, Southern Colorado, Arizona, Utah, and now Santa Cruz and San Diego HIEs are capable of sharing hospital admission, discharge, or transfer information with a Medicaid member’s home HIE if that member seeks care outside his or her Arizona or “home” HIE.
- **ADHS Bureau of Tobacco and Chronic Disease:** In collaboration with ADHS, AHCCCS monitors the utilization of and access to smoking cessation drugs and nicotine replacement therapy programs. AHCCCS members are encouraged to participate in ADHS’ Tobacco Education and Prevention Partnership (TEPP) smoking cessation support programs such as “ASHLine” and/or counseling in addition to seeking assistance from their PCPs. Additional efforts have been focused on the

integrated SMI population in connecting members to smoking cessation and nicotine replacement programs.

- **Emergency Medical Services (EMS) Treat and Refer Initiative:** AHCCCS began the process of studying treatment deferrals with City of Mesa EMS teams. EMS took members to the ED for treatment because AHCCCS had no other mechanism for payment when EMS teams were called to transport members. AHCCCS and the Mesa EMS team explored a broad-based approach to EMS care. AHCCCS has developed code sets to allow EMS teams to treat and release members as appropriate and bill for those evaluations versus billing for transport and creating an ED fee for the member. EMS teams are using their training to complete a thorough assessment of the member and make the best decision for the member's care, while limiting unnecessary treatment for the member. Members that need emergent services are expeditiously transported; however, if the situation does not warrant an ED visit, the EMS team can make a recommendation for home care and timely follow-up with the member's primary care physician.
- **Arizona Head Start Association:** The Arizona Head Start and Early Head Start programs provide education, development, health, nutrition, and family support services to qualifying families. The Arizona Head Start grantees—including the City of Phoenix, Maricopa County, Chicanos Por La Causa, and Southwest Human Development—continue to host community meetings quarterly. The meetings are attended by families participating in the Head Start program along with AHCCCS staff members and the AHCCCS Contractor MCH/EPSTDT coordinators.
- **Arizona Medical Association (ArMA) and the Arizona Chapter of the American Academy of Pediatrics (AAP):** AHCCCS collaborates with ArMA and the Arizona Chapter of the AAP in numerous ways, from development and review of assessment tools to data sharing and support of system enhancements for providers, including the Electronic Health Records (EHR) Incentive Program. During this year AHCCCS continued discussions related to increasing use of developmental screening tools, the primary care enhanced payment structure, and care and services delivered to members with a diagnosis of autism. In addition, AHCCCS worked with the organizations related to changes in billing codes for photo-ocular vision screening codes.
- **Arizona Perinatal Trust (APT):** The APT oversees voluntary certification of hospitals for the appropriate level of perinatal care according to established guidelines and conducts site visits for initial certification and recertification. AHCCCS covers over 50 percent of the births in Arizona; therefore, the site reviews provide AHCCCS with a better assessment of the hospitals that provide care to pregnant women and newborns, from normal labor and delivery to neonatal intensive care. Details of the site visit review are kept confidential; however, site visit reviews do allow opportunities for collaboration among healthcare professionals to learn about innovative practices that hospitals have implemented as well as sharing of best practices, policies, and guidelines. AHCCCS continues to support APT and participate in site visits regularly.
- **Arizona Newborn Screening Advisory Committee:** The Newborn Screening Advisory Committee was established to provide recommendations and advice to ADHS regarding tests that should be included in the newborn screening panel. The committee recommended including the 29 disorders, including hearing loss, of the core panel of the Uniform Screening Panel from the U.S. Department of Health and Human Services (HHS) Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. Any recommendation of a test to be added to the panel must be accompanied by a cost-benefit analysis. The committee is chaired by the ADHS Director and meets

at least annually. The Director appoints the members of the committee, to include seven physicians representing the medical specialties of endocrinology, pediatrics, neonatology, family practice, otology, and obstetrics (OB); a neonatal nurse practitioner; an audiologist; a representative of an agency that provides services under Part C of the Individuals with Disabilities Education Act; at least one parent of a child with a hearing loss or a congenital disorder; a representative from the insurance industry familiar with healthcare reimbursement issues; the AHCCCS Director or director's designee; and a representative of the hospital or healthcare industry.

- **Strong Families: Interagency Leadership Team (IALT):** IALT was established related to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant, which ensures that high-risk families have access to home visitation services in Arizona. IALT is composed of various stakeholders in the community including DES, the Department of Education, ADHS, and AHCCCS. The purpose of the leadership team is to discuss strategy for building a statewide home-visiting system. Additionally, this team oversees implementation of the MIECHV grant and any decisions required regarding home visitation practices. AHCCCS members benefit from home-visiting programs when identification and referrals are made by AHCCCS Contractors. AHCCCS continues to be a strong referral source to the home-visiting programs, with the anticipated results of improved birth outcomes for mothers and babies.
- **Innovations in Childhood Obesity Update:** AHCCCS was selected by the Center for Health Care Strategies (CHCS) to participate in this initiative; therefore, AHCCCS formed a collaborative workgroup to drive these improvements throughout the State. AHCCCS selected a Federally Qualified Health Center (FQHC) with which to work in partnership to collect data and implement interventions relevant to this initiative; AHCCCS Contractors joined the workgroup related to these directives. During Quarter 3, a multi-year childhood obesity initiative was finalized. This longitudinal initiative focused on a cohort of children between 2 to 5 years of age, each with a body mass index (BMI) of 85 percent or more. The study cohort was scattered across multiple contracted health plans, all of which were receiving services in an urban FQHC. The goals are to examine preliminary findings for prevalence of obesity in children of this age and to examine the potential effectiveness of behavioral health intervention strategies.
- **Value-Based Purchasing (VBP) Initiatives:** AHCCCS is promoting numerous VBP initiatives for both providers and Contractors. Implementation of initiatives is now contractually mandated, with requirements increasing each year. Additionally, AHCCCS leverages VBP strategies with the Contractors on certain performance measures, strengthening the focus on initiatives that AHCCCS deems most meaningful to the populations served.
- **Early Reach-In:** Contractors are required to participate in criminal justice system “reach-in” care coordination efforts through collaboration with criminal justice partners (e.g., jails; sheriff’s office; Correctional Health Services; and Arizona Department of Corrections, including community supervision and probation courts). AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend member eligibility upon incarceration rather than terminating coverage. Upon the member’s release, the member’s suspension of AHCCCS eligibility is lifted, allowing for immediate care coordination activities. Using the 834 data file to identify incarcerated members who have been incarcerated for 30 days or longer and who have anticipated release dates, the Contractor conducts reach-in care coordination for members with chronic and/or complex care needs, including assessment and identification of MAT-eligible members. The Contractors, with the criminal justice

partners, facilitate the transition of members out of jails and prisons and into communities. Members are provided with education regarding care, services, resources, appointments, and health plan case management contact information. Post-release initial physical and behavioral health appointments are scheduled within seven days of member release. Ongoing follow-up occurs with the member to assist with accessing and scheduling necessary services as identified in the member's care plan, including access to all three U.S. Food and Drug Administration (FDA)-approved MAT options covered under the AHCCCS Behavioral Health Drug List and assignment to peer support services to help navigate and retain the member in MAT when appropriate.

- **Foster Care Initiative:** AHCCCS is committed to providing comprehensive, quality healthcare for children in foster, kinship, or adoptive care. Foster children are eligible for medical and dental care, inpatient, outpatient, behavioral health, and other services through the Comprehensive Medical and Dental Program (CMDP) and the RBHAs or through CRS. Adoptive children are typically AHCCCS eligible and enroll in a health plan/RBHA or CRS like any Medicaid-eligible child. AHCCCS holds a variety of meetings related to improving service delivery for children in foster care. Monthly collaborative meetings with the Department of Children's Services (DCS)/CMDP occur to continue efforts to improve service delivery for children in the foster care system and to ensure that services identified as medically necessary are available. AHCCCS hosts monthly cross-divisional operational team meetings to continue efforts and quarterly meetings with RBHA and CRS leadership to review data and discuss system changes and best practices. System improvements include documenting frequently asked questions, developing behavioral health and crisis services flyers for foster and kinship caregivers, and streamlining health plan deliverables. Additionally, AHCCCS created a dashboard to track and trend utilization for children in foster care. Further, AHCCCS developed a policy (ACOM 449) that outlines specific requirements for behavioral health services for adopted children and for children within custody of the Department of Children's Services (DCS).
- **Long-Acting Reversible Contraceptive (LARC) Initiative:** AHCCCS instituted the LARC initiative to allow for purchase of LARC devices to be reimbursed outside of the regular hospital payment. Offering members access to LARC devices in the hospital after delivery is expected to increase utilization of such devices as many members do not attend their six-week postpartum office visits.
- **Behavioral Health Learning Opportunities:** With the advent of administrative simplification, AHCCCS recognized the need to provide learning opportunities for staff lacking behavioral healthcare experience and expertise due to previous historical hiring requirements for medically trained personnel. In July 2016 AHCCCS began to offer formal meetings as well as informal workshops, and lunch-hour trainings to ensure that staff had opportunities to increase behavioral health system knowledge. Internal behavioral health subject matter experts, licensed behavioral health practitioners, and community professionals have been procured to offer training on topics such as infant/toddler mental health, trauma-informed care, perinatal mood disorders, and adult system-of-care processes for individuals with general mental health needs and SMI.

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

- Regulatory requirements for individuals designated as having an SMI versus having general mental health and/or substance abuse needs (GMHSA)
- Grant-based housing for individuals with SMI



- Short-term behavioral health residential services
- Crisis process and requirements
- Diagnostic categories and symptoms
- Best-practice and evidence-based clinical approaches for adults and children
- Mental health awareness

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

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

## 5. Contractor Best and Emerging Practices

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

### Cenpatico Integrated Care (CIC)

- **Enhanced Data-Driven Quality of Care (QOC) Tracking/Trending:** The QOC SharePoint site implemented during CYE 2017 allows for enhanced tracking and trending of QOC investigations. Data pulled from this site can compare QOC data by provider/health home, behavioral health inpatient facility/behavioral health residential facility (BHIF/BHRF), and hospital. Through this site, multiple levels of tracking and trending can occur—including identification of allegation type, sub type, substantiation, outcome, and action. Based on data, CIC can determine appropriate action to be taken, whether with a letter of concern (LOC) or a corrective action plan (CAP). The Quality Care Committee has increased capacity to drill down to identify more focused performance initiatives related to QOC data that cannot be obtained through the AHCCCS portal alone.
- **Provider Dashboard:** Cenpatico rolled out a revised monthly dashboard with member-level detail to empower providers to outreach to members and to close care gaps. Cenpatico incorporated some aspects such as rankings, forecasting, and traffic light graphics into the revised quality metrics dashboard. Key highlights of this dashboard include the following:
  - Capability to view data as a whole or by specific health home or primary care physician (PCP)
  - Traffic light graphics demonstrating progress toward minimum performance standard (MPS)
  - Capability to view both previous and current quarter data within the same document
  - Specific numerator and denominator detail
  - Number of hits needed to meet MPS for a metric
  - Capability to see health home rankings on various measure sets
  - A forecast for future performance based on past performance
  - Control charts comparing specific provider performance to the plan average and to the MPS
  - A listing of care gaps for specific members related to each measure
- **Enhanced Member Complaint Identification and Referral:** Cenpatico developed a collaborative complaint review process between the chief medical officer (CMO) and complaint department to ensure that member issues that may be potential QOC concerns are urgently and appropriately routed to the QOC area for action. The process involves meetings throughout the week between the complaints manager, the grievance and appeals manager, and the CMO or designee to review new complaints. The CMO or designee determines which cases should be referred to QOC. The complaints manager then completes an internal referral for applicable cases. This process is tracked by the complaints manager, who documents the disposition for the reviewed complaint as a referral

to any of QOC, complaints, grievance, or claims departments. This process ensures that potential QOC issues are appropriately identified and referred timely to the QOC department.

## Health Choice Integrated Care (HCIC)

- **Health Buddy Discharge Outreach:** HCIC has implemented a “Health Care Buddy” system to improve outcomes and high-quality healthcare delivery to those in the SMI integrated population. HCIC has effectively reduced avoidable hospital readmissions by using an HCIC Healthcare Buddy to perform outreach phone calls to members within three days post-discharge from behavioral and acute hospitalization.
- **Safety, Help, Outreach, Understand, Track (SHOUT) Protocol:** HCIC integrated care managers and physicians ensure that high-risk members are immediately identified and tracked and that the SHOUT protocol is followed for those members during the subsequent year. Members with an attempted hanging, suffocation, strangulation, use of a firearm, or more than one attempt requiring medical intervention are placed on the registry. The SHOUT Protocol uses actionable, evidence-based interventions such as coordinating with the member’s PCP and other providers to reduce access to medication stock. In addition, the SHOUT protocol is incorporated into the provider contracts. Each person on the registry is followed, through monthly clinical rounds conducted by an HCIC integrated care manager with the provider clinical team, to ensure protocol adherence and clinical oversight.
- **Benzodiazepine and Opioid Warning Signs (BOWS) Prevention Protocol:** HCIC implemented the BOWS Prevention Protocol, designed to decrease the frequency of overdoses and deaths by overdose related to opioids and benzodiazepines. Providers and HCIC staff are trained to recognize warning signs of members at risk for overdose and to implement action steps to intervene early, before an overdose occurs. The BOWS Prevention Protocol uses many evidence-based interventions, including assessing immediate risk in the event of a suspected overdose, alerting all relevant care team members of warning signs and overdose risk, and making provider recommendations to prescribe naloxone for members on opioids.

## Mercy Maricopa Integrated Care (MMIC)

- **Neonatal Abstinence Syndrome (NAS) Intensive Care Management Program:** The NAS Intensive Care Management program was implemented in response to the rapidly growing rate of pregnant women with opioid use disorder (OUD). Pregnant women designated as SMI and assigned to an SMI clinic are identified for the program. Program goals include identification, evaluation, coordination of services and community resources, and education and substance abuse assessment. In addition, integrated care management staff members collaborate with the adult SMI outpatient team to assist with this initiative.
- **Opioid Prescribing Initiative:** One objective of MMIC’s initiative is to reduce morbidity and mortality associated with prescription drugs that have abuse potential by increasing awareness and coordination of care as well as by educating providers and members about appropriate uses of

opioids in the treatment of chronic, non-cancer pain. The other objective is to integrate drug screening education for providers and medication-assisted substance abuse treatment into existing initiatives to improve outcomes for members and to increase naloxone prescriptions. MMIC provides the community with education through materials, community presentations, sponsorships, and panel presentations.

- **Mercy 360 Academy:** The Mercy 360 Academy aimed to increase access to care for the most vulnerable populations by offering evidence-based trainings for practices to MMIC contracted providers and various stakeholders. The trainings focused on three different evidence-based practices: trauma-focused cognitive behavioral therapy (TF-CBT), cognitive behavioral therapy related to substance use disorder with an opioid focus (CBT-SUD), and use of Transition to Independence Process (TIP) needs assessments.

## 6. Organizational Assessment and Structure Performance

In accordance with 42 CFR §438.358, which describes activities related to external quality review, a state Medicaid agency; its agent that is not an MCO, PIHP, PAHP or PCCM entity; or an EQRO must conduct a review within the previous three-year period to determine the RBHA Contractors compliance with state standards set forth in subpart D of 42 CFR §438 and quality assessment and performance improvement requirements described in 42 CFR §438.330. AHCCCS meets the requirement by conducting operational reviews (ORs) of its RBHA 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 RBHA Contractors' compliance with federal and AHCCCS contract requirements. As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the activities associated with the federal Medicaid managed care mandatory compliance reviews. In accordance with and satisfying the requirements of 42 CFR §438.364, AHCCCS then contracted with HSAG as an EQRO to use the information that AHCCCS obtained from its compliance review activities to prepare this section of the annual EQR report.

CYE 2016 commenced a new review cycle of ORs for which AHCCCS conducted a comprehensive OR for one RBHA Contractor (Mercy Maricopa Integrated Care) as well as a focused review for Cenpatico Integrated Care (CIC) in CYE 2017. Health Choice Integrated Care had not yet undergone a scheduled OR.

Results of the comprehensive and focused OR for two RBHA Contractors and the CAPs and CAP responses for all RBHA Contractors as well as the challenges (if applicable) are described in this section of the annual EQR report.

### Conducting the Review

The following sections describe the process that AHCCCS uses to meet the requirements for ORs of RBHA Contractors' performance in complying with federal and AHCCCS' contract requirements.

#### *Objectives for Conducting the Review*

AHCCCS' objectives for conducting ORs are to:

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

- Provide technical assistance and identify areas in which the Contractors can improve as well as areas of noteworthy performance and accomplishment.
- Review the Contractor’s progress in implementing recommendations that AHCCCS made during prior ORs.
- Determine if the Contractor complied with its own policies and evaluate the effectiveness of those policies and procedures.
- Perform oversight of the Contractor as required by CMS in accordance with AHCCCS’ 1115 waiver.
- Provide information to HSAG as AHCCCS’ EQRO to use in preparing this report as described in 42 CFR 438.364.

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

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

AHCCCS’ methodology for conducting the OR included the following:

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

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

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

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

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<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: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf>. Accessed on: April 3, 2018.

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

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

## **Standards**

The CYE 2017 comprehensive OR for Mercy Maricopa Integrated Care (MMIC) was organized into 10 standard areas. For the RBHA Contractors, each standard area consisted of several elements designed to measure the RBHA Contractor's performance and compliance. Following are the 10 standards and number of elements involved in each standard used throughout the report:

- Corporate Compliance (CC), five elements
- Claims and Information Systems (CIS), 12 elements
- Delivery Systems (DS), 14 elements
- General Administration (GA), three elements
- Grievance Systems (GS), 17 elements
- Adult, EPSDT, and Maternal Child Health (MCH), 12 elements
- Medical Management (MM), 27 elements
- Member Information (MI), nine elements
- Quality Management (QM), 25 elements
- Third-Party Liability (TPL), seven elements

For the CYE 2017 focused OR for CIC, AHCCCS reviewed specific standards in the following categories, as indicated following.

- Claims and Information Systems (CIS), four elements
- Delivery Systems (DS), three elements
- Adult, EPSDT, and Maternal Child Health (MCH), seven elements
- Medical Management (MM), 17 elements
- Quality Management (QM), 16 elements

## **Scoring Methodology**

Each standard area contains elements designed to measure the Contractor's performance and compliance with the federal managed care rules and the AHCCCS RBHA contract provisions. A RBHA Contractor

may receive up to a maximum possible score of 100 percent for each standard measured in the CYE 2017 OR. Within each standard are specific scoring detail criteria worth defined percentages of the total possible score.

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

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

### **Corrective Action Statements**

As part of the AHCCCS methodology, each RBHA Contractor receives a report containing review findings. The RBHA Contractor has opportunity to respond to AHCCCS concerning any disagreements related to the findings. AHCCCS reviews and responds to any RBHA Contractor disagreements based on review of the RBHA Contractor information, and then revises the report if necessary. AHCCCS issues the final report to the RBHA Contractor, describing the findings, scores, and required CAPs.

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

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



## Contractor-Specific Results

For the CYE 2016 review period, in CYE 2017, AHCCCS conducted a comprehensive OR with 10 standards for MMIC and a focused OR with five standards for CIC. Contractor-specific results are presented following.

### *Mercy Maricopa Integrated Care (MMIC)*

AHCCCS conducted an on-site review of MMIC from July 17, 2017, through July 19, 2017. A copy of the draft version of the report was provided to the RBHA Contractor on August 30, 2017. MMIC was given a period of one week in which to file a challenge to any findings that the RBHA Contractor considered inaccurate, based on the evidence available at the time of review.

### Findings

For the CYE 2016 review period, AHCCCS conducted in CYE 2017 a comprehensive OR considering 10 standards. Table 6-1 presents the total number of elements scored for each standard; the standard area scores; and the total number, if any, of required corrective actions for each standard area reviewed.

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

Standard Area	Total Number of Elements Scored	Standard Area Score	Required Corrective Actions
Corporate Compliance	5	83%	2
Claims and Information Systems	12	99%	1
Delivery Systems	14	96%	2
General Administration	3	100%	0
Grievance Systems	17	100%	0
Adult, EPSDT, and Maternal Child Health	12	94%	1
Medical Management	27	95%	5
Member Information	9	100%	0
Quality Management	25	98%	2
Third-Party Liability	7	100%	0

Table 6-1 illustrates the following compliance results for the 10 standards reviewed for the MMIC OR:

- Corporate Compliance (CC): For the five elements within this standard, the Contractor received a score of 83 percent (417 out of 500).

- Claims and Information Systems (CIS): For the 12 elements within this standard, the Contractor received a score of 99 percent (1,191 out of 1,200).
- Delivery Systems (DS): For the 14 elements within this standard, the Contractor received a score of 96 percent (1,343 out of 1,400).
- General Administration (GA): For the three elements within this standard, the Contractor received a score of 100 percent or the equivalent to (300 out of 300).
- Grievance Systems (GS): For the 17 elements within this standard, the Contractor received a score of 100 percent (1,700 out of 1,700).
- Adult, EPSDT, and Maternal Child Health (MCH): For the 12 elements within this standard, the Contractor received a score of 94 percent (1,133 out of 1,400).
- Medical Management (MM): For the 27 elements within this standard, the Contractor received a score of 95 percent (2,576 out of 2,700).
- Member Information (MI): For the nine elements within this standard, the Contractor received a score of 100 percent (900 out of 900).
- Quality Management (QM): For the 25 elements within this standard, the Contractor received a score of 98 percent (2,438 out of 2,500).
- Third-Party Liability (TPL): For the seven elements within this standard, the Contractor received a score of 100 percent (700 out of 700).

## Strengths

For this OR, AHCCCS reviewed a total of 10 standards. MMIC was fully compliant (100 percent scores) for four of the 10 standards reviewed (GA, GS, MI, and TPL). The RBHA Contractor also demonstrated strong performance in the CIS, DS, MM, and QM standards, with compliance scores between 95 percent and 99 percent. For the GA standard, the RBHA Contractor has policies and procedures for the maintenance of records and policy development that comply with all AHCCCS requirements. For the GS standard, the RBHA Contractor complies with all timelines required in the standard, has a process for the intake and handling of member appeals that are filed orally, issues notices of appeal resolutions that include all information required by AHCCCS, and maintains claim dispute records.

MMIC demonstrated full compliance for the MI standard, which included the requirement to submit to AHCCCS for approval qualifying member information materials given to its current members and which do not fall within annual, semi-annual, or quarterly required submissions and to maintain a log of all member material distributed to members. Full compliance was met for the TPL standard, which involved a response to the request to provide a list of claims related to the joint or mass tort case within 10 business days of the request.

Although the CIS standard, with a score of 99 percent, did not achieve full compliance, MMIC performed at or above the “95 percent threshold” established by AHCCCS. For the CIS standard, CIC has policies and procedures in place to ensure that all claims are processed accurately and according to specific rules as required by AHCCCS. The RBHA Contractor conducts routine training for all new

hires and subcontractors on processing claims that are specific to AHCCCS' lines of business and provides periodic training updates to MMIC staff.

For the DS standard (scored at 96 percent), MMIC has a process to evaluate its provider services staffing levels based on the needs of the provider community and has identified the means to ensure that peer/recovery support specialists (and their supervisors) employed within the MMIC network have adequate access to continuing education specific to the practice of peer support. MMIC also performed well in the MM standard (scored at 95 percent), which includes the requirement that the RBHA Contractor identify, monitor, and implement interventions to prevent the misuse of controlled and non-controlled medications.

For the QM standard, for which MMIC received a score of 98 percent, MMIC demonstrated a structure and process in place for quality-of-care and abuse and complaint tracking and trending for system improvement. Additionally, AHCCCS determined that MMIC conducts a new member health risk assessment survey and identifies specific health care needs.

### Opportunities for Improvement and Recommendations

The results of the OR established opportunities for improvement as MMIC was less than fully compliant in four standards (the CIS, DS, MM, and QM standards) reviewed, with percentages that varied between 95 percent and 99 percent, and was below the 95 percent compliance threshold established by AHCCCS for two standards (the CC and MCH standards).

MMIC received a compliance score of 83 percent for the CC standard. AHCCCS noted that it was not stated in the RBHA Contractor's policy or plan that the corporate compliance officer is on-site. AHCCCS also noted that the brain-computer interface (BCI) Storyboard and Compliance 101 trainings did not include local contacts at MMIC or mechanisms for direct reporting to AHCCCS-OIG. For the MCH standard, MMIC received a score of 94 percent because the MCO did not have processes in place to inform members and all primary care and obstetrician/gynecologist providers of women's preventive care services. In addition, provider education materials were not implemented.

Although the CIS, DS, MM, and QM standards received scores that complied with the "at or above 95 percent" threshold established by AHCCCS, several opportunities for improvement were identified. During a review of overturned claim disputes (for the CIS standard), one claim was paid more than 15 business days from the date of the decision.

For the DS standard, AHCCCS determined that MMIC did not provide sufficient evidence that all providers were notified of required single audit submission requirements and sub award information. Additionally, MMIC's Substance Abuse Prevention and Treatment Block Grant (SABG) and Community Mental Services Health Block Grant (MHBG) internal policies and procedures did not comply with all State and federal requirements.

For the MM standard, AHCCCS identified that for most records reviewed, post-discharge telephone calls were not conducted. Indication exists of a gap in MMIC's process for monitoring the effectiveness of the care coordination and case management for members who have received SMI decertification. In

addition, for most records reviewed, the RBHA Contractor did not complete the enrollment transition information (ETIs) appropriately, with three fields left blank consistently. AHCCCS also identified that MMIC's Emergency Service and Post-Stabilization policy does not include the requirement stating, "The RBHA Contractor does not deny payment for the treatment of emergency services when a representative of the RBHA Contractor instructs the enrollee to seek emergency services." Further, the RBHA Contractor did not provide policies and procedures for outreach, engagement, re-engagement, and closure activities; and did not provide documentation that all re-engagement requirements are completed prior to a member's closure process.

AHCCCS identified a number of issues with the QM standard, including several discrepancies in closing letters and instances of a lack of documentation in files. In addition, MMIC did not provide evidence for members in home- and community-based services (HCBS) or behavioral health residential settings that those members had completed advance directives and that the documents are kept confidential but are available.

### Corrective Action Plans

In the report generated from MMIC's OR, AHCCCS included recommendations that required the submission of 13 CAPs by October 12, 2017. (The CAP submission that MMIC was required to provide was not available at the time of this report and is therefore not included.) On September 7, 2017, MMIC submitted requests for reconsideration for seven issues identified during the OR, of which three requests (for the DS and MM standards) were accepted in full. Scores for these standards were revised accordingly.

AHCCCS included the following findings and recommendations in the final OR report to MMIC. For the CC standard (which received a compliance score of 83 percent), MMIC must develop a CAP to incorporate the State's contractual requirements from Section 14, Corporate Compliance Program (14.1.7), into MMIC's policy and/or plan. The RBHA Contractor must also update the BCI Storyboard and Compliance 101 trainings with AHCCCS-OIG and current MMIC contacts. MMIC received a compliance score of 94 percent for the MCH standard. MMIC must submit a CAP to develop a written policy and procedure to inform members and all primary care and obstetrician/gynecologist providers of the availability of women's preventive care services as listed in the AHCCCS Medical Policy Manual (AMPM) 411.

Although MMIC received scores at or above the 95 percent threshold for the CIS, DS, MM, and QM standards, AHCCCS required MMIC to submit a CAP for each deficiency identified. For the CIS standard, MMIC must develop a CAP to ensure that MMIC processes and pays all overturned claim disputes in a manner consistent with the related decisions and within 15 business days of the decisions.

AHCCCS determined that MMIC must develop CAPs for the DS standard, which received a compliance score of 96 percent. MMIC must develop a plan to maintain up-to-date policies, procedures, and templates and must establish a process to ensure that policies, desktop procedures, and templates are up to date with current regulatory requirements. MMIC must submit the performance improvement plan that MMIC will implement to ensure notification to all providers of required sub award information. MMIC must revise MMIC's federal funding subrecipient tracking to include audit receipt dates and/or

Federal Audit Clearinghouse acceptance dates and revise the policy to state that management decisions must be issued, per 2 CFR 200.521, within six months of acceptance of the audit report by the Federal Clearinghouse. Additionally, MMIC must develop a plan to ensure a comprehensive annual review of providers SABG and MHBG internal policies and procedures, ensuring compliance with State and Federal requirements.

AHCCCS required MMIC to submit several CAPs for the MM standard. MMIC must complete a post-discharge telephone call within seven days of discharge and confirm that discharge needs were met. MMIC must also develop a plan to ensure a process for monitoring the effectiveness of the care coordination and case management for members who received serious mental illness (SMI) decertification as well as a plan to ensure completion of all sections of the ETI forms—leaving no blank spaces. MMIC’s policy for emergency services must include a statement that the RBHA Contractor does not deny payment for treatment for emergency services when a representative of the RBHA Contractor instructs the enrollee to seek emergency services. Further, MMIC must have policies and procedures for the outreach, engagement, re-engagement, and closure activities for behavioral health services and ensure that all re-engagement requirements are completed prior to the member closure process.

For the QM standard, MMIC must submit CAPs addressing various issues. MMIC must submit a plan to ensure that any information required to assist with the analysis of the quality of care (QOC) concern be obtained prior to sending a closing letter. Or, if additional information that may affect the outcome of the initial leveling and/or determination is received from the provider once a closing letter is sent, that analysis of the new or additional information by the RBHA Contractor must be clearly documented along with a response to amend the initial leveling and/or determination and that any required improvement or action plans be implemented. The RBHA Contractor must submit a policy and desktop procedure to reflect the process and evidence of staff training on this procedure.

In addition, MMIC must ensure that all parties who received opening letters regarding a QOC concern receive closing letters and that those parties directly involved in the QOC issue each receive a closing letter that includes allegation(s), determination, and leveling; the outcome of both provider and AHCCCS resolution reports must correspond. MMIC must demonstrate the activities mentioned through submission of policies and desktop procedures and must submit a sample of QOC files as evidence of implementation. Further, MMIC must have a system that ensures that documentation of provider responses to PIPs is received, maintained, and assessed for completeness and must submit a policy and desktop procedure to reflect receipt, process, and review of the completeness of provider responses to PIPs. MMIC must include a sample of QOC cases that required provider PIPs to demonstrate implementation. MMIC must also develop a plan to ensure that the “YES” box is checked on the Residential Review Tool if the member has completed an advance directive and verify that the document is stored in a confidential but accessible location should it be needed by emergency personnel entering the facility.

## Summary

MMIC was fully compliant (100 percent score) in the GA, GS, MI, and TPL standards. MMIC was within the 95 percent threshold of compliance for the CIS, DS, MM, and QM standards. The CC and MCH standards received the lowest scores (83 percent and 94 percent, respectively). CAPs were required for the CC, CIS, DS, MCH, MM, and QM standards. AHCCCS required MMIC to submit by October 12, 2017, proposed CAPs for the deficiencies that AHCCCS identified. (MMIC’s required CAP submission was not available at the time of this report and is therefore not included.)

## Cenpatico Integrated Care (CIC)

AHCCCS conducted a focused review of CIC in CYE 2017 for five standards. A copy of the draft version of the report was provided to the RBHA Contractor on March 10, 2017. CIC was given a period of one week in which to file a challenge to any findings that the RBHA Contractor considered inaccurate, based on the evidence available at the time of review.

## Findings

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

**Table 6-2—Standard Areas and Compliance Scores for CIC**

Standard Area	Total Number of Elements Scored	Standard Area Score	Required Corrective Actions
Claims and Information Systems	4	82%	2
Delivery Systems	3	100%	0
Adult, EPSDT, and Maternal Child Health	7	28%	7
Medical Management	17	83%	7
Quality Management	16	90%	4

Table 6-2 illustrates the following compliance scores for the five standards reviewed for the CIC-focused OR:

- Claims and Information Systems (CIS): For the four elements within this standard, the Contractor received a score of 82 percent (329 out of 400).
- Delivery Systems (DS): For the three elements within this standard, the Contractor received a score of 100 percent (300 out of 300).
- Adult, EPSDT, and Maternal Child Health (MCH): For the seven elements within this standard, the Contractor received a score of 28 percent (197 out of 700).

- Medical Management (MM): For the 17 elements within this standard, the Contractor received a score of 83 percent (1,407 out of 1,700).
- Quality Management (QM): For the 16 elements within this standard, the Contractor received a score of 90 percent (1,443 out of 1,600).

### Strengths

For this focused OR, AHCCCS reviewed a total of five standards. CIC was fully compliant, with a 100 percent score in one of the five standards reviewed (the DS standard).

For the DS standard, CIC provided documentation demonstrating adequate training for provider services representatives, that CIC has a mechanism for tracking and trending provider inquiries that includes timely acknowledgement and resolution as well as taking systemic action as appropriate, and that members are referred to out-of-network providers if CIC is unable to provide requested services in its network.

### Opportunities for Improvement and Recommendations

Results of the focused OR demonstrated opportunities for CIC to improve in various areas. For the CIS standard, for which CIC received a score of 82 percent, AHCCCS identified several issues requiring the RBHA Contractor improvement. For example, during AHCCCS' review of claims, the following issues were identified: an incorrect application of interest, an incorrect calculation of interest applied to claims, physicians' services not addressed in the associated hospital's contract that could not be matched to a contracted rate.

For the MCH standard (scored at 28 percent), CIC did not provide adequate documentation demonstrating that CIC established and operates a maternity care program with goals directed at achieving optimal birth outcomes that meet AHCCCS minimum requirements. Additionally, CIC did not provide documentation on the following processes: addressing postpartum depression screening, monitoring initial and return prenatal care visits, monitoring and evaluating postpartum activities and interventions to increase postpartum utilization, and identifying postpartum depression and connecting members to care. CIC did not provide adequate documentation demonstrating that CIC monitors provider compliance with providing EPSDT services; or that CIC has a process to identify the needs of EPSDT age members, coordinate their care, and conduct adequate follow-up to verify that members receive timely and appropriate treatment. AHCCCS also noted that CIC did not provide members documentation that addressed preventive care services for women.

AHCCCS noted for the MM standard, for which CIC received a compliance score of 83 percent, that the documentation CIC submitted did not adequately address the requirement to execute processes for assessing, planning, implementing, and evaluating utilization data management activities. Additionally, during AHCCCS' file review, some files did not have evidence of the following: proactive discharge planning; PCP follow-up arrangement; coordination of medications, therapy, and durable medical equipment (DME); follow-up telephone calls within seven days after discharge; referrals to community resources, case management, disease management, or care coordination completed by CIC. Further, CIC's MM committee meeting minutes did not discuss outcomes for the chronic care or disease

management programs or program revisions based on the committee's recommendations. CIC also did not demonstrate that ETIs are completed appropriately.

Further, having reviewed the requirement relating to collaboration in identifying members with high needs or high costs in order to improve coordination of care and individual outcomes, AHCCCS noted that actions and subsequent outcomes achieved (as a result of using data specific to members with high needs or high costs) were not reported to the MM committee and that no evidence was supplied of assessment and/or reassessment of the members' needs or subsequent actions taken. AHCCCS also noted that CIC's Notice and Appeal Requirements Policy and more than 50 percent of notice of action (NOA) letters were not compliant with NOA requirements.

For the QM standard (scored at 90 percent), AHCCCS found that during CIC's QOC review process, CIC QOC staff did not participate in the monitoring of CAPs and did not communicate directly with members. Also, resolution to QOC issues referred to the CAP committee and peer review committee was not documented in the original QOC file. AHCCCS also noted the following issues: CIC did not adequately implement a structured peer review process that included related administrative requirements, and CIC did not have a process for conducting provisional credentialing. Additionally, CIC did not provide adequate documentation to demonstrate that CIC ensures that individuals with special healthcare needs are assessed by providers with appropriate expertise.

### Corrective Action Plans

On April 17, 2017, CIC submitted proposed CAPs for each deficiency found during the focused OR for four standards (CIS, MCH, MM, and QM). On March 10, 2017, CIC submitted requests for reconsideration to AHCCCS for eight issues identified during the OR, of which one request (for the QM standard) was accepted in full and two requests (for the MCH standard) were accepted in part. Scores for these standards were revised accordingly. On September 27, 2017, AHCCCS recommended that CIC review the corrective actions identified in the CYE 2016 Focused Operational Review Final Report. With few exceptions, AHCCCS' expectation is that the issues identified in the final report would be addressed by the next complete OR. (Results for CIC's focused OR in 2017 occurred outside the review period and are therefore not included.)

For the CIS standard, CIC proposed to do the following: train all cross-functional teams to outline work initiatives, project plans, and system change requests; modify the claims processing workflow document; update system calculators for skilled nursing facilities; and develop and document the weekly claims technical assistance work process to validate that claim and interest rates are correct.

CIC developed CAPs for the MM standard, including implementation of a documented process for monitoring and evaluating utilization of services for identified variances in utilization patterns of providers and members and development of processes to identify members and providers who require intervention to correct patterns of abuse or misuse. CIC also provided a plan to ensure that documentation includes PCP follow-up; coordination of medications, therapies, and DME; telephone calls within seven days post discharge; and referrals to community resources, case management, or disease management. CIC will also document all care coordination efforts made in the electronic medical record for members identified as having special healthcare needs.



CIC proposed a CAP to define outcomes for the Disease Management Program and to ensure that the MM committee meeting minutes include annual discussion and approval of evidence-based guidelines for the Disease Management Program as well as discussion of interventions and outcomes that include new interventions and follow-up. CIC conducted a root cause analysis on the underlying reasons for the issues identified by AHCCCS regarding the utilization of AHCCCS ETI forms for members transitioning to another RBHA Contractor and, as a result, improved education, monitoring, and control of the transition process.

To ensure that denials of services and subsequent NOAs are completed by CIC (and not providers) and to ensure that NOA letters are compliant with all NOA requirements, CIC updated the language in CIC's Notice and Appeal Requirements Policy as well as in the NOA templates (which will be reviewed with all medical directors as well as during provider calls). CIC also provided a plan to document the review and analysis of members with high needs and high costs during the MM committee meetings and to collaboratively identify members for the RBHA Contractor member roster through quarterly data pulls.

For the QM standard, CIC developed a CAP that included implementation of a process to ensure that the resolution of issues referred to the CAP committee and peer review are noted in the original QOC investigation file. CIC also has included QOC specialists as permanent attendees of the CAL/CAP and peer review committees and has developed opening and closure letters for members who initiate QOC investigations.

## Summary

CIC was fully compliant (100 percent score) in the DS standard. The MCH standard received the lowest score (28 percent). CAPs were required for the CIS, MCH, MM, and QM standards. CIC is expected to address all issues identified during this focused OR prior to the comprehensive OR conducted in the next review period.

## Opportunities for Improvement and Recommendations

Opportunities for improvement exist for both RBHA Contractors. MMIC did not meet the 95 percent compliance threshold for the CC or MCH standards; however, MMIC was fully compliant in the GA, GS, MI, and TPL standards. AHCCCS required MMIC to submit 13 CAPs; however, MMIC submitted requests for consideration for seven issues and AHCCCS accepted three of the seven. On the other hand, for the focused OR, CIC scored 100 percent for DS; however, no other standards reviewed met the 95 percent compliance threshold.

Based on the two RBHA Contractors reviewed, MCH is problematic as neither RBHA Contractor achieved compliance above the 95 percent threshold and CIC only achieved 28 percent compliance on the MCH standard. In addition, CIC did not meet the 95 percent compliance threshold for the CIS, MM, or QM standards.

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

- Contractors should conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should cross-reference existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements and ensure, at a minimum, alignment with both the intent and content of AHCCCS standards, State rules, and federal regulations. For example, for the MCH standard, CIC could develop a document that describes its maternity care program, including all requirements that are mandated by AHCCCS.
- Contractors should assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes. When deficiencies are noted, the Contractors should develop mechanisms to address such areas and enhance existing procedures. In addition, Contractors should implement periodic assessments of those elements reviewed by AHCCCS for which Contractors are found deficient.
- Contractors should apply lessons learned from improving performance for one category of standards to other categories. For example, Contractors should look at CAPs completed from previous ORs to determine best practices specific to their organizations to identify and correct policies, procedures, and practices so as to address deficient standards and monitor subsequent compliance. Further, Contractors should use opportunities to address and discuss issues identified during ORs.
- Contractors should implement control systems to address specific findings in the MCH standard related to the women's preventive care services to ensure that services are provided in accordance with the AHCCCS Medical Policy Manual.

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

- AHCCCS should concentrate improvement efforts on the MCH standard as both RBHA Contractors scored below the 95 percent compliance threshold. For example, AHCCCS should consider distributing technical assistance documents to the RBHA Contractors and holding in-person meetings with RBHA Contractors regarding the MCH standard. In particular, AHCCCS might want to meet with CIC to determine what issues the RBHA Contractor has in implementing these requirements.
- AHCCCS should consider using the quarterly meetings with RBHA Contractors as forums in which to share lessons learned from both the State and RBHA Contractor perspectives. For example, for the MM standard, CIC did not meet the AHCCCS performance threshold and was required to submit seven corrective actions, while MMIC was required to submit five corrective actions. AHCCCS should present identified best practices regarding care coordination and case management, post-discharge telephone calls, and ETI documentation issues as these areas were problematic for both RBHA Contractors.

## 7. Performance Measure Performance

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

As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the functions associated with the mandatory activity of validating performance measures. In accordance with and satisfying the requirements of 42 CFR §438.364(a)(1–5), AHCCCS contracted with HSAG as an EQRO to use the information that AHCCCS obtained from the performance measure calculations and data validation activities to prepare this CYE 2017 annual report.

### Conducting the Review

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

- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up*
- *Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)—Total Inpatient, Maternity, Surgery, and Medicine*
- *Plan All-Cause Readmissions—Total*

For the SMI population, AHCCCS calculated and approved the rates for inclusion in this report for the following performance measures for CYE 2016:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Ambulatory Care (per 1,000 Member Months)—Emergency Department (ED) Visits—Total*
- *Annual Monitoring for Patients on Persistent Medications—Total*
- *Asthma in Younger Adults Admission Rate (per 100,000 Member Months)*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 Member Months)*

- *Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up*
- *Heart Failure Admission Rate (per 100,000 Member Months)*
- *Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)—Total Inpatient, Maternity, Surgery, and Medicine*
- *Plan All-Cause Readmissions—Total*

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

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

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

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

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

- Determine Contractor performance on each of the AHCCCS-selected measures.
- Compare Contractor performance to AHCCCS' MPS for each measure, if available.
- Provide data from analyzing the performance results that would allow HSAG to draw conclusions about the quality of, access to, and timeliness of care and services furnished by individual Contractors and statewide considering all Contractors.
- Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and statewide for all Contractors.

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

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

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

- Compared Contractor performance rates with standards defined by AHCCCS' contract

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

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

Performance measures used the HEDIS or a HEDIS-like methodology for rate calculation. The HEDIS administrative methodology used for data collection in the current measurement did not differ from the methodology used for the previous measurement period. NCQA updates its methodology annually to add new codes to better identify the eligible population and/or services being measured or to delete codes retired from standardized coding sets used by providers. Examples include Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) coding.

AHCCCS analyzed Contractor-specific and statewide aggregate results for each performance measure to determine if performance rates met or exceeded the corresponding AHCCCS MPS. For the RBHA Contractors, trending and analysis are presented to show the direction of any change in rates from the previous measurement period and if the change was statistically significant. As this was the first year of reporting for these measures for the GMH/SA Contractor, AHCCCS was unable to perform any trending of Contractor performance over time. Subsequent reporting will display trending and analysis for all Contractors.

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

The following sections describe HSAG's findings, conclusions, and recommendations for the Contractors for CYE 2016.

## General Mental Health/Substance Abuse (GMH/SA) Aggregate Results

### Findings

Table 7-1 presents the following information for each measure indicator for the GMH/SA Aggregate: the CYE 2016 performance measure rate and the AHCCCS MPS, when available.

**Table 7-1—GMH/SA Aggregate—Performance Measure Results**

Performance Measure	CYE 2016 Performance	Minimum Performance Standard
<b><i>Follow-Up After Hospitalization for Mental Illness</i></b>		
<i>7-Day Follow-Up</i>	51.5%	50.0%
<i>30-Day Follow-Up</i>	69.0%	70.0%
<b><i>Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)</i></b>		
<i>Total Inpatient</i>	8.5	—
<i>Maternity</i>	0.0	—
<i>Surgery</i>	0.0	—
<i>Medicine</i>	8.5	—
<b><i>Plan All-Cause Readmissions<sup>1</sup></i></b>		
<i>Total</i>	15.4%	—

<sup>1</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

— Indicates that an MPS has not yet been established by AHCCCS.

### CAPs

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

### Strengths

For CYE 2016, the GMH/SA Aggregate exceeded the MPS for measure rate *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* by 1.5 percentage points.

### Opportunities for Improvement

The performance measure rate for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* fell below the MPS by 1 percentage point, indicating an opportunity for improvement.

### Summary

Both performance measure rates with established MPSs were within 2 percentage points of the MPSs for CYE 2016; therefore, the GMH/SA Contractors have opportunities for improving access to follow-up care for beneficiaries hospitalized for mental illness.

Five performance measure rates reported for the GMH/SA Aggregate do not have corresponding MPSs. Even though an MPS has not been established for some measures, AHCCCS and the GMH/SA Contractors should monitor the performance of these measures.

### Contractor-Specific Results—SMI Population

AHCCCS provided data to HSAG on CYE 2016 performance measure rates for three RBHA Contractors for the SMI population. Historical data are only available for MMIC; therefore, only CYE 2016 performance measure results are presented for CIC and HCIC. As CYE 2016 performance measure results are still being reviewed by AHCCCS and its Contractors, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization. The performance measures reported by the RBHA Contractors serving the SMI population are listed in the “Conducting the Review” section preceding. As mentioned previously, no discussion of CAPs is included in the report this year for CYE 2016 data.

### Cenpatco Integrated Care (CIC)

#### Findings

Table 7-2 presents the performance measure performance rates for CIC. The table displays the CYE 2016 performance measure rate and the AHCCCS MPS, when available.

**Table 7-2—CIC—SMI Population—Performance Measure Results**

Performance Measure	CYE 2016 Performance	Minimum Performance Standard
<i>Adults’ Access to Preventive/Ambulatory Health Services</i>		
<i>Total</i>	92.0%	75.0%
<i>Ambulatory Care (per 1,000 Member Months)<sup>1</sup></i>		
<i>ED Visits—Total</i>	122	—
<i>Annual Monitoring for Patients on Persistent Medications</i>		
<i>Total</i>	89.6%	75.0%
<i>Asthma in Younger Adults Admission Rate (per 100,000 Member Months)<sup>1</sup></i>		
<i>Asthma in Younger Adults Admission Rate</i>	7.0	—

Performance Measure	CYE 2016 Performance	Minimum Performance Standard
<b>Breast Cancer Screening</b>		
Breast Cancer Screening	NA	50.0%
<b>Cervical Cancer Screening</b>		
Cervical Cancer Screening	14.6%	64.0%
<b>Chlamydia Screening in Women</b>		
Total	59.1%	63.0%
<b>COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)<sup>1</sup></b>		
COPD or Asthma in Older Adults Admission Rate	71.6	—
<b>Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)<sup>1</sup></b>		
Diabetes Short-Term Complications Admission Rate	43.7	—
<b>Follow-Up After Hospitalization for Mental Illness</b>		
7-Day Follow-Up	74.0%	50.0%
30-Day Follow-Up	88.5%	70.0%
<b>Heart Failure Admission Rate (per 100,000 Member Months)<sup>1</sup></b>		
Heart Failure Admission Rate	33.7	—
<b>Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)</b>		
Total Inpatient	187.8	—
Maternity	2.8	—
Surgery	23.2	—
Medicine	162.0	—
<b>Plan All-Cause Readmissions<sup>1</sup></b>		
Total	24.5%	—

<sup>1</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

— Indicates that an MPS has not yet been established by AHCCCS.

NA Indicates the rate was not displayed because the denominator was less than 30.

## CAPs

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

## Strengths

For CYE 2016, CIC exceeded the established MPS for four of the six performance measures with reportable rates (*Adults’ Access to Preventive/Ambulatory Care—Total*; *Annual Monitoring for Patients on Persistent Medications—Total*; and *Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up* and *30-Day Follow-Up*), all by more than 14 percentage points.



### Opportunities for Improvement

The performance measure rates for *Cervical Cancer Screening* and *Chlamydia Screening in Women—Total* fell below the MPS by 49.4 and 3.9 percentage points respectively, indicating an opportunity for improvement for the CIC population in screenings for women.

### Summary

Four of the six performance measures with reportable rates and established MPSs exceeded the MPSs for CYE 2016. With the rate of two performance measures (*Cervical Cancer Screening* and *Chlamydia Screening in Women—Total*) failing to meet the MPS, CIC has opportunities for improvement in screenings for women.

Ten performance measure rates reported by CIC did not have corresponding MPSs. Even though an MPS has not been established for some measures, CIC should monitor the performance of these measures.

### Health Choice Integrated Care (HCIC)

#### Findings

Table 7-3 presents the performance measure performance rates for HCIC. The table displays the CYE 2016 performance measure rate and the AHCCCS MPS, when available.

**Table 7-3—HCIC—SMI Population—Performance Measure Results**

Performance Measure	CYE 2016 Performance	Minimum Performance Standard
<b><i>Adults’ Access to Preventive/Ambulatory Health Services</i></b>		
<i>Total</i>	90.7%	75.0%
<b><i>Ambulatory Care (per 1,000 Member Months)<sup>1</sup></i></b>		
<i>ED Visits—Total</i>	103	—
<b><i>Annual Monitoring for Patients on Persistent Medications</i></b>		
<i>Total</i>	81.6%	75.0%
<b><i>Asthma in Younger Adults Admission Rate (per 100,000 Member Months)<sup>1</sup></i></b>		
<i>Asthma in Younger Adults Admission Rate</i>	9.5	—
<b><i>Breast Cancer Screening</i></b>		
<i>Breast Cancer Screening</i>	NA	50.0%
<b><i>Cervical Cancer Screening</i></b>		
<i>Cervical Cancer Screening</i>	10.2%	64.0%
<b><i>Chlamydia Screening in Women</i></b>		
<i>Total</i>	48.3%	63.0%

Performance Measure	CYE 2016 Performance	Minimum Performance Standard
<b><i>COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)<sup>1</sup></i></b>		
<i>COPD or Asthma in Older Adults Admission Rate</i>	72.6	—
<b><i>Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)<sup>1</sup></i></b>		
<i>Diabetes Short-Term Complications Admission Rate</i>	16.5	—
<b><i>Follow-Up After Hospitalization for Mental Illness</i></b>		
<i>7-Day Follow-Up</i>	62.1%	50.0%
<i>30-Day Follow-Up</i>	81.1%	70.0%
<b><i>Heart Failure Admission Rate (per 100,000 Member Months)<sup>1</sup></i></b>		
<i>Heart Failure Admission Rate</i>	18.0	—
<b><i>Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)</i></b>		
<i>Total Inpatient</i>	136.3	—
<i>Maternity</i>	2.2	—
<i>Surgery</i>	16.7	—
<i>Medicine</i>	117.6	—
<b><i>Plan All-Cause Readmissions<sup>1</sup></i></b>		
<i>Total</i>	16.2%	—

<sup>1</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

— Indicates that an MPS has not yet been established by AHCCCS.

NA Indicates the rate was not displayed because the denominator was less than 30.

## CAPs

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

## Strengths

For CYE 2016, HCIC exceeded the established MPS for four of the six performance measures with reportable rates (*Adults’ Access to Preventive/Ambulatory Care—Total*; *Annual Monitoring for Patients on Persistent Medications—Total*; and *Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up* and *30-Day Follow-Up*). Of note, the performance measure rates for *Adults’ Access to Preventive/Ambulatory Care—Total*; and *Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up* and *30-Day Follow-Up* exceeded the MPSs by 15.7, 12.1, and 11.1 percentage points, respectively.

## Opportunities for Improvement

The performance measure rates for *Cervical Cancer Screening* and *Chlamydia Screening in Women—Total* fell below the MPSs by 53.8 and 14.7 percentage points respectively, indicating an opportunity for improvement for the HCIC population in screenings for women.

## Summary

Four of the six performance measure with reportable rates and an established MPS exceeded the MPSs for CYE 2016. With the rate of two performance measures (*Cervical Cancer Screening* and *Chlamydia Screening in Women—Total*) failing to meet the MPSs, HCIC has opportunities for improvement in screenings for women.

Ten performance measure rates reported by HCIC did not have corresponding MPSs. Even though an MPS has not been established for some measures, HCIC should monitor the performance of these measures.

## Mercy Maricopa Integrated Care (MMIC)

### Findings

Table 7-4 presents the performance measure performance rates for MMIC. The table displays the following information for each measure: CYE 2015 performance; CYE 2016 performance; the relative percentage change between the CYE 2015 and CYE 2016 rates; the statistical significance of the relative percentage change; and the AHCCCS MPS, when available.

**Table 7-4—MMIC—SMI Population—Performance Measure Results**

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level ( <i>p</i> value) <sup>1</sup>	Minimum Performance Standard
<b>Adults' Access to Preventive/Ambulatory Health Services</b>					
<i>Adults' Access to Preventive/Ambulatory Health Services</i>	94.0%	94.0%	0.0%	P=.943	75.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>2</sup></b>					
<i>ED Visits—Total</i>	160	147	—	—	—
<b>Annual Monitoring for Patients on Persistent Medications</b>					
<i>Total</i>	—	95.3%	—	—	75.0%
<b>Asthma in Younger Adults Admission Rate (per 100,000 Member Months)<sup>2</sup></b>					
<i>Asthma in Younger Adults Admission Rate</i>	21.4	28.5	—	—	—
<b>Breast Cancer Screening</b>					
<i>Breast Cancer Screening</i>	NA	35.5%	—	—	50.0%
<b>Cervical Cancer Screening</b>					
<i>Cervical Cancer Screening</i>	22.0%	31.9%	45.0%	<b>P&lt;.001</b>	64.0%
<b>Chlamydia Screening in Women</b>					
<i>Total</i>	—	53.3%	—	—	63.0%
<b>COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)<sup>2</sup></b>					
<i>COPD or Asthma in Older Adults</i>	114.4	97.5	—	—	—

Performance Measure	CYE 2015 Performance	CYE 2016 Performance	Relative Percentage Change	Significance Level (p value) <sup>1</sup>	Minimum Performance Standard
<i>Admission Rate</i>					
<b>Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)<sup>2</sup></b>					
<i>Diabetes Short-Term Complications Admission Rate</i>	47.5	32.2	—	—	—
<b>Follow-Up After Hospitalization for Mental Illness</b>					
<i>7-Day Follow-Up</i>	72.8%	76.0%	4.4%	<b>P=.002</b>	50.0%
<i>30-Day Follow-Up</i>	85.4%	87.8%	2.8%	<b>P=.002</b>	70.0%
<b>Heart Failure Admission Rate (per 100,000 Member Months)<sup>2</sup></b>					
<i>Heart Failure Admission Rate</i>	32.7	34.2	—	—	—
<b>Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)</b>					
<i>Total Inpatient</i>	455.9	481.1	—	—	—
<i>Maternity</i>	5.9	5.7	—	—	—
<i>Surgery</i>	34.4	37.3	—	—	—
<i>Medicine</i>	416.0	438.3	—	—	—
<b>Plan All-Cause Readmissions<sup>2</sup></b>					
<i>Total</i>	26.1%	19.5%	-25.2%	<b>P&lt;.001</b>	—

<sup>1</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and HSAG and demonstrate the statistical significance between performance during CYE 2015 and performance during CYE 2016. Statistical significance is traditionally reached when the p value is ≤ 0.05. Rates in bold font indicate statistically significant values.

<sup>2</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

— Indicates the Contractors were not required to report the measure, a comparison of performance between CYE 2015 and CYE 2016 was not possible, or an MPS has not yet been established by AHCCCS.

NA Indicates the rate was not displayed because the denominator was less than 30.

### CAPs

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

### Strengths

MMIC exceeded the MPS for four of seven performance measure rates (*Adults’ Access to Preventive/Ambulatory Care—Total; Annual Monitoring for Patients on Persistent Medications—Total; and Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up and 30-Day Follow-Up*), all by over 17 percentage points. Of note, the performance measure rates for *Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up and 30-Day Follow-Up* also demonstrated statistically significant improvement from CYE 2015 to CYE 2016. Additionally, the *Plan All-Cause Readmissions* performance measure rate demonstrated statistically significant improvement from CYE 2015 to CYE 2016 as a lower rate indicates better performance for this measure.

## Opportunities for Improvement

Although *Cervical Cancer Screening* demonstrated significant improvement from CYE 2015 to CYE 2016, this performance measure rate still fell below the established MPS by 32.1 percentage points. Also of note, the *Breast Cancer Screening* and *Chlamydia Screening in Women—Total* performance measure rates performed below the respective MPSs for CYE 2016, by 14.5 and 9.7 percentage points respectively.

## Summary

Four measure rates (*Adults' Access to Preventive/Ambulatory Health Services*; *Annual Monitoring for Patients on Persistent Medications—Total*; and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*) exceeded the established MPSs for CYE 2016, while three measure rates (*Breast Cancer Screening*, *Cervical Cancer Screening*, and *Chlamydia Screening in Women—Total*) did not meet the MPSs. Further, four performance measure rates demonstrated statistically significant improvement from CYE 2015 to CYE 2016, while no performance measures demonstrated statistically significant declines.

Ten performance measure rates reported by MMIC do not have corresponding MPSs. Even though an MPS has not been established for some measures, MMIC should monitor the performance of these measures.

## RBHA Integrated SMI Aggregate Results

### Findings

Table 7-5 presents the aggregate performance measure rates for the three RBHA Contractors. The table displays the following information for each measure: CYE 2016 performance and AHCCCS' CYE 2016 MPS for all measures with an MPS. Although CYE 2016 was the second reporting year for the SMI population after the transition, only one year's worth of data could be reported because prior year results were inclusive of only one of the three RBHA Contractors (MMIC).

**Table 7-5—RBHA Integrated SMI Aggregate—Performance Measurement Results**

Performance Measure	CYE 2016 Performance	Minimum Performance Standard
<b>Adults' Access to Preventive/Ambulatory Health Services</b>		
<i>Total</i>	92.8%	75.0%
<b>Ambulatory Care (per 1,000 Member Months)<sup>1</sup></b>		
<i>ED Visits—Total</i>	132	—
<b>Annual Monitoring for Patients on Persistent Medications</b>		
<i>Total</i>	91.4%	75.0%
<b>Asthma in Younger Adults Admission Rate (per 100,000 Member Months)<sup>1</sup></b>		
<i>Asthma in Younger Adults Admission Rate</i>	19.1	—
<b>Breast Cancer Screening</b>		
<i>Breast Cancer Screening</i>	35.5%	50.0%
<b>Cervical Cancer Screening</b>		
<i>Cervical Cancer Screening</i>	22.5%	64.0%
<b>Chlamydia Screening in Women</b>		
<i>Total</i>	54.9%	63.0%
<b>COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)<sup>1</sup></b>		
<i>COPD or Asthma in Older Adults Admission Rate</i>	84.7	—
<b>Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)<sup>1</sup></b>		
<i>Diabetes Short-Term Complications Admission Rate</i>	33.9	—
<b>Follow-Up After Hospitalization for Mental Illness</b>		
<i>7-Day Follow-Up</i>	74.4%	50.0%
<i>30-Day Follow-Up</i>	87.4%	70.0%
<b>Heart Failure Admission Rate (per 100,000 Member Months)<sup>1</sup></b>		
<i>Heart Failure Admission Rate</i>	31.7	—
<b>Inpatient Utilization—General Hospital/Acute Care (Days per 1,000 Member Months)</b>		
<i>Total Inpatient</i>	332.1	—
<i>Maternity</i>	4.2	—

Performance Measure	CYE 2016 Performance	Minimum Performance Standard
<i>Surgery</i>	29.6	—
<i>Medicine</i>	298.6	—
<b><i>Plan All-Cause Readmissions<sup>1</sup></i></b>		
<i>Total</i>	19.6%	—

<sup>1</sup> A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

— Indicates that an MPS has not yet been established by AHCCCS.

### CAPs

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

### Strengths

For CYE 2016, four of the seven performance measure rates (*Adults’ Access to Preventive/Ambulatory Health Services; Annual Monitoring for Patients on Persistent Medications—Total; and Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up*) for the RBHA Integrated SMI Aggregate exceeded the established MPSs, all by upwards of 16 percentage points.

### Opportunities for Improvement

For the RBHA Integrated SMI Aggregate, the performance measure rates for *Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening in Women—Total* fell below the MPSs by 14.5, 41.5, and 8.1 percentage points, respectively, indicating an opportunity for improvement for the RBHA Integrated SMI Aggregate population in screenings for women.

### Summary

For the RBHA Integrated SMI Aggregate, four of seven measure rates (*Adults’ Access to Preventive/Ambulatory Health Services; Annual Monitoring for Patients on Persistent Medications—Total; and Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up*) exceeded the established MPSs for CYE 2016 while the remaining three measure rates (*Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening in Women—Total*) did not meet the MPSs.

Ten performance measure rates reported by the RBHA Contractors did not have corresponding MPSs. Even though an MPS has not been established for some measures, AHCCCS and the RBHA Contractors should monitor the performance of these measures.

## 8. Performance Improvement Project Performance

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

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

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

### Conducting the Review

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

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

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

In CYE 2015 (October 1, 2014, through September 30, 2015), AHCCCS implemented a new PIP, *E- Prescribing*, for all lines of business. The baseline measurement period included CYE 2014 (data from October 1, 2013 through September 30, 2014), to be followed by two remeasurement periods: CYE 2016 (October 1, 2015, through September 30, 2016), and CYE 2017 (October 1, 2016, through September 30, 2017). Upon initiation of the *E-Prescribing* PIP, all behavioral health services were provided under the Department of Behavioral Health Services (DBHS), an AHCCCS Contractor. However, behavioral health services for the General Mental Health/Substance Abuse (GMH/SA) and Serious Mental Illness (SMI) populations within Maricopa County transitioned to Mercy Maricopa Integrated Care (MMIC) effective April 1, 2014. GMH/SA and SMI members outside of Maricopa County transitioned to either Cenpatico Integrated Care (CIC) or Health Choice Integrated Care (HCIC) effective October 1, 2015. Therefore, the Regional Behavioral Health Authorities' (RBHAs') PIP



measurement periods differ from all other lines of business. Thus, this annual report will include CIC's CYE 2016 baseline rates, qualitative analysis, and interventions for GMH/SA and SMI members as well as HCIC's CYE 2016 baseline rates, qualitative analysis, and interventions for GMH/SA and SMI members.

AHCCCS implemented the *E-Prescribing* PIP because research suggested that an opportunity existed to improve preventable errors in using the standard, handwritten paper method to communicate a medication between a prescriber and a pharmacy. Research indicated that clinicians make seven times fewer errors (decreasing from 42.5 per 100 prescriptions to 6.6 per 100 prescriptions after one year) when using an electronic system rather than writing prescriptions by hand.<sup>8-1</sup> AHCCCS found that sending a clear and legible prescription electronically can reduce mistakes related to medication types, dosages, and member information. In addition, AHCCCS noted that electronic prescribing assists pharmacies in identifying potential problems related to medication management and potential reactions members may encounter, especially for those taking multiple medications.

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

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

In its objectives for evaluating Contractor PIPs, AHCCCS:

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

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

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

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

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

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

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

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

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

requires RBHA Contractors to use the PIP reporting format to document their analyses of baseline and remeasurement results, implementation of interventions, and assessment of improvement.

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

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

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

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

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

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

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

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

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

The following sections describe HSAG's findings, conclusions, and recommendations for each RBHA Contractor.

## Results

As noted previously, the RBHA Contractors' PIP measurement periods differ from all other lines of business; and AHCCCS elected to have the DBHS aggregate rates for CYE 2014 serve as the MMIC GMH/SA baseline rate. AHCCCS provided HSAG with its CYE 2016 Contractor PIP results for two RBHA Contractors. The RBHA Contractors for which data were provided were CIC and HCIC. The PIP conducted during CYE 2016 for the RBHA Contractors was *E-Prescribing*, which, to improve patient safety, focused on increasing the number of providers ordering prescriptions electronically and the percentage of prescriptions submitted electronically rather than via paper or other method.

During CYE 2016, the *E-Prescribing* PIP was in the baseline period for CIC and HCIC. Baseline data were used to assist the RBHA Contractors in identifying and/or implementing strategies to increase the number of providers ordering prescriptions electronically and to increase the percentage of prescriptions submitted electronically. AHCCCS expected that RBHA Contractor, provider, and member education efforts during this intervention period will result in a greater percentage of AHCCCS members being prescribed prescriptions electronically.

This section includes RBHA Contractors' PIP remeasurement results as calculated by AHCCCS., along with specific activities for CYE 2016. HSAG has minimally edited the analysis and interventions for grammar and punctuation; otherwise, they appear as provided by the RBHA Contractors.

## Cenpatico Integrated Care (CIC)

### Findings

Table 8-1 presents the baseline results for the *E-Prescribing* PIP for CIC’s GMH/SA members.

**Table 8-1—CIC GMH/SA *E-Prescribing* PIP**

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

CYE 2016 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-1 shows that 57.29 percent of CIC’s providers prescribed at least one prescription electronically and that 50.35 percent of prescriptions were sent by an AHCCCS-contracted provider electronically.

Table 8-2 presents the baseline results for the *E-Prescribing* PIP for CIC’s integrated members.

**Table 8-2—CIC SMI *E-Prescribing* PIP**

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

CYE 2016 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-2 shows that 57.17 percent of CIC’s providers prescribed at least one prescription electronically and that 59.10 percent of prescriptions were sent by an AHCCCS-contracted provider electronically.

CIC submitted the following qualitative analysis:

- Literature searches were completed to assist with identifying benefits, barriers, and interventions related to e-prescribing. Through the literature searches, the following were identified:
  - E-prescribing:
    - Increases member safety.
      - Reduces paper-based prescription errors.
      - Improves access to medication history and increases communication between prescribers.
      - Use of e-prescribing controlled substances (EPCS) reduces fraud and abuse.
      - EPCS is vital in the fight against prescription drug abuse.
    - Increases positive outcomes.
      - Increases first-fill medication adherence by 12 percent and first-fill pick-ups by 10 percent.
    - Increases efficiency

- Can save a medical practice an estimated \$15,769 per full-time physician per year due to increased efficiency.
- EPCS:
  - Reduces fraud and abuse.
  - Reduces paper-based prescription errors.
  - Increases communication between providers and pharmacies.
  - Identifies high-risk individuals.
- Root cause of barriers and source of variation in current process:
  - First, prescribers can only submit one prescription at a time as this is how pharmacies are set up to receive prescriptions. If multiple drugs are written on the same prescription, the EHR automatically converts the e-prescription to a fax.
  - Many intake and coordination of care (ICC) agencies are not set up to e-prescribe controlled substances. The ability to do so requires a certification for EPCS. CIC conducted a survey specific to EPCS and found that one of the 13 ICC agencies' respondents had been certified.
  - Pharmacies also need to be certified to accept e-prescriptions for controlled substances. Many of the larger pharmacies, such as Walgreens, have the ability to do this. The concern exists that many smaller or independent pharmacies will not have the ability to accept the controlled substances e-prescriptions.

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

- Identify how prescriptions are being sent to pharmacies and analyze the data monthly. Data Analytics will provide by the eighth of each month a report indicating all prescriptions filled through the pharmacy benefits manager (PBM) as well as the percentage sent electronically, by fax, or via other methods. The data will be analyzed by the pharmacy director monthly.
- Communicate e-prescribing data directly to ICC agencies in an effort to improve utilization. CIC will provide detailed information to providers in the monthly chief executive officer (CEO) meeting. The pharmacy administrator will meet one on one with each prescriber quarterly to review e-prescribing data and provide technical assistance as needed.
- Participate in all DBHS activities related to the *E-Prescribing* PIP. CIC will provide to ICC agencies financial incentives for meeting or exceeding e-prescribing performance goals each quarter.
- Sent out an e-prescribing survey in February 2015 to help identify barriers to improvement. Agencies will work to address each of the barriers in partnership with CIC. The following barriers were identified:
  - EHR has not been certified to e-prescribe controlled substances.
  - Telemedicine.
  - Additional cost.
  - Software not configured for e-prescribing.

- Provide for intake and coordination of care (ICC) agencies that meet e-prescribing goals financial incentives that increase quarterly. For quarter two of fiscal year 2015, ICC agencies e-prescribing at over 60 percent will receive an incentive. For Q3, the goal will be set at 70 percent; and for Q4, the goal will be set at 80 percent.
- Include recorded sessions available in Relias. Provide education on the CIC pharmacy process. Provide pharmacy updates from CIC and AHCCCS. Improve communication and outreach to medical practitioners. Three presentations will occur each quarter.
- Issue corrective action plans (CAPs) to ICC agencies that have not met pharmacy goals.
- Provide educational presentations in Provider Quality Improvement and CEO meetings. Information included details about EPCS, pharmacy acceptance of EPCS, cost of certification, and improving healthcare and outcomes using EPCS.
- Use internal data from the pharmacy to determine top providers who are not e-prescribing.
- Pushed out a survey to ICC agency providers to identify barriers related to e-prescribing.

### Strengths

CIC conducted literature searches, process mapping, and root cause analysis to identify barriers related to e-prescribing and to develop interventions to address them. CIC also surveyed providers to help identify barriers to improvement. In response to the barriers, ICC agencies plan to increase e-prescribing by becoming certified to e-prescribe controlled substances. The pharmacy administrator analyzes data monthly for reporting in the monthly CEO meeting as well as in quarterly meetings with prescribers. Finally, CIC will provide to ICC agencies financial incentives for meeting or exceeding e-prescribing performance goals each quarter.

### Opportunities for Improvement and Recommendations

CIC has an opportunity to increase the percentage of providers prescribing electronically and prescriptions sent electronically. HSAG recommends that CIC continue to monitor outcomes associated with the reported interventions. CIC should strive to improve the rates as this is a patient safety issue. In addition, HSAG recommends that AHCCCS continue the collaboration among RBHA Contractors to improve performance for these indicators.

### Summary

For the *E-Prescribing* PIP, CIC's GMH/SA baseline rate for Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 57.29 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 50.35 percent. CIC's integrated baseline rate for Indicator 1 was 57.17 and for Indicator 2 was 59.10 percent. CIC is encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, then adjust interventions as needed to ensure that the rates increase by statistically significant amounts during the first remeasurement period. In addition, as studies have demonstrated a correlation between e-prescribing and patient safety, CIC is encouraged to develop other solid interventions to increase both rates.



## Health Choice Integrated (HCIC)

### Findings

Table 8-3 presents the baseline results for the *E-Prescribing* PIP for HCIC’s GMH/SA members.

**Table 8-3—HCIC GMH/SA *E-Prescribing* PIP**

PIP Measure	Baseline Period Oct. 1, 2015, through Sept. 30, 2016	Remeasurement 1 Oct. 1, 2017, through Sept. 30, 2018	Remeasurement 2 Oct. 1, 2018, through Sept. 30, 2019	Relative Percentage Change From Baseline	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	57.37%	NA	NA	NA	NA
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically.	62.69%	NA	NA	NA	NA

CYE 2016 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-3 shows that 57.37 percent of HCIC’s providers prescribed at least one prescription electronically and that 62.69 percent of prescriptions were sent by an AHCCCS-contracted provider electronically.

Table 8-4 presents the baseline results for the *E-Prescribing* PIP for HCIC’s integrated members.

**Table 8-4—HCIC SMI *E-Prescribing* PIP**

PIP Measure	Baseline Period Oct. 1, 2015, through Sept. 30, 2016	Remeasurement 1 Oct. 1, 2017, through Sept. 30, 2018	Remeasurement 2 Oct. 1, 2018, through Sept. 30, 2019	Relative Percentage Change From Baseline	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically.	52.64%	NA	NA	NA	NA
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically.	54.99%	NA	NA	NA	NA

CYE 2016 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-4 shows that 52.64 percent of HCIC’s providers prescribed at least one prescription electronically and that 54.99 percent of the prescriptions were sent by an AHCCCS-contracted provider electronically.

HCIC submitted the following qualitative analysis:

- A potential change in the scope of work would be to provide targeted interventions with prescribers, to increase utilization of electronic prescribing for controlled substances and report these differences for each demographic group individually.
- A separate analysis of controlled substance e-prescribing was conducted, and it was determined to be an area for targeted intervention going forward. A much lower utilization of electronic prescribing for controlled substances exists among HCIC prescribers. HCIC is currently working on educational efforts and identifying unique barriers through provider outreach.

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

- Implemented value-based purchasing (VBP) incentive for e-prescribing, with payments made to providers with e-prescribing rates greater than 65 percent.

- Shared e-prescribing data within HCIC at QM meeting and with Behavioral Health Homes at behavioral health medical professional (BHMP) pharmacy and therapeutics (P&T) committee meeting.
- Participated in Health Current workgroup identifying barriers to e-prescribing. Monitored e-prescribing at the State level, with benchmarking and identification of outliers for targeted interventions. Developed standardized educational tools for all plans for consistency and ease of use.
- Published provider newsletter section titled “The Importance of E-Prescribing.”

### Strengths

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

### Opportunities for Improvement and Recommendations

HCIC has an opportunity for improvement to increase both the rates of providers that prescribe prescriptions electronically and of prescriptions electronically prescribed. HSAG recommends that HCIC monitor the outcomes associated with the reported interventions. HSAG also recommends that HCIC develop more interventions based on received data, to increase the rates of both indicators. In addition, HSAG recommends that AHCCCS continue the collaboration among RBHA Contractors to improve these indicators.

### Summary

HCIC’s GMH/SA baseline rate for the *E-Prescribing* PIP Indicator 1 (the percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 57.37 percent and for Indicator 2 (the percentage of prescriptions prescribed by an AHCCCS-contracted provider sent electronically) was 62.29 percent. HCIC’s integrated baseline rate for Indicator 1 was 52.64 and for Indicator 2 was 54.99 percent. HCIC is encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, then adjust interventions as needed to ensure that the rates increase by statistically significant amounts during the first remeasurement period. In addition, HCIC is encouraged to develop other solid interventions to increase both rates as studies have demonstrated a correlation between e-prescribing and patient safety.

### Recommendations for RBHA Contractors

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

- AHCCCS may want to consider offering and facilitating training opportunities to enhance the RBHA Contractors’ capacities to implement robust interventions, quality improvement (QI)

processes, and strategies for the *E-Prescribing* PIP. Increasing the RBHA Contractors' efficacy with QI tools such as root cause analyses, key driver diagrams, process mapping, failure modes and effects analysis (FMEA), and Plan-Do-Study-Act (PDSA) cycles should help to remove barriers to successfully achieving improvement for the PIP indicator rates.

- AHCCCS and the RBHA Contractors may want to use the quarterly collaboration meetings with stakeholders as opportunities to identify and address system-wide barriers to the PIP process, which may be impacting ability to achieve meaningful improvement.
- AHCCCS should continue the collaboration among RBHA Contractors in the workgroup to improve the PIP study indicator rates.
- AHCCCS should consider including in the workgroup additional stakeholders who may help with improvement of the PIP study indicator rates.
- AHCCCS may want to explore any connection to the Governor's Executive Order 2616-06, Prescription of Opioids, to see if the activities of the task force might impact the PIP.
- The RBHA Contractors should continue to identify and prioritize barriers so as to develop robust interventions for the *E-Prescribing* PIP.
- The RBHA Contractors are encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.
- For system-wide barriers, AHCCCS may consider the following: facilitate a session to identify system-wide barriers impeding the RBHA Contractors' abilities to impact Indicator 1 and Indicator 2; appoint a high-level AHCCCS manager as a champion for the workgroup; develop an action plan to address the system-wide barriers.

## Summary

This was the baseline reporting period for the *E-Prescribing* PIP. RBHA Contractors' baseline performance for CIC and HCIC for GMH/SA members ranged from 57.29 percent to 57.37 percent for Indicator 1. For SMI members, Indicator 1 baseline rates ranged from 52.64 percent to 57.17 percent. For Indicator 2, CIC and HCIC baseline performance for GMH/SA members ranged from 50.35 percent to 62.29 percent. For SMI members, Indicator 2 baseline rates ranged from 54.99 percent to 59.10 percent. This being a baseline year, comparisons cannot be made between rates and RBHA Contractors for each indicator. HSAG recommends that, prior to the first remeasurement period of the PIP, the RBHA Contractors continually monitor PIP rates to determine whether interventions are successful.

## 9. Consumer Assessment of Healthcare Providers and Systems Results

### CAHPS—Adult Survey

During 2016–2017, as an optional EQR activity, AHCCCS elected to conduct member satisfaction surveys of adult Medicaid members enrolled in Mercy Maricopa Integrated Care (MMIC), a RBHA Contractor. AHCCCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Surveys. This report presents statewide aggregate adult Medicaid CAHPS survey results for MMIC.

### Methodology for Conducting CAHPS Surveys

#### Overview

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

#### Objectives

As part of its objectives to measure, report, compare, and continually improve program performance, AHCCCS elected to conduct a CAHPS survey of adult Medicaid members served by MMIC. The primary objective of the CAHPS survey was to effectively and efficiently obtain information on adult Medicaid members' levels of satisfaction with their healthcare experiences.

#### Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of, to adult members, the *CAHPS 5.0 Adult Medicaid Health Plan Survey* with the HEDIS supplemental item set. Adult members eligible for the survey were 18 years of age or older as of March 31, 2016.

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

Spanish cover letter informing members that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire.

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

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

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

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

Additionally, to assess the overall performance of MMIC’s adult Medicaid population, each CAHPS global rating (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*), four of the CAHPS composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*), and one individual item measure (*Coordination of Care*) were scored on a three-point scale using the scoring methodology detailed in NCQA’s HEDIS Specifications for Survey Measures.<sup>9-1</sup> The resulting three-point mean scores were compared to NCQA’s *2017 HEDIS Benchmarks and Thresholds for Accreditation*.<sup>9-2</sup> Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, for which one is the lowest possible rating and five is the highest possible rating using the following percentile distributions:<sup>9-3</sup>

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<sup>9-1</sup> National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2016.

<sup>9-2</sup> National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA, May 4, 2017.

<sup>9-3</sup> NCQA does not provide benchmarks and thresholds for the *Shared Decision Making* composite measure or for the *Health Promotion and Education* individual item measure; therefore, overall member satisfaction ratings could not be derived for these CAHPS measures.

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

For purposes of this report, the MMIC survey findings were compared to 2016 NCQA CAHPS Adult Medicaid national averages. For MMIC’s results, a statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted with colors. A cell is highlighted in yellow if the lower bound of the confidence interval was higher than the national average. However, if the upper bound of the confidence interval was lower than the national average, the cell is highlighted in red.<sup>9-4</sup>

## Description of Data Obtained

For MMIC, HSAG calculated adult Medicaid CAHPS survey results for the statewide program in aggregate. The following sections describe HSAG’s findings, conclusions, and recommendations for MMIC.

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<sup>9-4</sup> NCQA national averages for the adult Medicaid population were used for comparative purposes. Given the potential differences in the demographics of these populations (i.e., adult Medicaid and Mercy Maricopa), caution should be exercised when interpreting these results.

## Results/Findings

Table 9-1 presents the 2016 CAHPS survey statewide results for MMIC. The table displays the following information: 2016 top-box rates (i.e., the percentage of respondents offering a positive response), three-point mean scores, and 2016 overall member satisfaction ratings (i.e., star ratings) for each CAHPS survey measure.<sup>9-5,9-6</sup>

**Table 9-1—Adult CAHPS Results for MMIC**

Measure	2016 Top-Box Rate	Three-Point Mean	Star Rating
<b>Global Ratings</b>			
<i>Rating of Health Plan</i>	49.7%	2.28	★
<i>Rating of All Health Care</i>	43.5%	2.21	★
<i>Rating of Personal Doctor</i>	56.1%	2.40	★
<i>Rating of Specialist Seen Most Often</i>	57.8%	2.42	★
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	82.9%	2.32	★★
<i>Getting Care Quickly</i>	81.1%	2.31	★
<i>How Well Doctors Communicate</i>	85.8%	2.46	★
<i>Customer Service</i>	87.3%	2.43	★
<i>Shared Decision Making</i>	75.9%	NA	NA
<b>Individual Item Measures</b>			
<i>Coordination of Care</i>	73.6%	2.15	★
<i>Health Promotion and Education</i>	71.5%	NA	NA
★★★★★ 90th or Above   ★★★★★ 75th-89th   ★★★ 50th-74th   ★★ 25th-49th   ★ Below 25th Cells highlighted in yellow represent scores that are statistically significantly higher than the 2016 national average. Cells highlighted in red represent scores that are statistically significantly lower than the 2016 national average. NA indicates that results are not available for the CAHPS measure.			

<sup>9-5</sup> NCQA’s benchmarks and thresholds for the adult Medicaid population were used to derive the overall member satisfaction ratings (i.e., star ratings); therefore, caution should be exercised when interpreting these results.

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



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

- Statistically significantly lower than the 2016 NCQA national adult Medicaid averages on six measures: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, How Well Doctors Communicate, and Coordination of Care.*

## Recommendations

HSAG identified general recommendations that may be considered to improve MMIC's performance and which are based on the most up-to-date information in CAHPS literature. AHCCCS and MMIC should evaluate these general recommendations in the context of their operational and quality improvement activities.<sup>9-7</sup>

### *Perform Root Cause Analyses*

MMIC could conduct root cause analyses of study indicators identified as areas of low performance. This type of analysis is typically conducted to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies. If used to study deficiencies in care or services provided to members, root cause analyses would enable MMIC to better understand the nature and scope of problems, identify causes and their interrelationships, identify specific populations for targeted interventions, and establish potential performance improvement strategies and solutions. Methods commonly used to conduct root cause analyses include process flow mapping, used to define and analyze processes and to identify opportunities for process improvement; and the four-stage Plan-Do-Study-Act (PDSA) problem-solving model, used for continuous process improvement.<sup>9-8</sup>

### *Conduct Frequent Assessments of Targeted Interventions*

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

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<sup>9-7</sup> AHRQ Web site. *CAHPS Improvement Guide*. Available at: <https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html>. Accessed on: February 7, 2018.

<sup>9-8</sup> Plan-Do-Study-Act (PDSA) Worksheet. *Institute for Healthcare Improvement*. Available at: <http://www.ihi.org/knowledge/Pages/Tools/PlanDoStudyActWorksheet.aspx>. Accessed on: February 7, 2018.

## ***Use Health Information Technology***

Contractors that use health information technology to its fullest have stronger patient-tracking capabilities and coordinated care. Health information technology would allow MMIC to access real-time data (e.g., the outcomes of face-to-face visits with patients) and can better facilitate documentation, communication, decision support, and automated reminders, thus ensuring that patients receive needed care. Furthermore, using health information technology may help to increase the number of patients who receive copies of their care plans.

## ***Share Data***

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

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

## ***Facilitate Coordinated Care***

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