

Arizona Health Care Cost Containment System



Contract Year Ending 2018 External Quality Review Annual Report *for* **Behavioral Health Services**

July 2019



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

The Code of Federal Regulations (CFR) at 42 CFR §438.3641¹⁻¹ requires that states use an external quality review organization (EQRO) to prepare an annual technical report that describes how data from activities conducted for Medicaid managed care organizations (MCOs), in accordance with the CFR, were aggregated and analyzed. The annual technical report draws conclusions about the quality of, timeliness of, and access to healthcare services that MCOs provide.

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

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

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

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

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

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

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

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

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

- A description of the manner in which the data from all activities conducted were aggregated and analyzed.
- For each external quality review (EQR)-related activity conducted:
 - Objectives.
 - Technical method of data collection and analysis.
 - Description of the data obtained.
 - Conclusions drawn from the data.
- An assessment of each Contractor's strengths and weaknesses.
- Recommendations for improving the quality of care furnished by each Contractor including how the State can target goals and objectives in the quality strategy, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid members.
- Methodologically appropriate comparative information about all Contractors (described in §438.310[c][2]), consistent with guidance included in the EQR protocols.
- An assessment of the degree to which each Contractor has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

HSAG has prepared the annual technical report for AHCCCS for 15 consecutive years. The report complies with all requirements set forth at 42 CFR §438.364.

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

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

- Section 2—An introduction to the annual technical report, including a description of the EQR mandatory activities.

- Section 3—An overview of AHCCCS’ background including the Medicaid managed care history, AHCCCS’ strategic plan with key accomplishments for CYE 2018, and AHCCCS’ quality strategy.
- Section 4—An overview of AHCCCS’ statewide quality initiatives across its Medicaid managed care program and those that are specific to the behavioral health program for CYE 2018.
- Section 5—An overview of the Contractors’ best and emerging practices for CYE 2018.
- Section 6 (Organizational Assessment and Structure Performance)—A presentation of the CYE 2018 Contractor-specific operational review (OR) results for two Contractors, (Cenpatico Integrated Care and Health Choice Integrated Care), including HSAG’s associated findings and recommendations and CAP updates for two Contractors (Mercy Maricopa Integrated Care and Cenpatico Integrated Care).
- Section 7 (Performance Measure Results)—A presentation of results for AHCCCS-selected performance measures for general mental health/substance abuse (GMH/SA) and each RBHA Integrated SMI Contractor, as well as HSAG’s associated findings and recommendations for CYE 2017.
- Section 8 (Performance Improvement Project Performance)—A presentation of Contractor-specific CYE 2017 PIP rates as well as qualitative analyses and interventions for the RBHA Contractors.

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

Contractors Reviewed

During the review cycle, AHCCCS contracted with the RBHA Contractors¹⁻² 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)

¹⁻² Note: Title 42 CFR §438.2 defines “managed care organization (MCO),” in part, as “an entity that has or is seeking to qualify for a comprehensive risk contract.” CMS designates all AHCCCS Contractors as MCOs. Unless citing Title 42 CFR, this report will refer to AHCCCS’ MCOs as Contractors.

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 CIC and HCIC in CYE 2018. During CYE 2017, AHCCCS conducted a comprehensive OR for MMIC and a focused OR for CIC. Between CYE 2017 and CYE 2018, AHCCCS monitored the progress of all RBHA Contractors in implementing their CAPs from the CYE 2016 OR review cycle.

The CYE 2018 comprehensive OR for CIC and HCIC was organized into 10 standard areas. Each standard area consisted of several elements designed to measure the RBHAs’ performance and compliance.

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

Each standard area contains elements designed to measure the Contractor’s performance and compliance with the federal managed care rules and the AHCCCS behavioral health contract provisions. A Contractor may receive up to a maximum possible score of 100 percent for each standard measured during the CYE 2016 OR review cycle. Within each standard are specific scoring detail criteria worth a defined percentage of the total possible score.

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

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

Findings

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

The following table summarizes outcomes of the reviews conducted by AHCCCS related to the two RBHA Contractors’ scores in the 10 standard areas for the comprehensive OR. Table 1-1 details the numbers of corrective actions for each standard area reviewed for the two RBHA Contractors with ORs conducted in CYE 2018.

Table 1-1—Number of Required Corrective Actions for CIC and HCIC

Standard Area	Number of Required Corrective Actions for CIC	Number of Required Corrective Actions for HCIC	Total Required Corrective Actions by Standard
Corporate Compliance (CC)	0	0	0
Claims and Information Systems (CIS)	3	5	8
Delivery Systems (DS)	3	4	7
General Administration (GA)	1	2	3
Grievance Systems (GS)	0	0	0
Adult, EPSDT*, and Maternal Child Health (MCH)	6	11	17
Medical Management (MM)	4	4	8
Member Information (MI)	1	0	1
Quality Management (QM)	1	2	3
Third-Party Liability (TPL)	0	0	0
Total	19	28	47

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

For the CYE 2018 ORs, AHCCCS required a total of 47 CAPs, with 28 CAPs required for HCIC and 19 CAPs required for CIC. Standards with greatest opportunity for improvement, based on the number of CAPs that CIC and HCIC were required to submit, were CIS, DS, MCH, and MM. Specifically, CIC and HCIC received the most required actions for the MCH standard (six and eleven, respectively). The strongest performances for CIC and HCIC were in the CC, GS, and TPL standards as actions were not required for these standards. Additionally, HCIC received no required actions for the MI standard.

Overall Compliance Scores for the CYE 2016 OR Review Cycle

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

Table 1-2—RBHA Contractors’ Standard Area Percentage Scores for the CYE 2016 OR Review Cycle

Standard Area	HCIC	CIC	MMIC
Corporate Compliance	100%	100%	83%
Claims and Information Systems	86%	91%	99%
Delivery Systems	78%	95%	96%
General Administration	56%	89%	100%
Grievance Systems	100%	100%	100%
Adult, EPSDT, and Maternal Child Health	55%	81%	94%
Medical Management	92%	96%	95%
Member Information	100%	96%	100%
Quality Management	99%	99%	98%
Third-Party Liability	100%	100%	100%

As indicated in Table 1-2, MMIC received standard area scores of 100 percent for four standards and received the least number of scores (two) below the 95 percent compliance threshold. Although HCIC received standard area scores of 100 percent for four standards as well, HCIC also received standard area scores below the 95 percent compliance threshold for five standards—more than the other RBHA Contractors. CIC received scores at or above the 95 percent threshold for seven standards and had three scores below the 95 percent threshold.

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

Table 1-3—Number of RBHA Contractors Meeting the Compliance Threshold

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

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

The strongest performances were in the GS and TPL standards, based on the number of Contractors that received a full compliance (100 percent). Most RBHA Contractors (two or more) scored at or above the 95 percent threshold for seven of the 10 standards. For the CIS, GA, and MCH standards, most RBHA Contractors scored below the 95 percent compliance threshold. Notably, for the MCH standard, all RBHA Contractors scored below the 95 percent compliance threshold.

Outstanding Corrective Action Plans

Between CYE 2017 and CYE 2018, AHCCCS monitored progress of CAP implementation from the 2016 OR review cycle. With few exceptions, AHCCCS' expectation was that the issues identified in CIC's CYE 2017 focused review would be addressed by the comprehensive OR in CYE 2018. CIC's standard area scores improved for all elements for which CIC received a CAP in the focused review, except for one element. However, CIC received CAPs for the same six elements in the CIS, MCH, and MM standards both in the focused review and the comprehensive OR. All CAPs from MMIC's comprehensive OR conducted in CYE 2017 were accepted and closed by the six-month update, except one CAP in the MCH standard. AHCCCS accepted all CAPs that HCIC submitted; however, AHCCCS required HCIC to submit CAP updates until HCIC has addressed the 18 CAPs that remain open.

Overall Strengths

Over the three-year review cycle, RBHA Contractors performed well in the GS, MI, QM, and TPL standards, as all met or exceeded the 95 percent compliance threshold. All RBHA Contractors received full compliance for the GS and TPL standards. For the CC standard, only one Contractor did not receive a full compliance score. Although for the MM standard, not all Contractors met the 95 percent compliance threshold, all RBHA Contractors scored 91 percent or above, as compared to the variation in scores that occurred in most other standards.

Overall Opportunities for Improvement and Recommendations

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

Based on AHCCCS' review of the RBHA Contractors' performance during the comprehensive ORs conducted in CYE 2017 and CYE 2018 (for the CYE 2016 review cycle) and subsequent CAP submissions, HSAG recommends the following for RBHA Contractors:

- Contractors should continue to conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should ensure existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements are cross-referenced with AHCCCS standards, State rules, and federal regulations.

- Contractors should continue to assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes. In addition, Contractors should implement periodic assessments of those elements reviewed by AHCCCS for which Contractors are found deficient and develop mechanisms to address such areas and enhance existing procedures.
- Contractors should apply lessons learned from improving performance for one category of standards to other categories. For example, Contractors should look at CAPs completed from previous ORs to determine best practices specific to their organizations to identify and correct policies, procedures, and practices so as to address deficient standards and monitor subsequent compliance. Further, Contractors should use opportunities to address and discuss issues identified during ORs.
- Contractors should continue to implement control systems to address specific findings in the MCH standard related to the women's preventative care services to ensure that services are provided in accordance with the AHCCCS Medical Policy Manual, as this was a finding for all RBHA Contractors.

Based on AHCCCS' review of the RBHA Contractors' performance conducted in CYE 2017 and CYE 2018 (for the CYE 2016 review cycle) and the subsequent CAP submissions, HSAG recommends the following:

- AHCCCS should concentrate improvement efforts on the CIS, GA, and MCH standard as most 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. In particular, AHCCCS might want to meet with the RBHA Contractors 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, all RBHA Contractors were required to submit a corrective action plan for the same element in the MCH standard. AHCCCS should present identified best practices regarding developing and implementing a written process to inform all primary care physicians (PCPs), obstetrician/gynecologist providers, and members of the availability of women's preventative care services as this was problematic for all RBHA Contractors.

Performance Measures

Aggregate Results for CYE 2017

AHCCCS collected data and reported Contractor performance for a set of performance measures for the CYE 2017 measurement period. For CYE 2017, AHCCCS selected one performance measure (two measure indicator rates) for the GMH/SA population and seven performance measures (eight measure indicator rates) for the RBHA Contractors serving the SMI population to be reported in the annual report. The following tables display the aggregate performance measure rates with established minimum performance standards (MPS). Of note, an MPS had not yet been established for all reported

performance measure rates. Contractor-specific results for performance measures with an MPS are included in Section 7, with additional performance measures (i.e., without an established MPS) included in Appendix B of this report.

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

Findings

Table 1-4 and Table 1-5 present the aggregate performance measure results with an MPS for the GMH/SA and RBHA Integrated SMI Contractors. The GMH/SA aggregate rates include all members who met the eligibility criteria for the GMH/SA program (excluding SMI members) regardless of RBHA. Due to changes in the technical specifications for *Follow-Up After Hospitalization for Mental Illness*, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, GMH/SA’s prior year’s rates and relative percentage change for this measure are not displayed in Table 1-4. Table 1-4 presents the CYE 2017 rates for the *Follow-Up After Hospitalization for Mental Illness* indicators for GMH/SA. The RBHA Integrated SMI aggregate rates represent the average of all three Contractors’ performance measure rates weighted by the eligible population. Table 1-5 displays the following information: CYE 2016 performance, where available; CYE 2017 performance; the relative percentage change between CYE 2016 and CYE 2017 rates, where available; the significance of the relative percentage change, where available; and the AHCCCS MPS. Performance measure rate cells shaded green indicate that aggregate performance met or exceeded the CYE 2017 MPS established by AHCCCS.

Table 1-4—CYE 2017 Aggregate Performance Measure Results—GMH/SA

Performance Measure	CYE 2017 Performance	MPS
Behavioral Health		
<i>Follow-Up After Hospitalization for Mental Illness</i>		
<i>7-Day Follow-Up</i>	48.1%	85.0%
<i>30-Day Follow-Up</i>	67.2%	95.0%


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

Table 1-5—CYE 2016 and CYE 2017 Aggregate Performance Measure Results—RBHA Integrated SMI Contractors


Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (<i>p</i> value) ¹	MPS
Access to Care					
<i>Adults’ Access to Preventive/Ambulatory Health Services</i>					
<i>Total</i>	92.8%	92.2%	-0.6%	P=0.004	75.0%
Preventive Screening					
<i>Breast Cancer Screening²</i>					
<i>Breast Cancer Screening</i>	—	38.7%	—	—	50.0%

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (<i>p</i> value) ¹	MPS
Chlamydia Screening in Women					
<i>Total</i>	54.9%	51.5%	-6.2%	P=0.285	63.0%
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness²					
<i>7-Day Follow-Up</i>	—	71.8%	—	—	85.0%
<i>30-Day Follow-Up</i>	—	87.7%	—	—	95.0%

¹ Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the *p* value is ≤0.05. Significance levels (*p* values) in bold font indicate statistically significant values.

² Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.

— Indicates that the CYE 2016 rate was not displayed due to technical specification changes, or that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate.

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

Conclusions

Compared to the CYE 2017 MPS, the GMH/SA aggregate's and RBHA Integrated SMI aggregate's performance in the **quality, access, and timeliness** areas indicated opportunities for improvement as both *Follow-Up After Hospitalization for Mental Illness* measure rates fell below the MPS.

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

Recommendations

HSAG recommends that AHCCCS work with the GMH/SA and RBHA Integrated SMI Contractors to increase rates for the *Follow-Up After Hospitalization for Mental Illness* performance measure that failed to meet the CYE 2017 MPS. AHCCCS and the Contractors should conduct root cause analyses for the low rates of follow-up visits after hospitalization for mental illness to determine the nature and scope of the issue (e.g., barriers to care, lack of continuity of care, transportation issues, ineffective communication). Effective transition of care programs have been shown to reduce readmissions and exacerbation of symptoms related to mental illness by engaging the patient and family members (e.g., structured discharge checklist for accountability, awareness of red flags), establishing clear transition and care plans (e.g., follow-up appointments scheduled prior to discharge), utilizing transition coaches and providers (e.g., visits and phone calls to review illness management and questions), and ensuring effective provider communication (e.g., healthcare professionals understanding of transition and care plan).¹⁻³ After the key factors related to the low rates are identified, AHCCCS and the Contractors

¹⁻³ Viggiano T, Pincus HA, and Crystal S. Care Transition Interventions in Mental Health. *Current Opinion in Psychiatry*. Vol. 25. No. 6. Nov. 2012.

should work with providers and members to establish potential performance improvement strategies and solutions to increase follow-up visits and improve member transitions of care.

Additionally, HSAG recommends that AHCCCS work with the RBHA Integrated SMI Contractors to increase preventive screenings for women. AHCCCS and the RBHA Integrated SMI Contractors should examine potential barriers to women receiving breast cancer and chlamydia screenings to understand the cause of the low rates (e.g., provider misconceptions, lack of education, member anxiety). Once the causes are identified, AHCCCS and the RBHA Integrated SMI Contractors should ensure that members receive screenings in accordance with the U.S. Preventive Services Task Force (USPSTF) screening recommendations for breast cancer and chlamydia in women.^{1-4,1-5}

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 the Division 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 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 for all other lines of business.

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.¹⁻⁶ 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.

¹⁻⁴ U.S. Preventive Services Task Force. *Breast Cancer: Screening*. Available at:

<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening?ds=1&s=breast>. Accessed on: Apr. 12, 2019.

¹⁻⁵ U.S. Preventive Services Task Force. *Chlamydia and Gonorrhea: Screening*. Available at:

<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/chlamydia-and-gonorrhea-screening?ds=1&s=chlamydia>. Accessed on: Apr. 5, 2019.

¹⁻⁶ 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.

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.

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

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

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

- Maintained or increased improvements in performance for at least one year after those improvements in performance are first achieved.
- Demonstrated how the improvement can be reasonably attributable to interventions undertaken by the organization (i.e., improvement occurred due to the project and its interventions, not another unrelated reason).

In addition, the AHCCCS Quality Improvement Team implemented multiple process improvement efforts during CYE 2018, including AHCCCS Medical Policy Manual (AMPM) PIP policy updates, implementation of a revised PIP reporting template structure to capture the evolution and progress of the Contractor throughout the PIP cycle, as well as the creation of an AHCCCS PIP-specific review checklist that enhances interrater reliability for coordinator reviews and the provision of more extensive feedback to the Contractors.

For this annual report, CYE 2017 was the Remeasurement 1 year for MMIC's GMH/SA and Integrated member populations, while both CIC and HCIC were in the intervention year for the GMH/SA and Integrated member populations.

Findings

This report is inclusive of the Remeasurement 1 reporting period for MMIC for both the GMH/SA and Integrated populations for the *E-Prescribing* PIP and the intervention year for CIC and HCIC; therefore, comparisons could not be made between rates for each indicator.

For MMIC's GMH/SA population, the Contractor achieved a relative percentage change over baseline of 6.72 percent for Indicator 1, the percentage of providers who prescribed at least one prescription electronically; while for Indicator 2, the percentage of prescriptions sent electronically, MMIC achieved

a relative percentage change from baseline of 13.05 percent. For MMIC's Integrated population, the Contractor achieved a relative percentage change over baseline of 8.61 percent for Indicator 1, the percentage of providers who prescribed at least one prescription electronically; while for Indicator 2, the percentage of prescriptions sent electronically, MMIC achieved a relative percentage change from baseline of 15.07 percent. MMIC achieved statistically significant improvement for both indicators in both populations.

All RBHA Contractors participated in an e-prescribing workgroup formed with other Arizona Contractors, Arizona Alliance of Health Plans (AZAHP) and Health Current (collectively referred to as "workgroup"). The workgroup developed two surveys. One survey asked providers to identify contributing factors to e-prescribing rates to identify best practices or barriers, and the other addressed Arizona electronic health record (EHR) vendors to determine system capabilities for e-prescribing controlled substances. Other interventions included educating providers and posting about e-prescribing on the website as well as pharmacy newsletters, including e-prescribing implementation as a required onboarding step for new integrated clinics, requiring clinics to create and implement formal written procedures, distributing surveys to providers to identify barriers related to e-prescribing, providing financial incentives to providers for meeting or exceeding e-prescribing performance goals, issuing corrective action letters to providers that did not meet minimum performance standards set by AHCCCS or the Contractor, and implementing value-based purchasing (VBP) incentives for providers.

Overall Opportunities for Improvement and Recommendations

The RBHA Contractors were in different phases of implementation for the *E-Prescribing* PIP. While MMIC achieved statistically significant improvement for both indicators in both populations, both CIC and HCIC were in the intervention phase of the PIP. However, both CIC and HCIC reported strong interventions and reported preliminarily that the interventions were producing positive results.

Based on the submitted and preliminary results for the *E-Prescribing* PIP, HSAG offers the following recommendations to improve PIP outcomes in the future:

- AHCCCS has made significant progress in making PIP process improvements in the past year, including the development of a new reporting template. AHCCCS may want to consider offering and facilitating training opportunities to enhance the RBHA Contractors' capacities to implement robust interventions, 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 systemwide 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 consider requiring for the RBHA Contractors new PIPs that pertain to aspects of the Arizona Complete Care activities.
- The RBHA Contractors should continue to identify and prioritize barriers so as to develop robust interventions for the *E-Prescribing* PIP.
- The RBHA Contractors are encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, and then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.

Overall Assessment of Progress in Meeting EQRO Recommendations

During previous years, HSAG made recommendations in the annual reports for each activity conducted. Table 1-6 is a summary of the follow-up actions per activity that AHCCCS completed in response to HSAG’s recommendations during State fiscal year (SFY) 2016–2017. Many of the Contractors have added rates in responses to the recommendations. Please note that AHCCCS has not approved or validated these rates.

Table 1-6—HSAG Recommendations With AHCCCS Actions

HSAG Recommendation	AHCCCS Action
Operational Review	
<ul style="list-style-type: none"> • AHCCCS should consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. • AHCCCS should present identified best practices on the predominant issues for RBHA Contractors’ issues and facilitate a group discussion about Contractors’ policies and procedures. In addition, AHCCCS should consider conducting a root cause analysis with the Contractors to determine why Contractors continue to have difficulty complying with specific standards. 	<p>The AHCCCS Medical Management (MM) Team presented all the changes that have been made in the AHCCCS Medical Policy Manual (AMPM) and intends to conduct an ad-hoc notice of action (NOA) audit in December 2018. In preparation for the integrated contract rollout, the AHCCCS MM Team held multiple workgroup meetings to discuss various topics (care coordination, crisis, emergency department wait times, autism spectrum disorder [ASD], Tribal Regional Behavioral Health Authority [T-RBHA] coordination). In addition, ongoing workgroups with the multispecialty integrated clinics (MSICs) and AHCCCS Complete Care (ACC) plans to discuss transition of Children’s Rehabilitative Services (CRS) members also occurred.</p> <p>AHCCCS Maternal Child Health and Early and Periodic Screening, Diagnostic, and Treatment (MCH/EPSDT) quarterly</p>

HSAG Recommendation	AHCCCS Action
	<p>Contractor meetings included the following agenda items: blood lead update, pregnancy risk monitoring systems, importance of early relationships, introduction to behavioral health guides and manuals, behavioral assessment, policy review and behavioral health tools, mental health advocacy, trauma, behavioral health tools, AHCCCS quality management portal demo, congenital syphilis, children’s system of care, Division of Health Care Advocacy and Advancement overview, and expectations for CYE 2019.</p>
<p>AHCCCS could consider developing a template or checklist for the Contractors to ensure that Contractors include all minimum required information in remittance advice to providers. The element requiring that Contractors (and their subcontractors) must include the reason and detailed descriptions related to payments less than billed charges, denials, and adjustments on remittances has been out of compliance for both the CYE 2016 and CYE 2017 ORs for all but one Contractor.</p> <p>AHCCCS may also consider reviewing the data capture and transfer processes used for the claims processing systems to ensure alignment with the requirements set forth in the claims information systems standard.</p> <p>AHCCCS will be working with Contractors (in some cases new Contractors) who will be providing integrated services, working with new populations, and operating in new geographic service areas; therefore, this is an important standard to target for compliance.</p>	<p>All requirements for the remit are found in contract and policy. It should be noted that most issues found on the last round of OR reviews of remits were related to the subcontractor, not specific to the Contractors. This was the first round of ORs for which AHCCCS reviewed and scored subcontractor remits as well.</p>
<p>Within the CYE 2017 EQRO reports, HSAG included an indication that AHCCCS should consider distributing technical assistance documents to all Contractors and holding in-person meetings with Contractors who scored lowest in the OR standards, including guidance on how to complete a CAP.</p>	<p>Technical assistance (TA) was provided to all Contractors prior to the CYE 2016 OR cycle. This TA went over changes made to the OR process, and included guidance on how to complete a corrective action plan (CAP). Prior to the next OR cycle, AHCCCS intends to hold another OR kickoff/TA session with</p>

HSAG Recommendation	AHCCCS Action
	<p>all Contractors. During this meeting, information on how to complete a CAP will be restated.</p> <p>Additionally, the AHCCCS QI Team created a QI-specific CAP checklist that is currently awaiting AHCCCS Policy Committee review and approval. It is expected that this checklist will assist Contractors in the identification and inclusion of essential elements required by the Contractors when seeking AHCCCS review and approval for mandated CAPs required based on Contractor performance related to performance measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)¹⁻⁷ surveys.</p>
<p>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.</p>	<p>Compliance with OR standards will be evaluated with the next round of ORs. The CYE 2016 OR cycle was the first round of ORs that AHCCCS conducted directly with the RBHAs.</p>
<p>AHCCCS should consider using the quarterly meetings with Contractors as forums in which to share lessons learned from both the State and Contractor perspectives. AHCCCS should present identified best practices on the predominant issues for RBHA Contractors and facilitate a group discussion on Contractors’ policies and procedures. In addition, AHCCCS should consider</p>	<p>Evaluation of root cause concerns with Contractors not compliant with specific OR standards will be reviewed after the next round of ORs. This will be the first round of ORs since the request for proposal (RFP), wherein a number of changes were made to the Contract requirements.</p>

¹⁻⁷ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HSAG Recommendation	AHCCCS Action
conducting a root cause analysis with the Contractors to determine why Contractors continue to have difficulty complying with specific standards.	
AHCCCS should concentrate improvement efforts on the CC and CIS standards as both standards were problematic in CYE 2016 and CYE 2017 ORs. For example, AHCCCS should consider distributing TA documents to all Contractors and holding in-person meetings with Contractors who scored lowest in these standards.	TA is something that can be considered in the future with the Contractors. OR elements are reviewed and may be changed with each cycle. In addition, AHCCCS conducts an OR kick-off meeting with the Contractors to provide a summary of changes and expectations and to address questions raised by the Contractors related to the review process.
No recommendation.	AHCCCS is reviewing all standards for the upcoming ORs beginning January 2019 and making revisions as necessary.
Performance Measures	
No recommendation.	AHCCCS conducted a series of web-based TA and education sessions aimed at providing contract quality management, QI, and other clinical staff a foundation for the following topics and to address barriers which may be impacting the Contractors’ ability to achieve meaningful improvement. Topics included: introduction to CRS; immunizations: Parts 1, 2, and 3—schedules and statutes; vaccines for children/Arizona State Immunization Information System (VFC/ASIIS) and audit results; dental data overview, varnish, sealants, and dental preventative-participation; system of care overview; and newborn screening.
Performance Improvement Projects	
AHCCCS may want to consider offering and facilitating training opportunities to enhance the Contractors’ capacity to implement robust interventions and QI processes and strategies for the <i>E-Prescribing</i> PIP. Increasing the Contractors’ efficacy with QI tools such as root cause analyses, key driver diagrams,	Based on the CYE 2017 closeout of the <i>E-Prescribing</i> PIP, as the final reports were not received until June 2018, AHCCCS was unable to implement those recommendations by HSAG specific to this PIP. However, AHCCCS is currently considering how the associated recommendations can be

HSAG Recommendation	AHCCCS Action
<p>process mapping, failure modes and effects analysis (FMEA), and PDSA cycles should help to remove barriers to successfully achieving improvement in the PIP indicator rates.</p>	<p>incorporated into other AHCCCS-mandated activities, current and upcoming, related to the Contractors’ PIP and performance measure evaluation and analysis efforts.</p>
<p>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.</p>	<p>Based on the CYE 2017 closeout of the <i>E- Prescribing</i> PIP, as the final reports were not received until June 2018, AHCCCS was unable to implement those recommendations by HSAG specific to this PIP.</p>
<p>AHCCCS may want to use the quarterly meetings with Contractors as opportunities to identify and address, related to the PIP process, systemwide barriers which may be impacting ability to achieve meaningful improvement.</p>	<p>AHCCCS used various Contractor quarterly meetings as opportunities to identify and address a wide array of topics, providing education and the setting to address barriers that may impact the Contractors’ abilities to achieve meaningful improvement in various focus areas.</p> <p>AHCCCS also introduced its Back to Basics efforts that included the selection of a child and adolescent preventative care measure PIP with the ability to help Contractors address a notable decline in rates specific to well-child and well-care visits. To help address barriers related to a notable systemwide decline specific to child and adolescent well-care and immunization rates, in addition to the Back to Basics PIP discussed previously AHCCCS also initiated a series of web-based TA and education sessions aimed at providing Contractor QM, QI, and other clinical staff a foundation for the following topics found within the “MCH and EPSDT Learning Opportunities” section of the Performance Measures as well as addressing barriers which may be impacting the Contractors’ abilities to achieve meaningful improvement.</p>
<p>AHCCCS should consider including in the workgroup additional stakeholders who may help with improvement of the PIP indicators’ rates.</p>	<p>Based on the CYE 2017 closeout of the <i>E- Prescribing</i> PIP, as the final reports were not received until June 2018, AHCCCS was unable to implement those recommendations by HSAG specific to this PIP. However,</p>

HSAG Recommendation	AHCCCS Action
	<p>AHCCCS is currently considering how the associated recommendations can be incorporated into the AHCCCS QI PIP-related activities.</p>
<p>AHCCCS should continue the collaboration among Contractors in the workgroup to improve the PIP study indicator rates.</p>	<p>Based on the CYE 2017 closeout of the <i>E-Prescribing</i> PIP, as the final reports were not received until June 2018, AHCCCS was unable to implement those recommendations by HSAG specific to this PIP. However, AHCCCS is currently considering how the associated recommendations can be incorporated into the AHCCCS QI PIP-related activities.</p>
<p>For systemwide barriers, AHCCCS may consider the following: facilitate a session to identify systemwide barriers impeding Contractors’ abilities to impact Indicator 1 and Indicator 2; appoint a high-level AHCCCS manager as a champion for the workgroup; develop an action plan to address the systemwide barriers.</p>	<p>AHCCCS used various Contractor quarterly meetings as opportunities to identify and address a wide array of topics, providing education and the setting to address barriers that may impact the Contractors’ abilities to achieve meaningful improvement in various focus areas.</p> <p>AHCCCS also introduced its Back to Basics efforts that included the selection of a child and adolescent preventative care measure PIP with the ability to help Contractors address a notable decline in rates specific to well-child and well-care visits. To help address barriers related to a notable systemwide decline specific to child and adolescent well-care and immunization rates, in addition to the Back to Basics PIP discussed previously AHCCCS also initiated a series of web-based TA and education sessions aimed at providing Contractor quality management, QI, and other clinical staff a foundation for the following topics found within the “MCH and EPSDT Learning Opportunities” section of the Performance Measures and at addressing barriers which may be impacting the Contractors’ ability to achieve meaningful improvement.</p>

HSAG Recommendation	AHCCCS Action
No recommendation.	During the latter portion of CYE 2018, the AHCCCS QI Team collaborated with the MCH and Executive Management teams to select a child and adolescent preventative care PIP with the ability to help Contractors address a notable decline in rates specific to well-child and well-care visits. This methodology has been approved and will soon be distributed to Contractors and posted to the AHCCCS website. The baseline measurement period for this PIP is CYE 2019, with data collection anticipated to start summer 2020; this time frame was intentionally selected to account for the most recent system changes that went into effect October 1, 2018.

Table 1-7 presents a summary of the follow-up actions per activity that the RBHA Contractors reported completing in response to HSAG’s recommendations during SFY 2016–2017.

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

Table 1-7—Contractors’ Responses to HSAG’s Follow-Up Recommendations

CIC
Operational Reviews
<p>HSAG Recommendations:</p> <ul style="list-style-type: none"> • RBHA Contractors should conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations. • RBHA Contractors should regularly monitor and ensure that updates are made to contracts with providers and that policy manual updates from AHCCCS are also included in Contractors’ policies, procedures, and manuals in a timely manner. • Specifically, CIC could develop a document that describes its maternal care program, including all requirements mandated by AHCCCS. • RBHA Contractors should apply lessons learned from improving performance for one category of standards to other categories. • RBHA Contractors should implement control systems to address specific findings in the CIS standard that are consistent compliance issues across Contractors related to the requirement that the Contractors must pay applicable interest on all claims.
CIC performs internal reviews of operational systems on a department-level regularly and

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cross-departmentally on a monthly and/or quarterly basis. The CARE Task Force is an example of this cross-departmental collaboration to identify and overcome barriers that impact standards and regulations, performance outcomes, policies and procedures, as well as member experience. This cross-departmental representation is measured through the meaningful engagement, collaboration, and problems solved by the following departments: care management; utilization management; quality management ; claims; credentialing; contracts; pharmacy; provider network; provider engagement; marketing; operations; individual and family affairs; customer service; grievance & appeals; analytics; and corporate representation. The CARE Task Force was operational throughout CYE 2018 and implemented an enhanced provider experience and engagement and obtained member feedback on care management support. In December 2017, CIC reported that provider groups were surveyed on whether or not they know that they have a provider engagement specialist (PES) assigned to them; 57.78 percent of those surveyed acknowledged having a PES assigned. Through the efforts of the CARE Task Force, an introductory letter was sent out to every provider providing contact information for their assigned PES and information about the role they fulfill. By June 2018, CIC reported that 63.37 percent of providers acknowledged having a PES assigned. The provider engagement team continues to outreach providers and provide resources to ensure providers know who their PES is and how to obtain resolution to any problems that arise. In January 2018, through collaboration with the CARE Task Force, the care management team implemented an after-call survey for members to gauge level of satisfaction. Since CIC's inception, members have expressed high levels of satisfaction, 95–100 percent month over month in 2018. The next step for CYE 2019 is to shift this after-call survey into an automated interactive voice response (IVR) survey.

Through monitoring and evaluation efforts and principles and tools of continuous quality improvement, lessons learned from successful and unsuccessful interventions are extrapolated and readdressed to ensure sustained positive impact and ongoing compliance with AHCCCS standards, State rules, and federal regulations. Appropriate processes and control systems have been established and are actively utilized by the CIC claims department to meet applicable compliance standards and regulations.

CIC established a Maternal Child Health (MCH) program which delivers a full continuum of maternity care services to enrolled seriously mentally ill (SMI), Title 19 (TXIX) members of childbearing age. The program is designed to ensure that every pregnant member in the integrated care program has early access to medical/prenatal care; and assists in coordinating care and addressing any barriers, with the goal of improving maternal and child health.

Priorities for healthy pregnancy outcomes align with AHCCCS Medical Policy Manual (AMPM) Chapter 400, including supporting the needs of pregnant women with opioid use disorder (NAS), reducing preterm birth, and reducing the number of babies born before 39 weeks. CIC's award-winning Start Smart for Your Baby Program (SSFB) provides pregnant women with a culturally competent, dedicated integrated care team with high-touch care management for women with high-risk pregnancies.

SSFB is available to all pregnant women within the integrated plan and provides an array of services to support pregnant women throughout their pregnancies and post-delivery. SSFB

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program materials are provided, to include text/email programs implemented in Q4 of FY 2018. Topics include: importance of timely prenatal and postpartum care, tobacco cessation, avoidance of alcohol and other harmful substances, availability of human immunodeficiency virus (HIV) and sexually transmitted infections (STI) screenings and/or counseling, transportation, signs of postpartum depression, and family planning.

In effort to engage this population, the MCH team implemented: texting for difficult to reach members or if members identified this as a preferred mode of communication; providing appointment reminders when applicable; completing home visits; and face-to-face visits with members in hospitals or treatment facilities. The MCH team also collaborates with outreach providers and promotoras in rural areas. Additionally, in Q4 of FY 2018, automated calls regarding the importance of timely prenatal and postpartum care were implemented with the goal of increasing prenatal and postpartum rates.

MCH team efforts include partnering with providers to ensure that ongoing coordination of care occurs for individual members. Education and focused technical assistance are delivered to providers using the health plan provider manual, monthly calls, provider forums, newsletters, fax blasts, and face-to-face visits.

CIC continues to monitor, evaluate, and reassess the effectiveness of MCH program strategies and interventions within the context of annual program evaluations and work plans. Program data are reviewed within the context of MCH subcommittee meetings as well as quarterly Medical Management and QMPI Committee meetings.

Finally, the OR conducted for CYE 2017 identified issues in four of the OR standard areas: medical management, claims information system, maternal and child health, and quality management. Due to these identified issues and scoring less than 95 percent in three standard areas, CAPs were created and approved by AHCCCS immediately following the notification of results to CIC. All of the CAPs required have been subsequently approved and closed through AHCCCS. Policies and procedures were created and continue to be reviewed for ongoing training purposes to ensure full compliance with AHCCCS standards, State rules, and federal regulations.

Performance Measures

HSAG Recommendation: CIC should focus on the following: *Cervical Cancer Screening*: CYE 2016 Performance: 14.6 percent, MPS: 64.0 percent and *Chlamydia Screening in Women*: CYE 2016 Performance: 59.1 percent, MPS: 63.0 percent.

CIC relies on the QMPI Committee as the body that reviews, monitors, evaluates, and develops interventions targeted at performance measures. The QMPI Committee is structured to ensure that data drill-down is completed with root-cause analysis and that PDSA cycles are developed to drive intervention development and implementation. Focused interventions on improvement of well-woman exams, cervical cancer screenings, and chlamydia screenings are developed within the Performance Improvement team. The Quality Improvement (QI) subcommittee met quarterly during CYE 2018 and reported on all AHCCCS mandated performance standards, with particular focus and emphasis on interventions and impact to the *Cervical Cancer Screening* and *Chlamydia Screening in Women* measures.

CIC

The Coordination of Care Performance Improvement Plan (COC-PIP) approved by AHCCCS instituted its intervention year during FY 2018. Performance measures make up one indicator for this plan, for which CIC has included both cervical cancer screening and chlamydia screening in women. Two specific system-level interventions that have been identified and implemented to sustain performance measure impact through coordination of care include: actively engage PCPs into collaborative CIC COC process and health information exchange (HIE) implementation. Both of these interventions aim to ensure that health homes, primary care physicians, and specialists remain connected and communicate the completion of or barriers to completing performance measures as well as ongoing communication for follow-up when members are due for a cervical cancer screening, chlamydia screening, or other performance measures. Additionally, through the Population Health Administer program CIC provided technical assistance to providers on cervical cancer screening and chlamydia screening in women best practices and technical guidance on understanding and tracking which members are eligible and need screenings completed.

CIC implemented a new member incentive program in Q1 CYE 2019, offering a \$25 member gift card per service (not to exceed \$75) when members receive a well visit or specific preventative screening. Cervical cancer screenings are an eligible screening to receive \$25 incentive. Because of the nature of well-women exams, it is likely that a member will complete the chlamydia screening concurrently with an incentivized completion of the cervical cancer screening. CIC has developed a calendar of interventions for these measures in partnership with care management, pharmacy, provider engagement and the payment innovations teams. These interventions incorporate lessons learned from previous PDSA projects and target both member and provider interventions.

Performance Improvement Projects

HSAG Recommendations: Continue to monitor and evaluate the effectiveness of interventions for the *E-Prescribing* PIP. Identify and rank providers with greatest volume of prescriptions and lowest e-prescribing rates. Incorporate e-prescribing education and presentations into provider forums and provider engagement meetings. Perform outreach to prescribers with low e-prescribing rates.

CIC has continued to show improvement in e-prescribing rates for both indicators tracked by AHCCCS: percentage of AHCCCS contracted prescribers using e-prescriptions and percentage of prescriptions submitted by AHCCCS-contracted prescribers electronically. Compared to baseline year rates for both the general mental health/substance abuse (GMH/SA) and SMI populations, both AHCCCS tracking indicators showed improvement over remeasurement years one and two. Data were not available for remeasurement year two for the percentage of prescriptions submitted by AHCCCS-contracted prescribers electronically indicator. Additionally, CIC has been tracking and targeting interventions surrounding indicators stratified by age and geographical county that address the percentage of prescriptions submitted electronically to a pharmacy. Again, all stratified indicators for both the SMI and GMH/SA populations have shown improvement over baseline rates in both remeasurement year one and remeasurement year two. CIC is also tracking the performance of each of its contracted health homes and international community corrections associations

CIC

(ICCA) and targeting interventions to those providers under the internally developed minimum performance standards (MPS) of 80 percent.

CIC engaged heavily in the *E-Prescribing* PIP and showed ongoing quarterly improvement over re-measurement periods one and two. Interventions in CYE 2018 targeted ongoing provider education. Beginning in February 2018, CIC actively engaged providers who encountered barriers or issues with e-prescribing through technical assistance support and guidance. The improvement in e-prescribing utilization can be reasonably attributed to interventions, including extensive and ongoing quarterly education of and technical assistance to medical directors and individual prescribers by CIC pharmacy staff, and issuance of CAPs to providers in need of additional support. In addition, financial incentives supported improvement, notably inclusion of e-prescribing incentive as a value-based payment (VBP) measure effective Q3 CY 2017.

Monitoring and evaluation efforts continue to drive identification of provider deficiencies and best practices to ensure that targeted education and interventions are successful at continuing to improve e-prescribing metrics. The pharmacy department will also continue to partner with various CIC departments to ensure that messaging and support to AHCCCS-contracted providers are consistent and ongoing.

HCIC

Operational Reviews

HCIC did not document HSAG recommendations but did include information on ORs.

HCIC conducted an OR with AHCCCS in CYE 2017. During that OR, AHCCCS reviewed 10 standards. The results of the OR demonstrated opportunities for improvement as HCIC was less than compliant in five of the 10 standards reviewed. HCIC completed corrective actions for all areas that were found deficient. All of these corrective actions have been accepted and closed by AHCCCS at the time of this update, and HCIC continues to monitor the actions taken to ensure that they remain in place.

Performance Measures

HCIC did not document HSAG recommendations but did include information on performance measures.

HCIC is committed to complying with AHCCCS quality management requirements to improve performance for all AHCCCS performance measures. Monitoring performance measures occurs through data reports, which are stratified by all populations. The results of performance measures monitoring are reviewed at least quarterly by the Quality Management Committee.

HCIC will deploy performance improvement coordinators (PICs) to partner with HCIC-contracted providers and practices to review, troubleshoot, and optimize office workflow, member outreach, and collection of supplemental data.

The PIC team will develop a playbook of potential interventions to improve performance on each targeted performance measure. On regularly scheduled visits to provider offices, PICs will conduct a needs assessment including identification of practice-specific areas of

HCIC

opportunity that can be leveraged to improve office efficiency, provider performance, and member care. Once an opportunity has been identified, PICs will select and right-size an intervention from the playbook and apply established principles of process improvement to gain stakeholder buy-in, drive change, and measure the effectiveness of the updated process. HCIC will maintain and expand existing partnerships with service delivery partners including mammography centers, eye care centers, transportation vendors, home health agencies, and others to address barriers to care and close care gaps. HCIC expects that the deployment of PICs will have tremendous and lasting benefits both to HCIC’s relationships with providers and the care that HCIC and HCIC’s providers deliver to our members.

The PIC team has a high level of oversight from senior and mid-level management. In-depth trainings are provided, and shadowing completes the onboarding process to ensure that messaging is effective and relationship-building with providers is optimized. Weekly meetings occur one-on-one and as a group to monitor progress and ensure that barriers are overcome. A custom application was built to integrate member data from a variety of sources and keep documentation up to date daily on progress toward gap closure.

HCIC has created 10 full-time equivalent (FTE) positions to work on targeted performance measures for Arizona Medicare and Medicaid, and have given those individuals specific training on engaging PCPs and parents or guardians to ensure completion of required services. PICs will be assigned to PCP group practices that have a high volume of gaps in care. PICs directly outreach to parents or guardians and PCPs to close gaps in care. Additional phone outreach is targeted at parents or guardians of those members that are overdue for vaccines. HCIC is implementing and distributing provider report cards and member rosters to share performance rates, targets, and member-level detail about immunization measures with providers themselves. HCIC sends provider representatives to provider site locations to help troubleshoot issues and problems. These provider representatives carry and distribute recently updated provider toolkits with resources for providers.

Performance Improvement Projects

HCIC did not document HSAG recommendations but did include information on performance improvement projects.

HCIC results show an increase in both the percentage of prescriptions that are prescribed electronically and an increase in the percentage of prescribers utilizing electronic prescribing. These increases are despite a huge increase in the number of prescriptions paid for by HCIC. HCIC efforts have shown an even more dramatic increase in electronic prescribing for controlled substances. The HCIC goal for electronic prescribing in CYE 2018 was set at 70 percent electronic prescribing of all prescriptions. HCIC met this goal in all eligibility groups, over all populations, and in all integrated health homes.

HCIC stratified data in order to focus efforts on any deficient areas or populations. However, HCIC noted an increase in electronic prescribing for all age ranges and populations. HCIC has conducted a comparative analysis from baseline measurement year to measurement year one, and from remeasurement year one to this interim year. HCIC found all results to be statistically significant.

HCIC
<p>During the data analysis, HCIC discovered a significant error in calculating both the prescribers that were utilizing electronic prescribing and the total number of prescriptions during the second remeasurement year. HCIC has recalculated the rates for the second remeasurement year to include a comparison between the second and third remeasurement years.</p>
<p>Consumer Assessment of Healthcare Providers and System</p>
<p>HSAG Recommendation: Perform root cause analysis.</p>
<p>HCIC employs the “Plan-Do-Study-Act” (PDSA) approach to performance improvement and Lean and Six Sigma’s “define, measure, analyze, improve, control” (DMAIC) to manage projects within a team-based approach to QM and performance improvement (PI). Using this philosophy of improvement, HCIC proactively works to continually improve outcomes and enhance staff and provider performance.</p> <p>In both models, root cause analysis (RCA) is an integral part of the first steps of any performance improvement project. The purpose of this step is to identify, validate, and select root cause for elimination. A large number of potential root causes of the project problem may be identified using RCA. RCA tools like workflow diagrams, Ishikawa diagrams, or 5-Whys exercises may be used to determine root causes. The top potential root causes are selected using multi-voting or other consensus tool for further validation.</p> <p>HCIC has trained staff in specific quality improvement methods including, among other topics, strategies to integrate QM functions across the organization and best practices in quality improvement.</p>
<p>HSAG Recommendation: Conduct frequent assessment of targeted interventions.</p>
<p>HCIC promotes improvement in quality of care and services provided to our enrolled members through ongoing monitoring, evaluating, and continuous improvement of the service delivery system and provider network. Through ongoing measurement and intervention, the QM program is designed to achieve and sustain significant improvements in the areas of clinical care and nonclinical care. The goal of continuous improvement is to positively impact health outcomes and member experience while achieving cost containment. HCIC implements actions in line with evidenced-based practices to correct deficiencies, administer targeted corrective action plans as needed, and improve the quality of care and services provided to our members.</p> <p>HCIC addresses findings from internal audits, external audits, and operational reviews—ensuring that corrective actions are incorporated into standard operating procedures throughout the respective areas of the organization. This is facilitated through ongoing monitoring throughout the year. These results are reported through the HCIC QMPI Committee in coordination with the HCIC Compliance Committee.</p> <p>HCIC maintains ongoing oversight and monitoring of operational/functional areas, which include formal assessments and evaluations on at least an annual basis. The HCIC Compliance team is a significant contributor to these efforts to guarantee full compliance with all policies and procedures in addition to State and federal regulatory standards. Efforts to identify and address areas in need of corrective action or process improvements are addressed, followed by</p>

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tracking and monitoring of implemented strategies.

Program descriptions and outcomes are reported through the Health Choice QMPI Committee, in coordination with the HCIC Compliance Committee. Each of these committees meets at minimum on a quarterly basis to encourage interdepartmental collaboration among key stakeholders and the dissemination of best practices within the organization. Further, these committees provide a platform to discuss and develop solutions for vulnerable operational systems, monitoring programs, and/or process improvement activities.

HSAG Recommendation: Use health information technology.

HCIC is restructuring the quality program to improve efficiency and efficacy primarily through adoption of more robust performance monitoring tools; rollout of revised, VBP contracts with a focus on incentivizing quality improvement; enhanced contract rates for specific services; expanded HIE and electronic medical record (EMR) connectivity; enhanced data stewardship; enhanced population targeting; and adoption of additional best practices and evidence-based interventions in performance areas of greatest opportunity. As the most effective and efficient processes and interventions are identified, additional learning-focused infrastructure that leverages a PDSA approach will be built to ensure sustainability and continued improvement over time.

Administrative and operational quality management are also included in the QM program scope of work. HCIC QM program staff engage all functional areas of the organization in proactive performance improvement activities to ensure the highest quality, most cost-effective administrative processes. A centralized QMPI email inbox ensures that all staff have open reporting, collaboration, and involvement with continuous quality improvement activities and opportunities. Processes and/or systems are included within the scope, including but not limited to customer service member/provider call metrics, credentialing processes, HIE, data transmission, information systems, workflow, member eligibility, and operational effectiveness. HCIC encourages the use of EMR systems across the system of care. To review provider activity and maintain compliance with program audit requirements, HCIC conducts provider data validation audits and verifies that services delivered to members are accurately and promptly reported and documented in the medical record. HCIC can connect directly to all large provider EMRs to complete reviews. Direct access through the information technology (IT) infrastructure allows HCIC to quickly identify areas where providers may show anomalies in their data and report any incidents to the State, per program requirements.

HCIC is expanding the use of health information technology in the auditing process. In CYE 2018, HCIC traced the records retrieval process to identify barriers and diagnose roadblocks to successful sharing of data and retrieval of vital information. Using that information, HCIC revised the chase logic to make it more efficient. HCIC created a standard operating procedure to ensure that all staff are able to consistently apply that logic. HCIC created secure email groups to facilitate fast electronic transfer of records from providers and significantly increased the number of EMR logins that HCIC staff have in provider systems to allow for easy remote retrieval of records. HCIC also implemented a shared data base to streamline and track records retrieval and enable task sharing with a larger group to eliminate rework and to increase

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<p>coordination among staff.</p> <p>Another way that HCIC utilizes health information technologies was noted as an emerging best practice in the EQR annual report last year. HCIC implemented the quality gap alert in CareRadius® in March 2017, with the objective to better close care gaps during point-of-service calls, thereby reducing number of calls to the member and streamlining this process. HCIC trained member service representatives and EPSDT teams on the care-gap alert, these staff members are now able to educate members regarding their gaps in care and assist members in scheduling PCP appointments as needed.</p>
<p>HSAG Recommendation: Share data.</p>
<p>HCIC has multiple ways of sharing data with providers, including provider portals where providers upload information to HCIC for review, monitoring, or performance.</p> <p>HCIC maintains active communication with the provider network on a number of issues. The most prominent of these with the greatest focus at this time is the exchange of data related to closing gaps in care as they relate to performance measures. HCIC has implemented provider scorecards related to a number of measures and delivers these scorecards to providers as they become available.</p> <p>The PIC team utilizes data received from HCIC’s data vendor to focus direct outreach to members. Gap reports are updated frequently, and new gaps reports are sent to providers as appointments are made to close gaps in care.</p>
<p>HSAG Recommendation: Facilitate coordinated care.</p>
<p>HCIC has multiple care management programs that consist of teams of clinicians that complete outreach to the teams serving a number of populations and subpopulations.</p> <p>HCIC’s care management program promotes and supports “seamless” care coordination across the entire delivery system so that members experience healthcare and their membership with HCIC as a single system treating the whole person. Data and support services are shared with providers in order to eliminate blind spots and gaps in medically necessary care. Opportunities for members to engage in their healthcare and improve outcomes and satisfaction are encouraged through HCIC’s use of condition-specific education, social media, the member portal, telehealth, and mobile applications.</p> <p>Care managers can assist in coordinating care with and between PCPs, emergency services, hospitals, and specialty providers to ensure that each part of a potentially complicated health system is understood by the member. Care managers complete care plans so that each patient’s team can see the whole picture and coordinate care within the team.</p> <p>One of the ways that HCIC facilitates coordinated care was mentioned as a best practice in the EQR annual report last year. HCIC’s medical management unit implemented two transition of care program innovations identified as best practices as they provide “high touch” to inpatient members. Objectives with this “high touch” programming include readmission reduction, improvement of customer experience, provision of seamless care transitions, and reduction of medical costs. Care management and assistance are provided to members via more frequent, direct contacts from HCIC management staff.</p>

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Performance Measures
<p>HSAG Recommendation for GMH/SA (not specific to MMIC): For CYE 2016, both <i>Follow-Up After Hospitalization for Mental Illness</i> measure rates were close to the MPS. 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.</p>
<p>The MMIC 7-day internal R12 rate at 10.71 percent and 30-day internal R12 rate at 16.67 percent are well below the 7-day and 30-day MPS, but exceed the first quarter rates, demonstrating improved performance. Therefore, the goal is considered partially met. The rates also exceeded the CYE 2017 internal rates for 7- and 30-day follow-up. Based on the demonstrated improvement in the outcomes, MMIC will continue the current interventions; however, MMIC will transition the reporting process for the GMH/SU members from the current process of using an internally developed report, to using data and reports from Inovalon, MMIC’s contracted National Committee for Quality Assurance (NCQA) certified Healthcare Effectiveness Data and Information Set (HEDIS®)¹⁻⁸ software vendor. As of December 2018, the CMDP GMH/SU population has already been added to the software; rates better reflect the services being received and far exceed the rates being reported using the internal reports.</p>
<p>Performance Measures—SMI (not specific to MMIC) The RBHA integrated SMI aggregate exhibited low performance related to screenings for women, with the rates for <i>Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening in Women—Total</i> falling below the MPS by 14.5, 41.5, and 8.1 percentage points, respectively. With all three rates falling below the MPS, efforts should be focused on increasing compliance with recommended screenings for women.</p>
<p><u><i>Breast Cancer Screening:</i></u> The MMIC internal fiscal year-to-date (FYTD) rate of 53.59 percent and R12 rate of 52.99 percent both exceed the MPS for this measure and exceed the first quarter rate, therefore; the goal is considered met. Both rates also exceed the CYE 2017 internal rate. MMIC mailed birthday reminder notices to those members who needed screenings. The QM outreach team continued calls to those members noncompliant for this measure. MMIC assisted members who were reached and agreed to make their appointments using a three-way call with their physician, and included transportation arrangements when needed. PCP gaps in care were sent electronically through the provider portal to those providers with members who needed mammograms.</p>
<p><u><i>Cervical Cancer Screening:</i></u> The MMIC internal FYTD rate of 53.72 percent and R12 rate of 53.01 percent are both below the MPS but exceeded the first quarter rate, demonstrating an improvement in outcomes; therefore, the goal is considered partially met. Both rates exceed the CYE 2017 internal rate. MMIC mailed members reminder notices using maternity packets and monthly birthday reminders.</p>

¹⁻⁸ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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<p>SMI and PCP gaps in care were sent electronically through the provider portal to providers with members identified as needing cervical cancer screenings. QM continued facilitation of technical assistance with SMI clinics on this measure. Additionally, MMIC has selected cervical cancer screening as the MMIC self-selected PIP topic for this population.</p> <p><u><i>Chlamydia Screening in Women—Total:</i></u></p> <p>The MMIC internal FYTD rate of 57.19 percent and R12 rate of 51.90 percent both fall below the MPS for this measure, but the FYTD rate exceeds the CYE 2017 internal rate for this measure. The FYTD rate, which is considered the year-end rate, also exceeds the first quarter rate demonstrating improved outcomes for this performance measure; therefore, the goal is considered partially met.</p> <p>MMIC mailed members reminder notices for this measure using maternity packets and monthly birthday reminders. PCP gaps in care were sent electronically through the provider portal to those providers with members who have not yet completed screenings.</p>
CAHPS
<p>HSAG Recommendations: Perform root cause analyses; conduct frequent assessments of targeted interventions; use health information technology; share data; and facilitate coordinated care.</p>
<p>MMIC submitted a corrective action plan to AHCCCS, and final approval was provided in April 2018.</p> <p>MMIC Quality Management (QM) met with Adult System Of Care (ASOC), Care Management, Customer Service, and Individual & Family Affairs areas to review the results of the CAHPS survey and developed plans on how to improve the baseline survey results. The MMIC QM Committee will continue to evaluate access to care and HEDIS metrics and interventions. The committee will make recommendations for new strategies as needed.</p> <p>To improve the rating of health plan and all health care measures, MMIC presented the following improvement plan:</p> <ul style="list-style-type: none"> • All SMI clinics will submit a monthly deliverable reflecting peer involvement and family participation in the development of the member’s individual service plan (ISP). MMIC regularly hosts and facilitates monthly community meetings regarding SMI services, including the “Welcome to Mercy” orientation. The focus is on engaging, educating, and providing to members and their families new to the behavioral health system information about system navigation, service array, and introducing new members to their direct care clinic team. This new community engagement opportunity provides education and information to new members receiving SMI services and introduces members and their families/families of choice to the Office of Individual and Family Affairs (OIFA) as well as the community and clinical provider network. • MMIC will develop a survey tool to compile member and family feedback that is received at monthly community engagements. Results will be compiled and reviewed internally through the existing monthly “Voice of the Community” meetings run by MMIC (OIFA) with recommendations brought forward to the MMIC Executive Leadership. A standing agenda item for survey results, reviewing implementation, progress, and barriers to this

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plan will be added to the Member Advisory Council meetings held monthly at the SMI clinics. Member survey results and advisory council feedback and recommendations will be staffed through the MMIC Member Advocacy Committee.

- QM has begun partnering Children’s System of Care (SOC) to increase utilization of EPSDT well-visits among 18-year-olds who have recently transitioned to the SMI system. MMIC will give the children’s behavioral health professional an updated transition plan which includes scheduling an EPSDT well-visit soon after the member turns 18 years old. QM has created slides and will begin a train-the-trainer process with the SOC staff to ensure that they are familiar with EPSDT requirements.

To improve *Rating of Personal Doctor*, MMIC presented the following improvement plan:

- The system is struggling to locate psychiatrists. Many clinics are using locum tenens and there is not consistency from one appointment to the next. MMIC will discuss the goal of developing internal plans around using locum tenens, utilizing clinical teams and /or a locum tenen policy.
- MMIC will require all SMI clinics to submit individual training plans that provide a comprehensive outline of the training program for new and ongoing employees, including training requirements for behavioral health medical professionals (BHMPs)/prescribers. At a minimum, all newly hired BHMPs/prescribers will be required to complete the Mercy Maricopa Integrated Care System Overview (1 hour online course) and Cultural Competency 101: Embracing Diversity (4.5 hour live class). All other BHMPs/prescribers will be required to complete an annual, approved refresher training relating to cultural competency.

To improve *Rating of Specialist Seen Most Often*, MMIC presented the following improvement plan:

- All SMI clinics will submit a monthly deliverable reflecting peer involvement and family participation in the development of the member’s ISP.
- MMIC hosts regular, monthly community engagement opportunities for members and their families/families of choice regarding SMI services, focusing on existing members and members new to the behavioral health system. The focus includes system navigation as well as education and sharing information and resources on the services available to members and their loved ones. The newest community engagement, the “welcome orientation,” is focused on new members and their families.
- OIFA chairs the monthly Member Advocacy Council (MAC) which is comprised of peers, family members, adoptive and kinship and youth. The primary focus of MAC is to ensure that the integrated health system is person- and family-centric, accessible, and recovery-oriented. The Council meets monthly and carries out ad-hoc projects to include but not limited to enhancements to the annual Member Satisfaction Survey.
- MMIC implemented a pilot program for SMI, Title 19 (T19) members diagnosed with diabetes who live in a limited supermarket access that links them with a peer community-health worker to improve member engagement with health care providers and improve health literacy.
- MMIC is piloting a new health information management tool, Care Unify, in certain

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provider practices to help with patient management.

- MMIC is using Admit–Discharge–Transition (ADT) Alerts in Care Unify to allow providers to coordinate care in a more real-time manner.

To improve *Getting Needed Care* and *Getting Care Quickly*, MMIC presented the following improvement plan:

- QM analyzed outcomes of EPSDT well visits scheduled by the QM outreach call team. These appointments are made during three-way calls with the members and provider; the member is offered a gift card for completing the visit, transportation is arranged during the call, and a reminder call is placed prior to the appointment. Despite use of these evidenced-based practices, the MMIC average no-show rate is 60 percent. Of members completing scheduled visits, MMIC noted that 15 percent did not meet CMS 416 requirements for inclusion in the EPSDT participation rate because providers used “sick visit” billing codes instead of the CMS 416 required codes for EPSDT well-visits. Findings of the no-show analysis and billing codes used indicate a need to refocus efforts on provider outreach. As a result, QM continues to work with SMI clinics, assertive community treatment (ACT) teams, and PCPs to ensure that all understand the billing requirements, the need to follow up with members to reschedule missed visits, and the need to proactively outreach to members who need visits.
- MMIC implemented a pilot program for SMI, Title 19 (T19) members diagnosed with diabetes who live in a limited supermarket access that links them with a peer community-health worker to improve member engagement with health care providers and improve health literacy.
- MMIC is piloting a new health information management tool, Care Unify, in certain provider practices to help with patient management.
- MMIC is using Admit–Discharge –Transition (ADT) Alerts in Care Unify to allow providers to coordinate care in a more real-time manner.

To improve *How Well Doctors Communicate*, MMIC presented the following improvement plan:

- MMIC care management staff members provide information about chronic conditions such as diabetes and chronic obstructive pulmonary disease by distributing flyers to members who have been identified in the clinics.
- MMIC staff train community-based care managers in the SMI clinics and integrated health home providers at least once per quarter to educate and improve staff knowledge about a chronic health or behavioral health condition, or social determinants of health.
- MMIC will require all SMI clinics to submit individual training plans that provide a comprehensive outline of the training program for new and ongoing employees, including training requirements for behavioral health medical professionals (BHMPs/prescribers). At a minimum, all newly hired BHMPs/prescribers will be required to complete the Mercy Maricopa Integrated Care System Overview (1 hour online course) and Cultural Competency 101: Embracing Diversity (4.5 hour live class). All other BHMPs/prescribers will be required to complete an annual, approved refresher training relating to cultural competency.

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- MMIC implemented a pilot program for SMI, Title 19 (T19) members diagnosed with diabetes who live in a limited supermarket access that links them with a peer-community-health worker to improve member engagement with healthcare providers and improve health literacy.

To improve *Customer Service*, MMIC presented the following improvement plan:

- Customer Service provides a two-week training program that includes Medicaid and RBHA trainings. MMIC includes Mental Health First Aide training with new hire training. In addition, MMIC trains staff about “soft skills” and safe talk. National Association for Mental illness presented to all customer service staff. MMIC management staff facilitate program-specific training. MMIC has hired a dedicated trainer to focus on new hire training, coaching, and development of new hires.
- Scorecards for all customer service representatives (CSRs) are used for monthly coaching, mid- and year-end performance evaluations, and as a tool to determine quarterly bonus qualification.
- Quality assurance analysts and supervisors perform call audits and provide feedback to the CSRs. Live monitoring is also conducted with immediate feedback to the CSR. Quality scores are a performance metric on monthly scorecards
- MMIC provides staff coaching by supervisors and quality assurance to improve scores.

To improve *Coordination of Care*, MMIC presented the following improvement plan:

- MMIC care management staff shares emergency department, PCP, and risk stratification scores with clinical leadership at SMI clinics monthly.
- MMIC care management staff provides information for chronic conditions such as diabetes and chronic obstructive pulmonary disease by distributing flyers to members who have been identified in the clinics.

2. Introduction to the Annual Technical Report

Description of EQR Activities

Mandatory Activities

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

- Validate Contractor PIPs—validation performed by AHCCCS.
- Validate Contractor performance measures—validation performed by AHCCCS.
- Summary and findings of Contractor’s performance in complying with the AHCCCS’ contract requirements and the federal Medicaid managed care regulations—review performed by AHCCCS.

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

For contracts starting on or after July 1, 2018, and no later than one year from the issuance of the revised EQR protocol, according to requirements set forth in 42 CFR §438.68, CMS will require validation of MCO, PIHP, and PAHP network adequacy as applicable. For the purposes of this report, network validation is not applicable.

Optional Activities

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

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

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

assess the effectiveness of its current strategic goals and related strategies and to provide a roadmap for potential changes and new goals and strategies.

Quality, Access, and Timeliness

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

- **Quality**, as it pertains to external quality review, means the degree to which an MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement.²⁻¹
- **Access**, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network Adequacy Standards) and §438.206 (Availability of Services). Under §438.206, availability of services means that each state must ensure that all services covered under the state’s plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that the MCO, PIHP, and PAHP provider networks for services covered in the contract meet the standards developed by the State in accordance with the network adequacy standards (§438.68). Any state that contracts with an MCO, PIHP, or PAHP to deliver Medicaid services is required by §438.68 to develop and enforce network adequacy standards.²⁻²
- **Timeliness**. Federal managed care regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services. HSAG extends the definition of “timeliness” to include other federal managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing expedited member grievances and appeals and providing timely follow-up care. In addition, NCQA defines “timeliness” relative to utilization decisions as follows: “The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”²⁻³ It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.

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

²⁻² Ibid.

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

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

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

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

AHCCCS Medicaid Managed Care Program History

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

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

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

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

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

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

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

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

Most recently, as part of Governor Ducey's administrative simplification initiative, behavioral health services were integrated at AHCCCS, eliminating the Arizona Division of Behavioral Health Services (DBHS) that historically provided behavioral health services through a contract with AHCCCS and subcontracts with the RBHAs. AHCCCS has stated that this merger was a positive step toward increasing integration in the healthcare system and has already resulted in beneficial outcomes and forward-thinking policy decisions which factor in care for both the mental and physical health of individuals.

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

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

AHCCCS Waiver Amendment Requests and Legislative Updates

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

AHCCCS Works Waiver Amendment

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

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

Prior Quarter Coverage Waiver Amendment

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

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

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

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

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

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

The SFY 2018–2019 budget package included the following:

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

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

Enacted legislation requires the following new reports:

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

Enacted legislation established the Diabetes Action Plan Team within ADHS.

AHCCCS' Strategic Plan

AHCCCS' Strategic Plan for State Fiscal Years 2018–2023 presents the strategy and direction for AHCCCS, including new programs, initiatives, and past accomplishments. The strategic plan identifies AHCCCS' mission, vision, and the agency's core values:³⁻¹

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

The strategic plan offers four overarching goals:

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

- Increase use of alternative payment models and AHCCCS fee schedule differentiation for all lines of business.

³⁻¹ AHCCCS Strategic Plan State Fiscal Years 2018-2023 Available at:
https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_18-23.pdf. Accessed on: February 14, 2019.

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

2. Pursue continuous quality improvement.

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

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

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

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

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

Key Accomplishments for AHCCCS

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

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

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

AHCCCS Quality Strategy

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

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs as well as examples of evidence-based clinical practice guidelines required by the State.
- The State's goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of each population that the State serves.
- A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP; the performance improvement projects to be implemented, including any interventions that the State proposes to improve access, quality, or timeliness of care.
- Arrangements for annual, external independent reviews of the quality outcome and timeliness of and access to, the covered services.
- A description of the State's transition of care policy.
- The State's plan to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status, to the extent practicable.
- Appropriate use of intermediate sanctions for MCOs.
- A description of how the State will assess the performance and quality outcomes achieved by each primary care case management (PCCM) entity.
- The mechanisms implemented by the State to comply with requirements relating to the identification of persons who need long-term services and supports or persons with special healthcare needs.
- Information relating to non-duplication of EQR activities.
- The State's definition of "significant change" related to instances in which significant changes are made to the quality strategy or occur in the State Medicaid program.

AHCCCS has had a formal quality assessment and performance improvement (QAPI) plan in place since 1994 and AHCCCS' Quality Strategy was first established in 2003. Since that time, AHCCCS has revised the Quality Strategy to reflect AHCCCS' innovative approaches to member care and continuous quality improvement efforts. The AHCCCS quality strategy was set for revision in CYE 2017. However, due to the introduction of proposed changes to the managed care regulations, AHCCCS elected to delay this revision until final publication was posted by CMS. AHCCCS has established an internal workgroup to head the expansive revisions that incorporate AHCCCS goals and initiatives, Contractor oversight, and the new requirements found within the managed care regulations. The revised Quality

Strategy draft was completed, submitted to CMS for review and approval, and posted to the AHCCCS website on July 1, 2018.

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

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

4. Quality Initiatives

AHCCCS continued to demonstrate innovative and collaborative approaches to managing costs while improving quality of systems, care, and services. The draft July 1, 2018, Quality Strategy, Assessment and Performance Improvement Report (Quality Strategy); the 2018–2023 strategic plan, and the quarterly quality assurance/monitoring activity reports provided compelling evidence of AHCCCS’ vision and leadership in identifying and proactively pursuing opportunities to improve access to, and the quality and timeliness of, care and services, as well as improve member health outcomes.

Quality Initiative Selection and Initiation

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

In selecting and initiating new quality improvement initiatives, AHCCCS:

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

Systemwide Quality Initiatives/Collaboratives

Administrative Simplification and the Integrated Model

The Division of Behavioral Health Services (DBHS), as part of the Arizona Department of Health Services (ADHS) transitioned, along with the programs it manages, to AHCCCS, effective July 1, 2016.

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

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

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

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

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

AHCCCS Complete Care (ACC)

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

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

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

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

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

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

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

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

AHCCCS CARE: Choice, Accountability, Responsibility, Engagement

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

- Health Savings Account: Adults over 100 percent of the federal poverty level (FPL) are required to pay a monthly premium of 2 percent of household income or \$25, whichever is lesser.
- Giving Citizens Tools to Manage Their Own Health: Member premium contributions go into their AHCCCS CARE accounts, which work like flexible health savings accounts. These funds can be withdrawn by members and used for non-covered services, including dental, vision, chiropractic care, recognized weight loss programs, nutrition counseling, gym membership, and sunscreen.
- Enforcing Member Contribution Requirements: Members will be disenrolled for failure to pay their monthly premium requirements.
- Engaging the Business and Philanthropic Community: Employers and charitable organizations may contribute funds into the AHCCCS CARE account to support a healthy workforce and to support members achieving health goals.
- Promoting Healthy Behaviors: The AHCCCS CARE program includes incentives to promote healthy behaviors. Members may defer their premium payments for six months if they meet healthy targets that include: meeting preventative health targets like getting a wellness exam, flu shot, mammogram, or cholesterol screening; or managing chronic illnesses like diabetes, asthma, or tobacco cessation. Meeting these healthy targets allows members to roll unused funds over into the next year and unlock funds available in the AHCCCS CARE account to be used for non-covered services.
- Supporting the Medical Home Through Strategic Coinsurance: The AHCCCS CARE program uses a strategic coinsurance strategy that only assesses payment requirements retrospectively so that members are not denied services and providers are not burdened with uncompensated care and administrative hassle. Strategic coinsurance only applies to: opioid use, use of brand name drugs when a generic is available, non-emergency use of the emergency department (ED), and seeing a specialist without a primary care provider's referral.
- Connecting to Employment Opportunities: Through an innovative partnership with the Arizona Department of Economic Security, all AHCCCS CARE members will be automatically enrolled in job-seeking programs.

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

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

Executive Order 2016-06—Prescription of Opioids

On October 24, 2016, the Governor of Arizona, Douglas Ducey, signed Executive Order 2016-06 to address the opioid crisis affecting the nation and, in particular, the state of Arizona. In this order, the Governor indicated that Arizona has the ninth highest rate of opioid deaths in the nation, and that approximately 404 people in the state died of prescribed opioid overdoses in 2015. The State presented alarming statistics showing that during 2013 enough prescription pain medications were dispensed to medicate every adult in Arizona around the clock for two weeks.

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

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

The overarching goal of this initiative is to reduce the prevalence of opioid use disorders and opioid-related overdose deaths. The initiative approach includes developing and supporting state, regional, and local-level collaborations and service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse, and dependency. Strategies include:

- Increasing access to naloxone through community-based education and distribution as well as a co-prescribing campaign for individuals receiving opioid prescriptions exceeding morphine-equivalent daily doses and receiving combinations of opioids and benzodiazepines.
- Increasing access to and participation and retention in medication-assisted treatment (MAT).
- Reducing the number of opioid-naïve members unnecessarily started on opioid treatment.
- Promoting best practices and improving care process models for chronic pain and high-risk members.

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

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

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

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

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

During 2018, the following efforts supporting this initiative were made:

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

Targeted Investments Program

On January 18, 2017, CMS approved Arizona's request to implement the Targeted Investments (TI) Program to support the State's ongoing efforts to integrate the healthcare delivery system for AHCCCS members. The TI Program is AHCCCS' strategy to provide financial incentives to participating AHCCCS providers to develop systems for integrated care. The TI Program will make almost \$300 million available over five years to Arizona providers who assist AHCCCS in promoting the integration of physical and behavioral healthcare, increasing efficiencies in care delivery and improving health outcomes.

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

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

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

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

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

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

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

American Indian Health Plan Integration

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

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

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

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

Quality Strategy

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

Arizona Management System (AMS)

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

Suicide Prevention Plan

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

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

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

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

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

Learning Collaborative

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

System Improvements

AHCCCS hosts various meetings to continue to direct system improvements:

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

Through these meetings, various system improvements have been identified:

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

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

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

Long-Acting Reversible Contraceptives (LARCs)

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

Summary of Activities Designed to Enhance the Medical Record Review Process

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

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

Other Systemwide Quality Initiatives/Collaboratives

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

- *Behavioral Health Needs of Children Involved with the Department of Child Safety: Psychotropic Prescribing Update:* AHCCCS is revising the Psychiatric and Psychotherapeutic Best Practices for Children Birth Through Five Years of Age guidance document to ensure that the most recent research on appropriate prescribing is provided to providers, children, and families. AHCCCS is also updating tools that provide best practice strategies related to infants and toddlers—including psychotropic prescribing, early childhood mental health intervention, and trauma-informed care. The document content focuses on the most current prescribing practices and psychotherapeutic approaches for use during early childhood, with the recommendation that psychotherapeutic approaches be the preferred method of treatment prior to implementation of psychopharmacologic intervention. To further ensure realization of the treatment recommendations within these tools, AHCCCS has begun a statewide Birth to Five initiative to address the unique needs of infants and toddlers. Additionally, AHCCCS is collaborating with CMDP for their Birth to Five learning collaborative.
- *Recommendations to Office of the Arizona Governor Policy Advisor for Health and Human Services on Autism Spectrum Disorder (ASD):* In February 2016, the ASD Advisory Committee (appointed by the Office of the Arizona Governor in spring 2015) publicized a report of recommendations to strengthen the healthcare system's ability to respond to the needs of AHCCCS members with or at-risk for ASD, including those with co-morbid diagnoses. During 2017, two centers of excellence opened in Maricopa County. AHCCCS Complete Care, the new contract for AHCCCS and the Contractors, is addressing the recommendation to integrate care for acute members. In addition, AHCCCS is developing a behavioral intervention policy that addresses this issue.
- *Summary of Activities Designed to Enhance the Monitoring of Physical Health Providers: Arizona Association of Health Plans (AzAHP),* comprised of all AHCCCS Contractors for Medicaid business except CMDP and the Arizona Department of Economic Security(DES)/Division of Developmental

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

- AHCCCS Quarterly Contractors' Quality Management/Maternal and Child Health Meeting: To further promote the integration of medical and behavioral health services, targeted education is included within the AHCCCS Quarterly Contractor's Quality Management/Maternal and Child Health (MCH) Meeting.
- Clinical Integration: The Medical Management (MM) unit, which regularly partners with the Quality Management (QM) and MCH/EPSTD units, added a second behavioral health coordinator to support efforts for the entire clinical team. The addition of a behavioral health coordinator enhances the ability for clinical considerations, service delivery, and program and contract development—to encompass a holistic approach in all aspects of care. AHCCCS continues to hire additional staff with behavioral health expertise from within its workforce.

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

- Required tracking of performance on the frequency of diabetic screening for individuals with schizophrenia or bipolar disorder.
- Tracking performance on prenatal and postpartum timeliness of care, with supplemental training provided to contracted health plan staff relative to physical and behavioral health aspects of perinatal mood disorders.
- Implementation of regular community-based meetings open to AHCCCS membership—with focus on enhancing member and stakeholder involvement and investment in performance as well as on enhancing quality improvement activities for physical and behavioral healthcare.
- Involvement of Stakeholders and Community Subject Matter Experts: Throughout 2017, AHCCCS continually involved stakeholders and community subject matter experts as members of AHCCCS committees, quality meetings, policy workgroups, and advisory councils. Subject matter experts provided technical assistance, guidance, and advisement related to various areas and issues (e.g., special needs populations, consumer advocacy, ASD, early intervention, trauma-informed care, behavioral health system best practices, integrated care).
- Medical Director Meetings: AHCCCS involves medical directors from Contractors in quarterly meetings. These meetings are designed to inform medical directors of changes in policy, regulation,

billing practices, and current or future system updates. Additionally, these quarterly medical director meetings are designed to provide information on best practices in medical, behavioral care, and/or prescribing practices.

- ADHS Bureau of the United States Department of Agriculture (USDA) Nutrition Programs: AHCCCS works with ADHS Bureau of USDA Nutrition Programs on many initiatives ranging from Contractor education to Women, Infants, and Children promotion and obesity issues. The nutrition coordinators present the most up-to-date information at the AHCCCS Contractor quarterly meetings.
- Arizona Early Intervention Program: The Arizona Early Intervention Program (AzeIP), Arizona's IDEA Part C program, is administered by the Division of Developmental Disabilities. Maternal and child health (MCH) staff in the Clinical Quality Management unit at AHCCCS work with AzeIP to facilitate early intervention services for children younger than 3 years of age who are enrolled with AHCCCS Contractors. These services are closely monitored to ensure timely access and availability of services to members. AHCCCS and AzeIP continue to collaborate and meet regularly to ensure that members receive care in a timely manner. As an ongoing effort to promote care coordination and system clarification the MCH/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 on-going TAPI Steering Committee meetings and subcommittee meetings concerning community awareness, provider issues, and adult immunizations. TAPI regularly communicates immunization trends and best practices with AHCCCS and its Contractors. TAPI's Provider Awareness and Adult and Community Awareness committees continue to focus on long-term projects such as updating the TAPI website with the most current information for providers, parents, and the community at large. In addition to the website, TAPI provides vaccination handouts. TAPI has a teen vaccination campaign (Tdap, meningococcal and human papillomavirus [HPV] vaccines) that involves provider education as well as parent and teen outreach. Protect Me with 3, a parent-focused campaign, reminds parents that their children still need them to protect them and to help with healthy decisions. Take Control, a teen campaign, addresses teen vaccinations required to maintain health as teens begin to take control of their lives in the realms of college, driving, and even health decisions.
- Health Current: Formerly Arizona Health-e Connection, this non-profit organization is a health information exchange organization (HIO) and is the single statewide Health Information Exchange (HIE). Health Current currently has 500 unique participants, which include hospitals, accountable care organizations, health plans, behavioral health providers, laboratories, ambulatory practices, long-term care providers, and more. (For a complete list of participants, Health Current maintains a count on their website: <https://healthcurrent.org/hie/the-network-participants/>). To improve care coordination, AHCCCS requires all managed care contractors to join the HIE. Health Current electronically shares hospital data with several other out-of-state HIEs through a project called the Patient-Centered Data Home (PCDH). The PCDH project provides the technical and legal agreements to support cross-state data sharing for care coordination. Launched in early 2017, Southern Colorado, Arizona, Utah, and now Santa Cruz and San Diego HIEs are capable of sharing

hospital admission, discharge, or transfer information with a Medicaid member's home HIE if that member seeks care outside his or her Arizona or "home" HIE.

- **ADHS Bureau of Tobacco and Chronic Disease:** In collaboration with ADHS, AHCCCS monitors the utilization of and access to smoking cessation drugs and nicotine replacement therapy program. AHCCCS members are encouraged to participate in ADHS' Tobacco Education and Prevention Partnership (TEPP) smoking cessation support programs such as "ASHLine" and/or counseling in addition to seeking assistance from their PCPs. Additional efforts have been focused on the integrated SMI population in connecting members to smoking cessation and nicotine replacement programs.
- **Medicare and Medicaid Alignment for Duals:** Arizona leads the nation with the highest percentage of dual-eligible members aligned in the same plan for Medicaid and Medicare outside the demonstration authority. Arizona has over 64,000 members enrolled in the same plan for Medicare and Medicaid. AHCCCS conducted a study to determine the impact on plan alignment related to dual-eligible members. The study compared national data for dual-eligible members enrolled in traditional Medicare fee-for-service to data for aligned dual-eligible members served by one of the AHCCCS health plans. The study found that the aligned AHCCCS dual-eligible members exhibited a 31 percent lower rate of hospitalization, a 43 percent lower rate of days spent in a hospital, a 9 percent lower rate of ED use, and a 21 percent lower readmissions rate.
- **Early Reach-In:** Contractors are required to participate in criminal justice system "reach-in" care coordination efforts through collaboration with criminal justice partners (e.g., jails; sheriff's office; Correctional Health Services; and Arizona Department of Corrections, including community supervision and probation courts). AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend member eligibility upon incarceration rather than terminating coverage. Upon the member's release, the member's suspension of AHCCCS eligibility is lifted, allowing for immediate care coordination activities. Using the 834 data file to identify incarcerated members who have been incarcerated for 30 days or longer and who have anticipated release dates, the Contractor conducts reach-in care coordination for members with chronic and/or complex care needs, including assessment and identification of MAT-eligible members. The Contractors, with the criminal justice partners, facilitate the transition of members out of jails and prisons and into communities. Members are provided with education regarding care, services, resources, appointments, and health plan case management contact information. Post-release initial physical and behavioral health appointments are scheduled within seven days of member release. Ongoing follow-up occurs with the member to assist with accessing and scheduling necessary services as identified in the member's care plan, including access to all three U.S. Food and Drug Administration (FDA)-approved MAT options covered under the AHCCCS Behavioral Health Drug List and assignment to peer support services to help navigate and retain the member in MAT when appropriate.
- **Foster Care Initiative:** AHCCCS is committed to providing comprehensive, quality healthcare for children in foster, kinship, or adoptive care. Foster children are eligible for medical and dental care, inpatient, outpatient, behavioral health, and other services through CMDP, RBHAs, or CRS. Adoptive children are typically AHCCCS eligible and enroll in a health plan/RBHA or CRS like any Medicaid-eligible child. AHCCCS holds a variety of meetings related to improving service delivery for children in foster care.

- **Behavioral Health Learning Opportunities:** With the advent of administrative simplification, AHCCCS recognized the need to provide learning opportunities for staff lacking behavioral healthcare experience and expertise due to previous historical hiring requirements for medically trained personnel. AHCCCS offers formal meetings as well as informal workshops, and lunch-hour trainings to ensure that staff had ample opportunities to increase behavioral health system knowledge. Internal behavioral health subject matter experts, licensed behavioral health practitioners, and community professionals have been procured to offer training on topics such as infant/toddler mental health, trauma-informed care, perinatal mood disorders, and adult system-of-care processes for individuals with general mental health needs and SMI.
Quality Management (QM) is providing additional behavioral health “Lunch and Learn” trainings for QM and quality of care (QOC) staff especially, with attendance open to other departments based on department need. Topics include the following:
 - Regulatory requirements for individuals designated as having an SMI versus having general mental health and/or substance abuse needs (GMH/SA)
 - Grant-based housing for individuals with SMI
 - Short-term behavioral health residential services
 - Crisis process and requirements
 - Diagnostic categories and symptoms
 - Best-practice and evidence-based clinical approaches for adults and children
 - Mental health awareness
 - AHCCCS Waiver process
 - Meeting the needs of members with developmental disabilities and behavioral health challenges
 - Coordination of benefits (e.g., AHCCCS, Medicare, commercial coverage)

Regional Behavioral Health Authority (RBHA) Quality Initiatives/Collaboratives

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

- **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.

5. Contractor Best and Emerging Practices

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

Cenpatico Integrated Care (CIC)

- **Improved Member Outreach:** CIC implemented a program to more effectively increase outreach to members using the interactive voice recording (IVR) vendor, Eliza. Eliza provided nationwide data, indicating that this method of outreach has a higher impact on more members related to receiving preventative care, acquiring accurate updates on preferred PCPs, and engaging members in care. The IVR contains options that include warm transferring the member to customer service or a follow-up call or referral to care management. Eliza was implemented in stages, beginning in April 2018, and completed in July 2018. Programs will run for a full year prior to completing an evaluation.
- **Improved Provider Education:** CIC provided consistent provider education throughout 2016 and 2017; however, providers continued to have many of the same questions specific to performance measures and preventative care. CIC wanted a method to provide information in a more effective and concise manner, so CIC developed the Health Spark reference guide which included easy to understand measure summaries, tips on improving the measures at the provider level, and information on Contractor interventions. Health Spark is intended to be a living document, incorporating best practices and effective interventions. CIC distributed Health Spark at targeted technical assistance sessions and provider forums and posted the document on the website. Providers changed the types of questions they were asking from “how is a measure calculated,” to “how to execute effective interventions.” This is CIC’s intended outcome of the document and distribution method, anticipating that effective education will lead to action and an improvement in the health of members.
- **Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Follow-Up:** CIC’s goal for the EPSDT follow-up was to improve the comprehensiveness of well visits and completion of all screenings on the EPSDT form through follow-up and education with physicians. CIC’s EPSDT team reviews each AHCCCS EPSDT form received from a physician. If all screenings were not completed, CIC generates a letter educating the physician on the need to complete all necessary screenings. If a developmental screening is indicated as completed, the EPSDT team confirms that a claim was received and billed to meet the screening measure. If this is not the case, the team generates a letter to educate the physician on the measure. When a trend is found with a physician or group, contact is made by phone or on-site visit to discuss EPSDT, physician practices, and improvement processes. In addition, claims for EPSDT visits for which an AHCCCS EPSDT form was not submitted receive follow-up by phone or an on-site visit from the EPSDT team to educate physicians on the forms. In addition, the EPSDT team sends providers a list quarterly of assigned members in need of immunizations and well visits.

Health Choice Integrated Care (HCIC)

- Disease Management Program Focused on Member Self-Management: During contract year 2017, the Disease Management program (implemented by Steward Health Choice Arizona in October 2015) was expanded to include asthma, coronary artery disease, diabetes (including non-insulin dependent diabetes), high cholesterol, and hypertension, in addition to the diagnoses previously managed (congestive heart failure, chronic obstructive pulmonary disease, insulin-dependent diabetes, human immunodeficiency virus (HIV), hepatitis C while receiving antiviral therapy, and high-risk obstetrics (OB) members). New Disease Management programs focusing on healthy weight and Morphine Equivalent Daily Dosing (MEDD) and Diazepam Equivalent Daily Dosing (DEDD) utilization were added in contract year 2018. The Disease Management program focuses on promotion of self-management and includes health promotion care plan letters mailed to members with relevant diagnoses, with copies sent to their assigned PCPs and behavioral health homes, and which provide information about the diagnosis, strategies for wellness, preventative care recommendations, and local resources.

In 2018, the Disease Management program for SMI and Title 19 members included various interventions and educational resources such as the following: the “Chronic Disease Integration in Behavioral Healthcare” training series (geared toward behavioral health staff); a flu shot promotion flyer mailed to all active members in the Disease Management and Integrated Care Management programs as part of a systemwide effort to increase flu shot rates; provider toolkits sent to behavioral health homes for each disease management condition (with a focus on colorectal screening, cervical cancer screening, chlamydia screening, prevention, and immunizations).

Program outcomes were evaluated for the Asthma Disease Management Program as sufficient time had elapsed since the interventions to evaluate changes in claims for related services. HCIC compared claims data for the six-month period prior to the intervention implementation date to the six-month period after the intervention implementation date. The following measures were evaluated:

- Emergency department visits for diagnosis codes related to asthma
- Inpatient admissions for diagnosis codes related to asthma
- Ambulatory and preventative care visits
- Self-Management Programs for Improving Whole Health: HCIC has continued the Stanford University Patient Education Self-Management programs implemented by Northern Arizona RBHA. The goals of the initiative and related interventions occurring during the most recent contract year are to:
 - Develop additional capacity to offer Stanford Chronic Disease Self-Management programs.
 - Continue to hold self-management workshops related to chronic pain.
 - Ensure that at least 50 percent of trained leaders in self-management programs are employed as peer, recovery, and family support specialists.

- Quality Management Performance Improvement Coordinator Program (PIC): The HCIC system of care has been utilizing the PIC program to work alongside providers to improve quality outcomes. The program promotes partnerships by acting as liaison to the plan, the member, and the provider. The goals of the program are to:
 - Support HCIC’s practices in addressing quality gaps in care by promoting continuity and coordination of care. PICs collaborate with practice staff using various tactics to promote delivery of high quality care, including on-site pre-visit and post-visit planning, measures training, and documentation guidelines. PICs ensure that providers receive member-level gaps in care rosters either by in-person delivery, email, or via self-directed pulls from the provider portal.
 - Monitor and report in real time gaps in member care and coordination of visits. The PIC program eliminates barriers to accessing care or keeping appointments and works to ultimately benefit the member and practitioner.
 - Perform direct member outreach to inform members of the recommended preventative screenings due, and offer to connect the member to his or her primary care provider to schedule an appointment.
 - Provide education and ongoing oversight activities such as monitoring targeted metrics, developing quality improvement plans, distributing tools and resources to efficiently and effectively reduce errors, promoting safe and best practices, and gathering the necessary real-time data to allow all stakeholders to make informed decisions.
 - Ensure internal coordination of programs in which the member is enrolled.

Mercy Maricopa Integrated Care (MMIC)

- Increasing Access to Care through Preventative Screenings via Collaborative Partnerships with Institutions in the Medical Neighborhood with A New Leaf: A New Leaf is a pediatric and adolescent behavioral health agency which has collaborated with A.T. Still University to increase access to care through preventative screenings. A New Leaf has demonstrated achievements in two of the Transforming Clinical Practice Initiative (TCPI) Aims: specifically, improving health outcomes for millions of Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries and building the evidence base on practice transformation so that effective solutions can be scaled.

A New Leaf worked with the practice transformation consultant (PTC) to identify opportunities for expansion into integrated healthcare. The PTC evaluated available internal resources and decided that partnership with an external agency or institution would be the best option for achieving the integrated healthcare service. The PTC introduced the quality improvement team from A New Leaf to the A.T. Still University Center for Resilience in Aging director as well as to department chairs from the School of Audiology and the School of Osteopathic Medicine. Together, this group of stakeholders agreed to collaborate to offer preventative health screenings to children and teens participating in the after-school program at A New Leaf’s Larry Simmons Campus.

A New Leaf had demonstrated significant success around TCPI Milestone 8 (Practice facilitates referrals to appropriate community resources), including community organizations and agencies as well as direct care providers. The collaboration with A.T. Still University improved further on this milestone. Additionally, A New Leaf has employed evidence-based protocols to support Milestone 11 (Practice uses evidence-based protocols or care maps where appropriate to improve patient care and safety). In addition to the best practice of increasing access to care through preventative screenings, the model of inter-professional education and collaborative practice serves as an evidence-based protocol.

- Patient and Family Engagement in a Rural Community: Desert Senita Community Health Center (DSCHC) noted a gradual decline in body mass index (BMI) in some age groups since the implementation of the school garden activity and biking. DSCHC is a Federally Qualified Health Center (FQHC) with three practice sites located in the rural community of Ajo, Arizona. More than 33 percent of Desert Senita's patients live below the federal poverty level and have a high incidence of obesity and diabetes. DSCHC is a patient-centered medical home, certified by the Accreditation Association for Ambulatory Health Care.

DSCHC has excelled at implementing person and family engagement (PFE) metrics. They have a long-standing signature community program, the Edible Ajo School Yard (EASY), designed to engage students in focusing on their health and activity through growing produce for the Ajo Unified School District cafeteria. The clinic facilitated the creation of a school garden, in which students in pre-kindergarten through sixth grade participate. Home-grown produce is introduced to children who may have not been offered it in their own homes. In addition to EASY, the behavioral health staff partnered with the Ajo Community Garden to create a healing labyrinth to promote stress reduction, meditation, aromatherapy and "food for the soul." Herbs are sold at the weekly farmer's market to help pay for water expenses. The DSCHC garden program will be expanded to include healthy cooking class events with traditional community cuisines in mind. The health center will be participating in the Ajo Sustainable Community group to promote diabetes prevention and healthy eating habits, supporting the expansion of DSCHC's diabetes education program.

Practice transformation consultants (PTCs) worked with DSCHC to link the established programs to meaningful clinical outcomes. While programs provide an exceptional value to an impoverished, medically underserved community, the direct linkage of the program to health improvements was anecdotal. For example, DSCHC noted a gradual decline in BMI in some age groups since the implementation of the school garden activity. The PTC worked with them to connect the data elements to the PFE.

Bike Ajo, a biking program initially started with a Boys and Girls Club in Tucson, was adopted and adapted for DSCHC. Due to great results from the program, Bike Ajo and weekly bike classes have been expanded from the first semester to the full school year for sixth grade students. DSCHC has now been developing an internal wellness program emphasizing healthy habits and bringing Bike Ajo into the employee community by encouraging lunchtime exercise through biking. DSCHC is preparing to reach out to Pima County to expand the bike availability to support this program and explore new and family-friendly bike trails.

In August 2018, DSCHC began initial staff training on a population health software application called Azara Healthcare Solutions. This program interfaces with the EHR, allowing data mapping

which provides key information to assist in the improvement of clients' health. DSCHC will continue transformational activities by gathering health improvement data to track program outcomes and develop best practices to share with other communities.

DSCHC adopted a data-driven quality improvement methodology leading to the development of utilization metrics in which improvements were made in PFE metrics. In addition, DSCHC reported increased measuring and recording of BMI, from 3 percent to 51 percent. Provider education has been ongoing to teach new providers unfamiliar with requirements of FQHCs to record education each time. One of DSCHC's next steps is to formalize data collection to continue to track BMI, hemoglobin A1c, and weight-loss measures. The importance of linking this clinic's efforts to others' in the community is to work toward the goal of widening implementation of whole health activities that will lead to increased wellness and reduction in long-term healthcare costs in the community at large.

- Practice Transformation Using Care Coordination and Data-Centric Approach at St. Elizabeth's Health Center: St. Elizabeth's Health Center is a faith-based FQHC with two practice sites in southern Arizona. The center provides primary medical and dental care as well as behavioral health services to Medicaid and uninsured patients. Their practice transformation can be attributed to multiple factors including an engaged leadership, focus on data-driven quality improvement using metrics to reduce the cost of care, working on opioid stewardship, and receiving patient-centered medical home recognition. Central to their transformation is care coordination focused on patients with significant burden of physical and mental health problems.

St. Elizabeth's Health Center connected to the Health Information Exchange (HIE) in 2016 and began receiving Admission, Discharge, or Transfer (ADT) alerts in 2017, which improved ability to manage high-risk patients. The practices worked on multiple measures of improvement, including addressing high-cost, high-utilizing members, with a special focus on integrated care and quality metrics such as diabetes, asthma, tobacco cessation, breast cancer screening, cervical cancer screening, and preventative visits. They developed workflows to integrate the HIE alerts for their high-risk patients and implement a high-risk patient registry. The goal of the workflows was to optimize the information with a focus on identifying patients at the time of admission and discharge from hospital encounters (to provide timely transition of care to clinic and follow-up) and to identify high-risk members to facilitate contact with members of the care team including clinicians, case managers, and social services. By using a data-centric approach as a best practice, this organization has worked on optimizing information gained through the HIE and alerts, chart preparation, and evaluation across disciplines to engage all members of the care team in patients' care plans.

6. Organizational Assessment and Structure Performance

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

AHCCCS has extensive experience preparing for, conducting, and reporting findings from its reviews of Contractors' compliance with federal and AHCCCS contractual requirements. As permitted by 42 CFR §438.358(a), AHCCCS elected to conduct the activities associated with the federal Medicaid managed care mandatory compliance reviews. In accordance with and satisfying the requirements of 42 CFR §438.364, AHCCCS then contracted with HSAG as an EQRO, to use the information AHCCCS obtained from its compliance review activities to prepare this section of the annual EQR report.

Conducting the Review

AHCCCS conducted a comprehensive OR for CIC and HCIC in CYE 2018. During CYE 2017, AHCCCS conducted a comprehensive OR for MMIC and a focused OR for CIC. Between CYE 2017 and CYE 2018, AHCCCS monitored the progress of all RBHA Contractors in implementing their CAPs from the CYE 2016 OR review cycle.

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

Standards

The comprehensive ORs conducted in CYE 2018 for CIC and HCIC were 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 MM Standard, 27 elements were scored for MMIC and 26 elements were scored for CIC and HCIC.

Contractor-Specific Results

Cenpatco Integrated Care (CIC)

AHCCCS conducted an on-site review of CIC from August 28, 2017, through August 30, 2017. A copy of the draft version of the report was provided to the Contractor on October 11, 2017. CIC was given a period of one week in which to file a challenge to any findings that the Contractor considered inaccurate, based on the evidence available at the time of review.

Findings

For the CYE 2016 review cycle, AHCCCS conducted in CYE 2018 a comprehensive OR considering 10 standards. Table 6-1 presents the total number of elements; the standard area scores; and the total number, if any, of required corrective actions for each standard area reviewed.

Table 6-1 presents compliance results for the 10 standards reviewed for the CIC OR.

Table 6-1—Standard Areas and Compliance Scores for CIC

Standard Area (Number of Elements Scored)	Standard Area Score/Maximum Possible Score*	Standard Area Percentage Score	Number of Required Corrective Actions
Corporate Compliance (5)	500/500	100%	0
Claims and Information Systems (12)	1,095/1,200	91%	3
Delivery Systems (14)	1,333/1,400	95%	3
General Administration (3)	267/300	89%	1
Grievance Systems (17)	1,700/1,700	100%	0
Adult, EPSDT, and Maternal Child Health (12)	971/1,200	81%	6
Medical Management (26)	2,506/2,600	96%	4
Member Information (9)	867/900	96%	1
Quality Management (25)	2,487/2,500	99%	1

Standard Area (Number of Elements Scored)	Standard Area Score/Maximum Possible Score*	Standard Area Percentage Score	Number of Required Corrective Actions
Third Party Liability (7)	700/700	100%	0

*Standard area scores and maximum possible scores were provided by AHCCCS.

The strongest performances were in the CC, GS, and TPL standards, wherein CIC received 100 percent standard area scores and no CAPs. Additionally, CIC met the 95 percent threshold for the DS, MM, MI, and QM standards. Standards requiring the fewest CAPs were GA, MI, and QM, with one CAP required for each. Standards with greatest opportunity for improvement based on number of CAPs required were MCH and MM. For the CIS, GA, and MCH standards, CIC scored below the 95 percent threshold.

Strengths for CIC

For this OR, AHCCCS reviewed a total of 10 standards. For seven of those, CIC achieved either full compliance or compliance. Of those seven standards, CIC was fully compliant, with 100 percent scores, for three (CC, GS, and TPL). CIC also demonstrated strong performance in the DS, MM, MI, and QM standards, with compliance scores between 95 percent and 99 percent.

For the CC standard, CIC had an operational corporate compliance program, including a work plan that detailed compliance activities. The program was administered and monitored by a compliance officer, an on-site official reporting directly to the Contractor’s top management. In addition, the Contractor had a compliance committee that monitored, reviewed, and assessed the effectiveness of the compliance program and timeliness of reporting. For the GS standard, CIC complied with all timelines required in the standard, transferred denied expedited appeal requests to the standard appeal review process, issued a written notice to the member when an extension was taken, and issued appeal decisions as expeditiously as the member’s health condition required. Full compliance was demonstrated by CIC for the TPL standard, which involved processes to identify claims and services potentially subject to third-party payment as well as filing liens on total plan casualty cases that exceeded \$250.

Although the following standards did not meet full compliance, CIC performed at or above the “95 percent threshold” established by AHCCCS. For the DS standard (scored at 95 percent), CIC had a mechanism for tracking and trending provider inquiries, which included timely acknowledgement and resolution and taking systemic action as appropriate. CIC also performed well in the MM standard (scored at 96 percent), which included the requirement to execute processes to assess, plan, implement, and evaluate utilization data management activities. CIC demonstrated compliance for the MI standard (scored at 96 percent), which included the requirement to ensure that the Contractor’s new member information packets met AHCCCS standards for content and distribution. For the QM standard (scored at 99 percent), CIC demonstrated that a structure and process was in place for quality-of-care and abuse complaint tracking and trending for member or system resolution.

Opportunities for Improvement and Required Actions for CIC

The results of the OR demonstrated opportunities for improvement as CIC received 19 required corrective actions for seven standards. CIC was less than compliant in three of the 10 standards

reviewed (CIS, GA, and MCH), and although having met compliance for four other standards (DS, MM, MI, and QM), CIC received required actions for these standards.

For the CIS standard (scored at 91 percent), AHCCCS found several deficiencies regarding the minimum information required in CIC's remittance advice. To address a CAP for this element, CIC must include the reason(s) for denials and adjustments, provider rights for claim disputes, instructions and time frames for the submission of claim disputes, and instructions and time frames for the submission of corrected claims.

During AHCCCS' review of claims, the following issues were identified in the CIS standard: an incorrect application of interest, an incorrect calculation of interest applied to claims, and physicians' services not addressed in the associated hospital's contract that could not be matched to a contracted rate. The same issues were identified during CIC's focused review in CYE 2017. AHCCCS recommended that CIC develop a desktop procedure and train staff to use CIC's manual interest calculator when calculating interest. To address the CAP for this element, CIC must also ensure payment of applicable interest on all claims, including overturned claim disputes. Additionally, CIC must ensure processing and paying all overturned claim disputes in a manner consistent with the decision and within 15 business days of the decision in order to remedy the deficiency identified during the comprehensive OR.

For the GA standard (scored at 89 percent), AHCCCS noted that the electronic review and signature process that CIC used to track annual policy reviews listed policies that had been reviewed or were due for review during 2017 along with the next proposed annual review date. However, the tracker did not include the previous annual review date. CIC must ensure that all policies and procedures are reviewed annually.

For the MCH standard (scored at 81 percent), AHCCCS identified that CIC must develop and implement a written process to educate providers to assist them in referring those members who will lose AHCCCS eligibility for low- or no-cost primary care or family planning services. Although CIC improved the standard area score for the MCH standard during the comprehensive OR compared to the focused review, CIC must submit a CAP to develop and implement a written process to coordinate referrals of high-risk members to appropriate service providers to ensure that services are received, which includes revising the plan of care as appropriate. Several deficiencies were identified in the element relating to the requirement to monitor provider compliance with providing EPSDT services. CIC's compliance score did improve from the focused review for this element; however, CIC must submit a CAP to develop and implement a written process to monitor providers' use of the AHCCCS-approved EPSDT tracking forms. Additionally, to address a CAP for another element, CIC must develop and implement a written process to monitor providers to determine if oral health and dental services are provided according to the AHCCCS Dental Periodicity Schedule. CIC must also submit a CAP to develop and implement a written process for monitoring implementation of referrals for underweight and overweight members as well as provider compliance in implementing interventions with members identified as overweight, including education and/or nutrition referral. Lastly, CIC did not submit documentation for the element relating to the requirement for ensuring that women's preventative care services are provided according to the AHCCCS Medical Policy Manual (AMPM). Therefore, CIC must submit a CAP to: develop and implement a written process to inform all primary care providers (PCPs)

and obstetrician/gynecologist (OB/GYN) providers of the availability of women's preventative care services, develop and implement a written process to inform members about women's preventative health services, and monitor provider compliance for delivery of well-woman preventative care services as listed in AMPM 411.

Although overall CIC met compliance in the DS, MM, MI, and QM standards, several deficiencies were identified by AHCCCS. For the MM standard, CIC did not demonstrate (during the focused review conducted in CYE 2017 or the comprehensive OR conducted in CYE 2018) that sufficient proactive discharge planning for members admitted into acute care facilities was conducted; therefore, CIC must submit another CAP to adhere to AHCCCS requirements and the Contractor's policies and procedure for proactive discharge planning and ensure that documentation is present that includes PCP follow-up including coordination of medications; therapies and durable medical equipment; telephone calls within seven days after discharge; and appropriate referral to case management, disease management, or community resources. During a case review, AHCCCS discovered that nine of 30 cases were reviewed by individuals without the appropriate clinical expertise to conduct retrospective review; therefore, CIC must submit a CAP describing how CIC will ensure that clinical staff who conduct retrospective reviews have the appropriate clinical expertise, as in accordance with the Contractor's internal policy and the AHCCCS AMPM. Although CIC was able to provide enrollment transition information (ETI) forms for the comprehensive OR conducted in CYE 2018 CIC (as CIC was not able to do so during the focused review conducted in CYE 2017), CIC had blank spaces in the ETI forms that AHCCCS reviewed; therefore, CIC must submit a CAP for completing all sections of the ETI forms for applicable items and must mark "N/A" for non-applicable items. Lastly, CIC must submit a CAP to develop policies and procedures related to assisting homeless clinics in obtaining prior authorization and referrals to specialists.

For the DS standard, CIC did not adequately demonstrate that CIC notified all providers of the required subaward information or issued management decisions for all findings within six months after acceptance of single audit by the Federal Audit Clearinghouse. Additionally, CIC did not provide sufficient evidence of how the Contractor communicated prohibited uses of substance abuse prevention and treatment (SABG) and mental health block grant (MHBG) funds to providers. AHCCCS noted that for the MI standard CIC sent provider termination letters outside the 15-day notification time period. For the QM standard, not all quality of care (QOC) issues were identified and investigated in some of the sample files submitted for AHCCCS review; therefore, those issues were not addressed in the opening or closing letters and no determination or leveling or system or member resolution occurred. In addition, some QOC sample files had no evidence to show that appropriate regulatory agencies were notified in instances of allegations of abuse.

Corrective Action Plans

In the report generated from CIC's OR, AHCCCS required that CIC develop 19 CAPs for issues that AHCCCS identified. CIC submitted the first CAP submission to AHCCCS by November 21, 2017. On December 21, 2017, AHCCCS accepted all CAPs that CIC proposed and closed eight of those CAPs. To close those eight CAPs, CIC completed the following:

- Submitted documentation demonstrating compliance with the requirement that policies and procedures are reviewed annually.
- Revised desktop processes to include general mental health and substance abuse (GMH/SA) members discharging from acute care facilities in discharge follow-up protocols and trained staff on the changes.
- Implemented a new communication process when identifying members with complex needs and trained staff on discharge follow-up protocols.
- Re-assigned retrospective reviews to staff with appropriate clinical expertise.
- Updated ETI form processes and trained staff on the changes.
- Developed a formal policy for assisting homeless clinics related to prior authorization and referrals to specialists and determined that staff will receive education and updates during weekly team meetings.
- Updated the provider termination processing schedule.
- Revised the PCP change letter to include language to reflect that a member is receiving the letter because the member requested a PCP change or because his or her PCP was termed and a new PCP was assigned.
- Revised the QOC desktop procedure and policy to reflect the criteria for making referrals to regulatory agencies.
- Trained staff on identifying all potential allegations; and implemented a tracking spreadsheet to document referrals to a regulatory agency.

AHCCCS required that CIC submit to AHCCCS by June 20, 2018, an update for the 11 CAPs that remained open. With few exceptions, AHCCCS' expected all CAP steps to be completed within six months. (The six-month CAP update that CIC was required to provide was not available at the time of this report and is therefore not included.)

Health Choice Integrated Care (HCIC)

AHCCCS conducted an on-site review of HCIC from October 2, 2017, through October 4, 2017. A copy of the draft version of the report was provided to the Contractor on November 15, 2017. HCIC was given a period of one week in which to file a challenge to any findings that the Contractor considered inaccurate, based on the evidence available at the time of review.

Findings

For the CYE 2016 review cycle, AHCCCS conducted in CYE 2018 a comprehensive OR considering 10 standards. Table 6-2 presents the total number of elements; the standard area scores; and the total number, if any, of required corrective actions for each standard area reviewed.

Table 6-2 illustrates the following compliance results for the 10 standards reviewed for the HCIC OR.

Table 6-2—Standard Areas and Compliance Scores for HCIC

Standard Area (Number of Elements Scored)	Standard Area Score/Maximum Possible Score*	Standard Area Percentage Score	Number of Required Corrective Actions
Corporate Compliance (5)	500/500	100%	0
Claims and Information Systems (12)	1,029/1,200	86%	5
Delivery Systems (14)	1,095/1,400	78%	4
General Administration (3)	167/300	56%	2
Grievance Systems (17)	1,700/1,700	100%	0
Adult, EPSDT, and Maternal Child Health (12)	656/1,200	55%	11
Medical Management (26)	2,381/2,600	92%	4
Member Information (9)	900/900	100%	0
Quality Management (25)	2,470/2,500	99%	2
Third Party Liability (7)	700/700	100%	0

*Standard area scores and maximum possible scores were provided by AHCCCS.

The strongest performances were in the CC, GS, MI, and TPL standards, wherein HCIC received 100 percent standard area scores and no CAPs. Additionally, HCIC met the 95 percent threshold for the QM standard. Standards requiring the fewest CAPs were CC, GS, MI, and TPL with no CAPs required, while GA and QM required two CAPs each. HCIC scored below the 95 percent threshold in the CIS, DS, GA, MCH, and MM standards, demonstrating the greatest opportunity for improvement in those standards. HCIC was required to complete the highest number of CAPs for the CIS, DS, MCH, and MM standards.

Strengths for HCIC

For this OR, AHCCCS reviewed a total of 10 standards. HCIC achieved either full compliance or compliance with five standards. HCIC was fully compliant, with 100 percent scores, for four of the standards reviewed (CC, GS, MI, and TPL). HCIC also demonstrated strong performance in the QM standard, with a compliance score of 99 percent.

HCIC audited providers through its claims payment system or any other data analytics system for accuracy and identified billing inconsistencies and potential instances of fraud, waste, or abuse. Additionally, HCIC had a process for the intake and handling of member appeals filed orally and assessed and evaluated PCP capacity prior to assigning new members. Further, HCIC filed liens on total plan casualty cases that exceeded \$250. HCIC has implemented a structured peer review process which includes administrative requirements related to that peer review process; that implementation was a requirement for the QM standard (scored at 99 percent).

Opportunities for Improvement and Required Actions for HCIC

The results of the OR demonstrated opportunities for improvement as HCIC was less than compliant in five of the 10 standards reviewed. Scores for the MM, CIS, DS, GA, and MCH standards were 92, 86, 78, 56, and 55 percent, respectively. HCIC received 28 required corrective actions for six standards.

For the MM standard (scored at 92 percent), AHCCCS identified that HCIC did not provide compliant policies and procedures for conducting concurrent review in inpatient settings or for identifying and managing members who were potential candidates for transplants. HCIC did not have transition policies and procedures to ensure continuity of care for members transitioning to and from the Contractor. Additionally, HCIC did not provide policies or procedures to identify, monitor, or implement interventions to prevent the misuse of controlled and non-controlled medications.

AHCCCS identified several deficiencies when reviewing the CIS standard (scored at 86 percent). HCIC did not include all the required information in the remittance advice. Dates that the claims were received could not be validated for purposes of calculating interest; interest claims were incorrectly calculated or applied, with one claim paid more than 30 days from the day the claim was received and a quick pay discount incorrectly applied; and claims were processed more than 15 business days from the date of the dispute decision. Additionally, HCIC did not provide adequate policies and procedures for auditing the contract loading process for accuracy of payment against hard copy contracts and policies did not contain provisions for auditing periodicity.

For the DS standard (scored at 78 percent), HCIC did not demonstrate that provider services representatives were adequately trained and did not submit sample notices that informed providers when a material change in the network occurred. HCIC did not have adequate official policies and procedures for the acknowledgement and response to provider inquiries that included AHCCCS requirements and did not submit evidence of tracking provider inquiries for adherence to the AHCCCS requirements. AHCCCS identified several deficiencies when reviewing the GA standard, which also had one of the lowest standard area scores (56 percent). AHCCCS noted that some of HCIC's submitted training materials did not reflect applicability to HCIC and that examples of staff training regarding changes in the AHCCCS program were not provided. Additionally, HCIC did not adequately demonstrate that all policies and procedures had been reviewed annually.

HCIC received the lowest standard area score (55 percent) for the MCH standard. HCIC did not perform the following adequately:

- Establish and operate a maternity care program (with goals directed at achieving optimal birth outcomes that meet AHCCCS minimum requirements).
- Monitor provider compliance of perinatal and postpartum depression screenings conducted at least once during the pregnancy and again at the postpartum visit, with appropriate counseling and referrals made if a positive screening is obtained.
- Ensure that postpartum care was provided for a period of up to 60 days after delivery.

- Ensure that physicians and other practitioners document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services.
- Monitor medical necessity for sterilizations of members under 21 years of age.
- Measure the effectiveness of member and provider outreach activities and implement process improvement activities as necessary to improve member participation in EPSDT and well-child services.
- Monitor member compliance with obtaining EPSDT services or provider compliance with providing EPSDT services.
- Ensure that an oral health screening was provided by the PCP or another practitioner during the EPSDT visit.
- Monitor, track, and evaluate PCP fluoride varnish applications for children under 2 years of age.
- Monitor and evaluate the effectiveness of oral health and dental outreach activities.
- Monitor EPSDT providers for participation in the Arizona State Immunization Information System (ASIIS) or Vaccine for Children (VFC) program.
- Monitor, evaluate, and improve utilization of nutritional screenings and appropriate interventions, including medically necessary supplemental nutrition to EPSDT members.
- Ensure that women's preventative care services were provided according to the AHCCCS Medical Policy Manual.

Although the QM standard received a score that complied with the “at or above 95 percent” threshold established by AHCCCS, opportunities for improvement were identified. AHCCCS found that for the QM standard (scored at 99 percent) HCIC had no structure or process in place for quality-of-care and abuse complaint tracking and trending for members, system resolution, or to adequately conduct PIPs to assess the quality and appropriateness of service provision and to improve performance.

Corrective Action Plans

AHCCCS required the submission of 28 CAPs for HCIC. HCIC submitted CAPs for the CIS, DS, GA, MCH, MM, and QM standards, with proposed activities to correct the deficiencies. In January 2018, AHCCCS accepted and closed nine CAPs; however, AHCCCS did not accept all the CAPs, and HCIC must resubmit those identified CAPs. To address the CAPs that AHCCCS closed, HCIC implemented a new tracking mechanism that created tighter control over compliant processing of claim disputes. HCIC submitted the routing tracker spreadsheet; however, despite the fact that the remit showed that the claim payment was timely, the spreadsheet did not appear to track the actual payment date of the claim. AHCCCS recommended that HCIC also track the paid date to ensure that claims are paid within 15 business days from the decision date. HCIC did the following: provided a copy of the provider communication, announcing HCIC's transition to Veyo (non-emergent transportation services); updated applicable policies related to the contracts committee; corrected the references to AHCCCS in the identified policies; revised existing and developed new EPSDT policies and procedures and desktop protocols; submitted the EPSDT Member Outreach Health Buddy script, EPSDT provider toolkit, and provider communication and reminders; submitted the missed EPSDT well-child visit reminder letter;

and submitted the newly developed maternal child health-EPSDT outreach tracking log. Additionally, HCIC submitted: the revised Physical Health Inpatient Behavioral Health Inpatient Facility Authorization Criteria policy and procedure; the newly developed ETI policy and procedure; the revised Performance Improvement Projects policy; and various documents addressing the requirement to identify, monitor, and implement interventions to prevent the misuse of controlled and noncontrolled medications.

HCIC submitted a second CAP submission; and on February 22, 2018, AHCCCS accepted all CAPs and informed HCIC that AHCCCS must see demonstrated progress in the proposed steps before AHCCCS agrees that HCIC has addressed the findings for the 18 CAPs that remained open. With few exceptions, AHCCCS expected that all CAP steps would be completed within six months. (HCIC's six-month CAP update was not available at the time of this report and is therefore not included.)

Recommendations for CIC and HCIC

Based on the CAPs that CIC and HCIC developed to address actions required by AHCCCS, HSAG recommends that CIC and HCIC consider the following:

- Contractors should continue to conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards, State rules, and federal regulations. Specifically, Contractors should ensure that existing policies, procedures, and information distributed to providers, subcontractors, and members with AHCCCS requirements are cross-referenced with AHCCCS standards, State rules, and federal regulations.
- Contractors should continue to assess current monitoring processes and activities to identify strengths and opportunities for improvement within operational processes. In addition, Contractors should implement periodic assessments of those elements reviewed by AHCCCS for which Contractors are found deficient and develop mechanisms to address such areas and enhance existing procedures.
- Contractors should continue to implement control systems to address specific findings in the MCH standard related to women's preventative care services to ensure that services are provided in accordance with the AHCCCS Medical Policy Manual as this was a finding for both RBHA Contractors.

Outstanding CAPs From Plans With ORs in CYE 2017

Mercy Maricopa Integrated Care (MMIC)

Corrective Action Plans

In the report generated from MMIC's CYE 2017 OR, AHCCCS required the submission of 13 CAPs. MMIC submitted CAPs for the CC, CIS, DS, MCH, MM, and QM standards, with proposed activities to correct the deficiencies. On October 12, 2017, AHCCCS accepted and closed five CAPs; however, AHCCCS did not accept all the CAPs, and MMIC must resubmit those identified CAPs. To address the five CAPs that AHCCCS closed, MMIC updated applicable policies related to the Corporate Compliance program, updated the SMI Determinations and Member Transition policies and developed an associated SMI decertification tool, updated the ETI desktop process and trained staff on the updates, implemented an automated ETI form designed to include the member's pertinent medical and authorization information and conducted regular audits on ETI form utilization, and updated the policy for emergency services. Additionally, MMIC revised the residential tool and scoring guidelines and provided results of the audit using the revised tool and scoring guidelines.

The second CAP update submission was received by AHCCCS on November 21, 2017. On December 20, 2017, AHCCCS accepted and closed four CAPs; however, AHCCCS did not accept all the CAPs and informed MMIC that AHCCCS must see demonstrated progress in the proposed steps before AHCCCS agrees that MMIC did address the findings for the five CAPs that remained open. With few exceptions, AHCCCS expected that all CAP steps would be completed within six months. To address the four CAPs that AHCCCS closed, MMIC provided the following: evidence of training completed and an example of the daily report mentioned in the CAP; the revised SABG-MHBG desktop procedure; the final training material, including training roster and enhanced discharge reports related to post-discharge telephone calls; the newly developed policy for outreach, engagement, re-engagement, and closure activities for behavioral health services; and updated comprehensive medication management reimbursement (CMMR) tool.

The six-month CAP update resubmission was received by AHCCCS; and, on August 6, 2018, AHCCCS closed three CAPs. To close the three CAPs, MMIC submitted the following information: revised local trainings that included Mercy Maricopa contacts and mechanisms for direct reporting to AHCCCS Office of the Inspector General (OIG); revised finance SABG/MHBG desktop procedures and provider monitoring policy; trained on the revised PIP/CAP procedure; and included sample cases that demonstrated implementation of the open/close procedure described in the CAP previously submitted. MMIC was informed that, for the one CAP that remained open in the MCH standard, MMIC must reassess the CAP and provide a status update. In the update, MMIC must develop a written process and procedure to inform all members, PCPs, and OB/GYN providers of the availability of women's preventative care services as listed in AMPM. (The status update that MCP was required to provide was not available at the time of this report and is therefore not included.)

Cenpatico Integrated Care (CIC)

Corrective Action Plans

AHCCCS conducted a focused review of CIC in CYE 2017 for 47 elements in five standards. On September 27, 2017, AHCCCS recommended that CIC review the 20 corrective actions identified in the CYE 2016 Focused Operational Review Final Report.

Standard area scores improved for all elements for which CIC received a CAP in the focused review, excepting one. Of the 19 CAPs that CIC received for elements scored in both the focused review and comprehensive OR, 13 elements were determined to be within compliance during the comprehensive OR. Although standard area scores did improve, CIC received CAPs for the same six elements in the CIS, MCH, and MM standards in both the focused review and the comprehensive OR. Additionally, two elements for which CIC was in compliance with at the time of the focused review were determined to have deficiencies during the comprehensive OR; CIC was required to complete CAPs for those two elements during the comprehensive OR.

Strengths

During the comprehensive OR conducted in CYE 2018, CIC and HCIC both demonstrated compliance for the CC, GS, MI, QM, and TPL standards. Notably, although CIC fell below the 95 percent compliance threshold for three standards, for all elements (except one) in which CIC received a CAP during the focused review, CIC's standard area scores improved. Notably, all of MMIC's CAPs were closed except one.

Opportunities for Improvement

Opportunities for improvement exist for the CIS, GA, and MCH standards, as neither CIC nor HCIC met compliance for these standards during the comprehensive OR conducted in CYE 2018. For the CAPs that MMIC was required to complete as a result of the comprehensive OR conducted in CYE 2017, one CAP remained open, in the MCH standard.

Overall Recommendations

Recommendations for CIC and HCIC were included preceding. Recommendations for MMIC were included in the CYE 2017 Annual Report, and only CAP updates for MMIC were included in Section 6 of this report. Please see the Executive Summary for the overall recommendations for all Contractors over the 2016 three-year review cycle.

7. Performance Measure Results

Methodology

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

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

Required Performance Measures

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

Table 7-1 displays the CYE 2017 performance measures presented within this report; the associated measure specifications used to calculate each measure rate; and the established MPS, if applicable, for the GMH/SA and RBHA Integrated SMI Contractors. GMH/SA was only required to report a subset of the following performance measures for inclusion in this report; therefore, GMH/SA’s required performance measures are noted (†) in Table 7-1. An MPS had not yet been established for all reported performance measure rates.

Table 7-1—CYE 2017 Performance Measure for GMH/SA and RBHA Integrated SMI Contractors

Performance Measure	Measure Specification	MPS
Access to Care		
<i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i>	HEDIS	75.0%
Preventive Screening		
<i>Breast Cancer Screening</i>	Adult Core Set	50.0%
<i>Chlamydia Screening in Women—Total</i>	Adult Core Set and Child Core Set	63.0%

Performance Measure	Measure Specification	MPS
Behavioral Health		
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up[†]</i>	HEDIS	85.0%
<i>Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up[†]</i>	HEDIS	95.0%
Utilization		
<i>Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*</i>	HEDIS	—
<i>Inpatient Utilization—General Hospital/Acute Care—Days per 1,000 Member Months (Total Inpatient)—Total</i>	HEDIS	—
<i>Plan All-Cause Readmissions—Total*</i>	Adult Core Set	—

[†] Indicates that GMH/SA was required to report the performance measure for inclusion in this report.

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


* A lower rate indicates better performance for this measure; therefore, rates must fall at or below the established MPS in order to exceed the CYE 2017 MPS.

Performance Measure Results—GMH/SA

Table 7-2 presents the CYE 2017 performance measure rates with an MPS for the GMH/SA population. The following results include performance measure rates for the DES/DDD and CMDP subpopulations, which include members eligible for the GMH/SA program while enrolled in their respective program. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the CYE 2017 MPS established by AHCCCS.

Table 7-2—CYE 2017 Performance Measure Results—GMH/SA

Performance Measure	DES/DDD-Specific	CMDP-Specific	GMH/SA Aggregate
Behavioral Health			
<i>Follow-Up After Hospitalization for Mental Illness</i>			
<i>7-Day Follow-Up</i>	73.9%	63.4%	48.1%
<i>30-Day Follow-Up</i>	91.3%	82.8%	67.2%

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

Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, comparison to the prior year’s results are not appropriate for the *Follow-Up After Hospitalization for Mental Illness* measure.

Strengths and Opportunities for Improvement

For CYE 2017, no performance measure rates for *Follow-Up After Hospitalization for Mental Illness* met or exceeded the MPS, demonstrating opportunities to improve care. Inpatient hospital readmissions due to mental illness have been shown to occur due to poor transition of care services and lack of access to appropriate outpatient treatment.⁷⁻¹ The Reducing Avoidable Readmissions Effectively (RARE) Campaign—a collaboration of the Institute for Clinical Systems Improvement, Minnesota Hospital Association, and Stratis Health—recommends improving care transitions following an inpatient hospital admission by focusing on patient and family engagement, medication management, comprehensive transition planning, care transition support, and transition communications. Patients should have follow-up appointments scheduled prior to discharge, and mental health practitioners should ensure availability to review each patient’s progress and care plan within the first seven days post discharge.⁷⁻² Following a member’s discharge from an inpatient admission, Contractors should perform a follow-up call with that member within three days to address any questions or concerns and to discuss progress of the care plan.^{7-3,7-4} AHCCCS and the GMH/SA Contractors should ensure that these follow-up calls are being conducted and confirm during each call that the member has a follow-up visit scheduled with a mental health practitioner and access to necessary community resources.

Performance Measure Results—RBHA Integrated SMI Contractors

Table 7-3 presents the CYE 2017 performance measure rates with an MPS for each RBHA Integrated SMI Contractor and the statewide aggregate. Performance measure rate cells shaded green indicate that the Contractor met or exceeded the CYE 2017 MPS established by AHCCCS.

Table 7-3—CYE 2017 Performance Measure Results—RBHA Integrated SMI Contractors

Performance Measure	CIC	HCIC	MMIC	Aggregate
Access to Care				
<i>Adults’ Access to Preventive/Ambulatory Health Services</i>				
Total	90.4%	90.3%	93.9%	92.2%
Preventive Screening				
<i>Breast Cancer Screening</i>				

⁷⁻¹ Madi N, Zhao H, and Li JF. Hospital Readmissions for Patients with Mental Illness in Canada. *Healthcare Quarterly*. Vol. 10 No. 2. 2007.

⁷⁻² Reducing Avoidable Readmissions Effectively. *Recommended Actions for Improved Care Transitions: Mental Illness and/or Substance Use Disorders*. Available at: http://www.rareadmissions.org/documents/Recommended_Actions_Mental_Health.pdf. Accessed: Apr. 16, 2019.

⁷⁻³ Arizona Health Care Cost Containment System. *How A Hospital Discharge Plan Helps AHCCCS Members Return to Good Health*. Available at: <https://www.azahcccs.gov/AHCCCS/Downloads/HospitalDischarge.pdf>. Accessed on: Apr. 23, 2019.

⁷⁻⁴ Arizona Health Care Cost Containment System. *AHCCCS Presentation Care Coordination Discharge Planning*. Available at: <http://files.constantcontact.com/b108b018001/a0e54380-8b8a-4cda-abfa-464c2a417bbf.pdf>. Accessed on: Apr. 23, 2019.

Performance Measure	CIC	HCIC	MMIC	Aggregate
<i>Breast Cancer Screening</i>	NA	NA	38.7%	38.7%
Chlamydia Screening in Women				
<i>Total</i>	62.9%	42.3%	49.5%	51.5%
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness				
<i>7-Day Follow-Up</i>	65.8%	61.9%	75.4%	71.8%
<i>30-Day Follow-Up</i>	85.9%	81.0%	89.2%	87.7%

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


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

Table 7-4 presents comparison of the RBHA Integrated SMI Contractors’ CYE 2016 to CYE 2017 rates. Performance measure rates were compared to determine if there was a significant difference between CYE 2016 and CYE 2017 using a Chi-square test of proportions. In cases where the numerator was less than five (i.e., fewer than five people were either numerator positive or numerator negative for either reporting year), a Fisher’s exact test was used in place of a Chi-square test. The results of the statistical tests were considered significant when the *p* value was ≤0.05. A green upward arrow (↑) indicates a significant improvement in performance, a red downward arrow (↓) indicates a significant decline in performance, and a dash (—) indicates that the change in performance was not significant.

For some measures, statistical significance testing was not performed, either because comparison to the prior year was not appropriate due to technical specification changes (i.e., *Breast Cancer Screening* and *Follow-Up After Hospitalization for Mental Illness*), or the measure data were not appropriate for statistical testing (i.e., *Ambulatory Care* and *Inpatient Utilization*).

Table 7-4—Trend Analysis From CYE 2016 to CYE 2017—RBHA Integrated SMI Contractors

Performance Measure	CIC	HCIC	MMIC	Aggregate
Access to Care				
Adults’ Access to Preventive/Ambulatory Health Services				
<i>Total</i>	↓	—	—	↓
Preventive Screening				
Chlamydia Screening in Women				
<i>Total</i>	—	—	—	—
Utilization				
Plan All-Cause Readmissions				
<i>Total*</i>	—	—	↓	↓

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

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

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

Strengths and Opportunities for Improvement

For CYE 2017, the RBHA Integrated SMI Contractors were high performers for the measure rates within the Access to Care domain as all Contractors exceeded the MPS for *Adults' Access to Preventive/Ambulatory Health Services* by at least 15 percentage points. Although the *Adults' Access to Preventive/Ambulatory Health Services* performance measure rates are considered an area of strength, the rates for CIC and the RBHA Integrated SMI aggregate declined significantly from CYE 2016 to CYE 2017. Despite the high performance for this measure, the cause of this decline should be assessed to ensure that performance stays above the MPS in future years.

Conversely, no reportable performance measure rates within the Preventive Screening (*Breast Cancer Screening* and *Chlamydia Screening in Women*) or Behavioral Health (*Follow-Up After Hospitalization for Mental Illness*) domains met or exceeded the CYE 2017 MPS, demonstrating opportunities to improve care coordination and access to screenings for members with serious mental illnesses. Of note, the *Breast Cancer Screening* aggregate rate is mostly representative of the performance of MMIC as the rates for CIC and HCIC were too small to report (i.e., denominator less than 30). Research shows that women with SMI experience disparities in the timely screening for preventive diseases and care; yet, women with SMI develop cancer at the same rate as the general population.⁷⁻⁵ Additionally, women with SMI are more likely to have multiple sexual partners and have unprotected sex which leads to potential increased risk of sexually transmitted diseases (STDs) such as chlamydia.⁷⁻⁶ Women with SMI have cited lack of preventive care due to perceived discrimination, provider characteristics (e.g., gender), and inaccurate health perception.⁷⁻⁷ AHCCCS and the RBHA Integrated SMI Contractors should focus efforts on identifying the factors contributing to low rates for these measures and implement improvement strategies to increase screenings for breast cancer and chlamydia in women and follow-up visits after hospitalization for mental illness.

⁷⁻⁵ Woodhead C, Cunningham R, Ashworth M, et al. Cervical and breast cancer screening uptake among women with serious mental illness: a data linkage study. *BMC Cancer*. 2016 Oct 21;16(1):819. doi: 10.1186/s12885-016-2842-8.

⁷⁻⁶ Senn TE and Carey MP. HIV, STD, and Sexual Risk Reduction for Individuals with a Severe Mental Illness: Review of the Intervention Literature. *Curr Psychiatry Rev*. 2008 May; 4(2): 87–100.

⁷⁻⁷ Xiong GL, Iosif AM, Bermudes RA, et al. Preventive Medical Services Use Among Community Mental Health Patients With Severe Mental Illness: The Influence of Gender and Insurance Coverage. *Prim Care Companion J Clin Psychiatry*. 2010; 12(5): PCC.09m00927.

8. Performance Improvement Project Performance

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

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

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

Conducting the Review

In the AHCCCS Medical Policy Manual, 980—Performance Improvement Projects, AHCCCS mandates that Contractors participate in PIPs selected by AHCCCS. In addition, with AHCCCS approval, Contractors may select and design additional PIPs specific to needs and data identified through internal surveillance of trends. Mandated PIP topics are selected through AHCCCS' analysis of internal and external data and trends that may include Contractor input. AHCCCS considers topics such as comprehensive aspects of enrollee needs, care, and services for a broad spectrum of members or for a focused subset of the population, including those members with special healthcare needs or receiving Long Term Services and Supports (LTSS) (42 CFR §438.330).

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

In CYE 2015 (October 1, 2014, through September 30, 2015), AHCCCS implemented a new PIP, *E-Prescribing*, for all lines of business. The baseline measurement period covered CYE 2014 (data from October 1, 2013, through September 30, 2014), to be followed by two remeasurement periods: Remeasurement 1 (October 1, 2015, through September 30, 2016) and Remeasurement 2 (October 1, 2016, through September 30, 2017).

AHCCCS implemented the *E-Prescribing* PIP because research suggested that an opportunity existed to improve preventable errors experienced using the standard, handwritten paper method to communicate a medication between a prescriber and a pharmacy. Research indicated that clinicians make seven times

fewer errors (decreasing from 42.5 per 100 prescriptions to 6.6 per 100 prescriptions after one year) when using an electronic system rather than writing prescriptions by hand. AHCCCS found that sending a clear and legible prescription electronically can reduce mistakes related to medication types, dosages, and member information. In addition, AHCCCS noted that electronic prescribing assists pharmacies in identifying potential problems related to medication management and potential reactions that members may encounter, especially for those taking multiple medications.

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

Contractor-Specific Results

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

This section includes RBHA Contractors' PIP results as calculated by AHCCCS, along with specific activities conducted during CYE 2017. HSAG has minimally edited the analysis and interventions for grammar and punctuation; otherwise, they appear as provided by the RBHA Contractors.

Mercy Maricopa Integrated Care (MMIC)

Findings

Table 8-1 presents the baseline and Remeasurement 1 period results for the *E-Prescribing* PIP for MMIC's general mental health/substance abuse (GMH/SA) member population.

Table 8-1—MMIC GMH/SA E-Prescribing

PIP Measure	Baseline Period Oct. 1, 2013, to Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2016, to Sept. 30, 2017	Remeasurement Period 2 Oct. 1, 2017, to Sept. 30, 2018	Relative Percentage Change From Baseline	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	48.44%	59.24%	NA	6.72%	P<.001
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically	31.96%	58.49%	NA	13.05%	P<.001

CYE 2014 was the GMH/SA baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-1 shows that for the GMH/SA population baseline measurement period 48.44 percent of MMIC’s providers prescribed at least one prescription electronically and 31.96 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the GMH/SA population, MMIC’s Remeasurement 1 rate at 59.24 percent for Indicator 1 demonstrated a relative percentage change from baseline of 6.72 percent, while the Remeasurement 1 rate of 58.49 for Indicator 2 demonstrated a relative percentage change from baseline of 13.05 percent. MMIC demonstrated statistically significant improvements for both indicators for this PIP.

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

Table 8-2—MMIC Integrated E-Prescribing

PIP Measure	Baseline Period Oct. 1, 2014, to Sept. 30, 2015	Remeasurement Period 1 Oct. 1, 2016, to Sept. 30, 2017	Remeasurement Period 2 Oct. 1, 2017, to Sept. 30, 2018	Relative Percentage Change From Baseline	Statistical Significance
Indicator 1: The percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one prescription electronically	51.54%	59.51%	NA	8.61%	P<.001

PIP Measure	Baseline Period Oct. 1, 2014, to Sept. 30, 2015	Remeasurement Period 1 Oct. 1, 2016, to Sept. 30, 2017	Remeasurement Period 2 Oct. 1, 2017, to Sept. 30, 2018	Relative Percentage Change From Baseline	Statistical Significance
Indicator 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically	42.34%	58.19%	NA	15.07%	P<.001

CYE 2015 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-2 shows that for the integrated population baseline measurement period 51.54 percent of MMIC’s providers prescribed at least one prescription electronically and 42.34 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically. For the integrated population, MMIC’s Remeasurement 1 rate at 59.51 percent for Indicator 1 demonstrated a relative percentage change from baseline of 8.61 percent, while the Remeasurement 1 rate of 58.19 for Indicator 2 demonstrated a relative percentage change from baseline of 15.07 percent. MMIC demonstrated statistically significant improvements for both indicators for this PIP.

MMIC submitted the following qualitative analysis:

Limitations:

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

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

MMIC noted in The National Center for Biotechnology Information article, “Electronic Prescribing, “Improving the Efficiency and Accuracy of Prescribing in the Ambulatory Care Setting,” published

April 1, 2014:⁸⁻¹ “Results of this research study suggest that e-prescribing reduces prescribing errors, increases efficiency, and helps to save on healthcare costs. Medication errors have been reduced to as little as a seventh of their previous level, and cost savings due to improved patient outcomes and decreased patient visits are estimated to be between \$140 billion and \$240 billion over 10 years for practices that implement e-prescribing. However, there have been significant barriers to implementation including cost, lack of provider support, patient privacy, system errors, and legal issues.”

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

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

Lessons learned:

MMIC reported the following challenges and barriers:

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

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

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

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

MMIC-specific interventions include:

- Provided prescribers feedback regarding their rates and educated them about the importance of prescribing electronically. Seriously mentally ill (SMI) clinic prescribers were provided their rates in 2015 and early 2016. MMIC encountered limitations with connecting prescribers to the clinic where the prescriptions were prescribed. MMIC is revising the intervention and will list only prescribers and their rates.
- Educated providers using a primary care provider (PCP) outreach manual that was posted on the website and by using pharmacy newsletters.
- Provided individual provider technical assistance by email and telephone, upon request from the provider.
- Surveyed the top 10 EHR vendors used by the MMIC network to determine the extent to which EPCS was supported by the EHR software. The survey revealed that four of the 10 did not support EPCS in Arizona. MMIC will advocate with the vendors to allow EPCS.
- Included e-prescribing implementation as a required onboarding step for new integrated clinics.
- Required SMI clinics to create and implement formal written procedures to improve e-prescribing rates.

Strengths

MMIC was successful in increasing performance rates for the GMH/SA population for Indicator 1 with a rate of 59.25 percent, an increase from baseline of 6.72 percent and for Indicator 2 with a rate of 58.49 percent, an increase of 13.05 percent. MMIC was also successful in increasing performance rates for the integrated population for Indicator 1 with a rate of 59.51 percent, an increase from baseline of 8.61 percent and for Indicator 2 with a rate of 58.19 percent, an increase of 15.07 percent. MMIC provided feedback to prescribers regarding their e-prescribing rates and educated them about the importance of e-prescribing; updated their website with e-prescribing educational materials and pharmacy newsletters; and provided technical assistance by email and phone, upon request from providers. MMIC surveyed the top 10 EHR vendors used by the MMIC network to determine the extent to which e-prescribing of controlled substances was supported by the EHR software. MMIC will advocate with the vendors to allow electronic prescribing of controlled substances. The Contractor implemented a major intervention when MMIC required e-prescribing implementation as an onboarding step for new integrated clinics and required SMI clinics to create and implement formal written procedures to improve their e-prescribing rates.

Opportunities for Improvement and Recommendations

MMIC has an opportunity for improvement for the rate of providers prescribing prescriptions electronically for both populations as the rates are under the AHCCCS aggregate rate of 73.42 percent. Even though the rates for both populations for Indicator 2 are above the AHCCCS aggregate rate of 55.76 percent, an opportunity for improvement still exists.

MMIC collaborated with another acute care Contractor to survey physical health providers because they share a provider network. HSAG recommends that MMIC continue this collaboration to increase the rates for both indicators.

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

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

Cenpatico Integrated Care (CIC)

Findings

Table 8-3 presents the baseline results for the *E-Prescribing* PIP for CIC’s GMH/SA members. CYE 2017 was an intervention year for CIC; therefore, rates will not be reported.

Table 8-3—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

Table 8-4 presents the baseline results for the *E-Prescribing* PIP for CIC’s integrated members. CYE 2017 was an intervention year for CIC; therefore, rates will not be reported.

Table 8-4—CIC Integrated E-Prescribing PIP

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

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 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	59.10%	NA	NA	NA	NA

CIC submitted the following qualitative analysis:

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

Limitations:

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

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

- Handwritten prescriptions are provided to members.
- An electronic prescription is not generated or sent to the pharmacy, thereby lowering e-prescribing utilization.
- The handwritten prescription is not delivered to the pharmacy.

- Members do not receive the prescription, which lowers adherence rates and positive member outcomes.

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

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

Lessons learned:

CIC learned that quality of information, frequency, and consistency of provider education by qualified staff and pharmacists as well as quarterly feedback on provider improvements in e-prescribing are important interventions to improve performance. CIC used CAPs to improve performance for a few providers new to the network. CIC instituted VBP as an intervention to provide a financial incentive but was not able to evaluate the effect as the intervention was too new. Feedback from the provider survey CIC conducted indicated that prescribers viewed e-prescribing favorably; however, CIC noted that intervention with pharmacies to improve mechanics of e-prescribing of controlled substances may be necessary.

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

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

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

Strengths

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

Opportunities for Improvement and Recommendations

CIC has an opportunity to increase the percentage of providers prescribing electronically and prescriptions sent electronically. One intervention that CIC implemented was to identify how prescriptions are sent to pharmacies, analyzing the data monthly and providing a report that indicates all prescriptions filled through the PBM as well as the percentage sent electronically, by fax, or via other method. HSAG recommends that CIC monitor outcomes associated with this intervention as well as all interventions. In addition, HSAG recommends that CIC provide monthly updates on all interventions at the CEO meeting, especially the financial incentive and CAP interventions. Finally, HSAG recommends that AHCCCS continue the collaboration among RBHA Contractors to improve performance for these indicators.

Health Choice Integrated Care (HCIC)

Findings

Table 8-5 presents the baseline results for the *E-Prescribing* PIP for HCIC’s GMH/SA members. CYE 2017 was an intervention year for HCIC; therefore, rates will not be reported.

Table 8-5—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	62.29%	NA	NA	NA	NA

Table 8-6 presents the baseline results for the *E-Prescribing* PIP for HCIC’s integrated members. CYE 2017 was an intervention year for HCIC; therefore, rates will not be reported.

Table 8-6—HCIC Integrated E-Prescribing PIP

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

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 2: The percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider and sent electronically	54.99%	NA	NA	NA	NA

HCIC submitted the following qualitative analysis:

Limitations:

HCIC identified the following limitations:

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

Lessons learned:

HCIC expects to meet the MPS for this PIP in the next measurement. HCIC reported that the Contractor learned about the unique difficulties and barriers experienced by each provider and agency serving members. HCIC determined that differing technologies used by each agency provided specific challenges for e-prescribers. HCIC found that most providers were in support of e-prescribing as its challenges were no greater than challenges in a system where only handwritten prescriptions were used.

HCIC noted that the improvement in member safety was worth the effort of changing practices to newer technologies.

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

- Implemented a 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 the quality management meeting.
- Participated in the workgroup identifying barriers to e-prescribing. Monitored e-prescribing at the State level, with benchmarking and identification of outliers for targeted interventions. Developed standardized educational tools for all plans for consistency and ease of use.
- Published provider newsletter section titled “The Importance of E-Prescribing.”
- Continued individualized support and technical assistance for prescribers and support staff.

Strengths

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

Opportunities for Improvement and Recommendations

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

Recommendations for RBHA Contractors

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

- AHCCCS has made significant progress in making PIP process improvements in the past year, including the development of a new reporting template. AHCCCS may want to consider offering and facilitating training opportunities to enhance the RBHA Contractors' capacities to implement robust interventions, 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 systemwide 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.
- The RBHA Contractors should continue to identify and prioritize barriers so as to develop robust interventions for the *E-Prescribing* PIP.
- The RBHA Contractors are encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and prescriptions sent electronically, then adjust interventions as needed to ensure that the rates continue to increase by statistically significant amounts during the second remeasurement period.
- AHCCCS may want to consider requiring, from the RBHA Contractors, new PIPs that pertain to aspects of the Arizona Complete Care activities.

Appendix A. Validation of Organizational Assessment and Structure Performance Methodology

Objectives for Conducting the Review

AHCCCS' objectives for conducting ORs are to:

- Determine if the Contractor satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statutes, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR §438).
- Increase AHCCCS' knowledge of the Contractor's operational encounter processing procedures.
- Provide technical assistance and identify areas in which the Contractor can improve as well as areas of noteworthy performance and accomplishments.
- Review the Contractor's progress in implementing recommendations that AHCCCS made during prior ORs.
- Determine if the Contractor complied with its own policies and evaluate the effectiveness of those policies and procedures.
- Perform oversight of the Contractor as required by CMS in accordance with AHCCCS' 1115 waiver.

Provide information to HSAG as AHCCCS' EQRO to use in preparing this report as described in 42 CFR 438.364.

Methodology for Conducting the Review

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

AHCCCS' methodology for conducting the OR included the following:

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

^{A-1} Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf>. Accessed on: February 14, 2019.

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

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

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

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

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

Scoring Methodology

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

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

Corrective Action Statements

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

Contractor, describing the findings, scores, and required CAPs.

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

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

Appendix B. Validation of Performance Measure Methodology and Additional Results

In accordance with 42 CFR §438.240(b), AHCCCS requires Contractors to have a Quality Management/Performance Improvement (QM/PI) program that includes measuring and submitting data to AHCCCS related to Contractor performance. Validating MCO and PIHP performance measures is one of the three mandatory EQR activities described at 42 CFR 4§38.358(b)(2). The requirement §438.358(a) allows states, their agents that are not MCOs or PIHPs, or an EQRO to conduct the mandatory activities. MCOs/PIHPs may report performance results to a state (as required by the state), or the state may calculate the MCOs'/PIHPs' performance on the measures for the preceding 12 months. Performance must be reported by the MCOs/PIHPs—or calculated by the state—and validated annually.

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

Conducting the Review

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

Using the results and statistical analysis of Contractors' performance measure rates, HSAG organized, aggregated, and analyzed the performance data. From the analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality of, access to, and timeliness of care and services provided to AHCCCS members for CYE 2017.

Objectives for Conducting the Review

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

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

Methodology for Conducting the Review

For the CYE 2017 review period (i.e., measurement year ending September 30, 2017), AHCCCS conducted the following activities:

- Collected Contractor encounter data associated with each State-selected measure.
- Calculated Contractor-specific performance rates and statewide aggregate rates for all Contractors for each measure.
- Reported Contractor performance results by individual Contractor and a statewide aggregate.
- Compared Contractor performance rates with minimum performance standards (MPS) defined by AHCCCS' contract, if available.

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

HSAG calculated results on AHCCCS' behalf for a variety of performance measures to address different quality initiatives using the following technical specifications: NCQA's HEDIS, CMS Adult Core Set, and CMS Child Core Set. The Contractors' performance rates were calculated for AHCCCS-selected measures using administrative data collected from the automated managed care data system known as the Prepaid Medicaid Management Information System (PMMIS). The administrative methodology used for data collection in the current measurement did not differ from the methodology used for the previous measurement period. NCQA and CMS update their respective methodologies annually to add new codes to better identify the eligible populations and/or services being measured or to delete codes retired from standardized coding sets used by providers.

HSAG analyzed Contractor-specific and statewide aggregate performance results for each measure to determine if performance rates met or exceeded each corresponding AHCCCS MPS. Relative rate changes and statistical analyses are presented to show the magnitude and direction of any change in rates from the previous measurement period and whether that change was significant.

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

Performance Measure Results—RBHA Integrated SMI Contractors

The following tables include performance measure results for the RBHA Integrated SMI Contractors. The tables display the following information: CYE 2016 performance, where available; CYE 2017 performance; the relative percentage change between CYE 2016 and CYE 2017 rates, where available; the statistical significance of the relative percentage change, where available; and the AHCCCS MPS, where available. Performance measure rate cells shaded green indicate that performance met or exceeded the CYE 2017 MPS established by AHCCCS. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the established MPS are shaded green.

Cenpatico Integrated Care (CIC)

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

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (p value) ¹	MPS
Access to Care					
<i>Adults' Access to Preventive/Ambulatory Health Services</i>					
<i>Total</i>	92.0%	90.4%	-1.7%	P<0.001	75.0%
Preventive Screening					
<i>Breast Cancer Screening²</i>					
<i>Breast Cancer Screening</i>	—	NA	—	—	50.0%
<i>Chlamydia Screening in Women</i>					
<i>Total</i>	59.1%	62.9%	6.4%	P=0.550	63.0%
Behavioral Health					
<i>Follow-Up After Hospitalization for Mental Illness²</i>					
<i>7-Day Follow-Up</i>	—	65.8%	—	—	85.0%
<i>30-Day Follow-Up</i>	—	85.9%	—	—	95.0%
Utilization					
<i>Ambulatory Care (per 1,000 Member Months)</i>					
<i>ED Visits—Total*</i>	122.1	123.0	0.8%	—	—
<i>Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total</i>					
<i>Days per 1,000 Member Months (Total Inpatient)—Total</i>	187.8	67.3	-64.2%	—	—
Plan All-Cause Readmissions					
<i>Total*</i>	24.5%	23.2%	-5.3%	P=0.711	—


* A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

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

¹ Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤0.05. Significance levels (p values) in bold font indicate statistically significant values.

² Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.

— Indicates that the CYE 2016 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.

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

Health Choice Integrated Care (HCIC)

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

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (p value) ¹	MPS
Access to Care					
<i>Adults' Access to Preventive/Ambulatory Health Services</i>					
<i>Total</i>	90.7%	90.3%	-0.4%	P=0.481	75.0%
Preventive Screening					
<i>Breast Cancer Screening²</i>					
<i>Breast Cancer Screening</i>	—	NA	—	—	50.0%
<i>Chlamydia Screening in Women</i>					
<i>Total</i>	48.3%	42.3%	-12.4%	P=0.486	63.0%
Behavioral Health					
<i>Follow-Up After Hospitalization for Mental Illness²</i>					
<i>7-Day Follow-Up</i>	—	61.9%	—	—	85.0%
<i>30-Day Follow-Up</i>	—	81.0%	—	—	95.0%
Utilization					
<i>Ambulatory Care (per 1,000 Member Months)</i>					
<i>ED Visits—Total*</i>	102.7	107.2	4.3%	—	—
<i>Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total</i>					
<i>Days per 1,000 Member Months (Total Inpatient)—Total</i>	136.3	36.3	-73.4%	—	—
Plan All-Cause Readmissions					
<i>Total*</i>	16.2%	11.4%	-29.6%	P=0.378	—

* A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

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

¹ Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤ 0.05 . Significance levels (p values) in bold font indicate statistically significant values.

² Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.

— Indicates that the CYE 2016 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.

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

Mercy Maricopa Integrated Care (MMIC)

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

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (p value) ¹	MPS
Access to Care					
<i>Adults' Access to Preventive/Ambulatory Health Services</i>					
<i>Total</i>	94.0%	93.9%	-0.1%	P=0.880	75.0%
Preventive Screening					
<i>Breast Cancer Screening²</i>					
<i>Breast Cancer Screening</i>	—	38.7%	—	—	50.0%
<i>Chlamydia Screening in Women</i>					
<i>Total</i>	53.3%	49.5%	-7.1%	P=0.349	63.0%
Behavioral Health					
<i>Follow-Up After Hospitalization for Mental Illness²</i>					
<i>7-Day Follow-Up</i>	—	75.4%	—	—	85.0%
<i>30-Day Follow-Up</i>	—	89.2%	—	—	95.0%
Utilization					
<i>Ambulatory Care (per 1,000 Member Months)</i>					
<i>ED Visits—Total*</i>	147.1	146.6	-0.4%	—	—
<i>Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total</i>					
<i>Days per 1,000 Member Months (Total Inpatient)—Total</i>	481.1	86.1	-82.1%	—	—
Plan All-Cause Readmissions					
<i>Total*</i>	19.5%	23.5%	20.5%	P<0.001	—

* A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

¹ Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤ 0.05 . Significance levels (p values) in bold font indicate statistically significant values.

² Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.

— Indicates that the CYE 2016 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.

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

RBHA Integrated SMI Aggregate

Table B-4—CYE 2016 and CYE 2017 Performance Measure Results—RBHA Integrated SMI Contractors

Performance Measure	CYE 2016 Performance	CYE 2017 Performance	Relative Percentage Change	Significance Level (p value) ¹	MPS
Access to Care					
<i>Adults' Access to Preventive/Ambulatory Health Services</i>					
<i>Total</i>	92.8%	92.2%	-0.6%	P=0.004	75.0%
Preventive Screening					
<i>Breast Cancer Screening²</i>					
<i>Breast Cancer Screening</i>	—	38.7%	—	—	50.0%
<i>Chlamydia Screening in Women</i>					
<i>Total</i>	54.9%	51.5%	-6.2%	P=0.285	63.0%
Behavioral Health					
<i>Follow-Up After Hospitalization for Mental Illness²</i>					
<i>7-Day Follow-Up</i>	—	71.8%	—	—	85.0%
<i>30-Day Follow-Up</i>	—	87.7%	—	—	95.0%
Utilization					
<i>Ambulatory Care (per 1,000 Member Months)</i>					
<i>ED Visits—Total*</i>	132.3	133.1	0.7%	—	—
<i>Inpatient Utilization—General Hospital/Acute Care (per 1,000 Member Months)—Total</i>					
<i>Days per 1,000 Member Months (Total Inpatient)—Total</i>	332.1	72.8	-78.1%	—	—
Plan All-Cause Readmissions					
<i>Total*</i>	19.6%	22.7%	15.8%	P<0.001	—

* A lower rate indicates better performance for this measure; therefore, an increase in a rate indicates a decline in performance.

¹ Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrate whether the differences in performance between CYE 2016 and CYE 2017 were statistically significant. The threshold for a result being considered statistically significant is traditionally reached when the p value is ≤ 0.05 . Significance levels (p values) in bold font indicate statistically significant values.

² Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between CYE 2017 and prior years; therefore, prior years' rates are not displayed, and the relative percentage change is not calculated for this measure.

— Indicates that the CYE 2016 rate was not displayed due to technical specification changes, that a comparison of performance between CYE 2016 and CYE 2017 was not possible or appropriate, or that an MPS had not yet been established by AHCCCS.

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

Appendix C. Validation of Performance Improvement Project Methodology

Performance Improvement Project Design

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

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

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

Data Collection Methodology

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

Measurement of Significant Improvement

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

evidenced in repeated measurements of the quality indicators specified for each PIP undertaken by the Contractors.

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

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

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

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

Performance Improvement Project Time Frames

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

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

AHCCCS will conduct annual measurements to evaluate Contractor performance and may conduct interim measurements, depending on the resources required, to collect and analyze data. Contractors must include internal annual measurements/rates and results, used as the basis for analysis (both quantitative and qualitative) and selection/modification of interventions, within the Contractors' annual PIP report submissions.

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