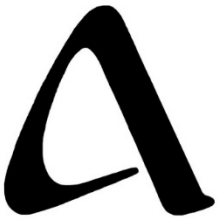
Arizona Health Care Cost Containment System



AHCCCS

2015–16 External Quality Review Annual Report

for

UnitedHealthcare Community Plan

January 2017

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

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

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

The Arizona Health Care Cost Containment System (AHCCCS), the first statewide Medicaid managed care system in the nation, continues as a national leader and innovator in designing and administering effective and efficient financing, contracting, and service delivery models for Medicaid managed care programs. The AHCCCS Contractor for the Children's Rehabilitative Services (CRS) program is UnitedHealthcare Community Plan-CRS (UHCCP-CRS).

As permitted by the Centers for Medicare & Medicaid Services (CMS) and as allowed under federal regulation, AHCCCS elected to retain responsibility for performing the three mandatory activities described in 42 CFR 438. AHCCCS prepared Contractor-specific reports of findings related to each activity and, as applicable, required its 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 EQRO to prepare this annual 2015–2016 EQR technical report. This report presents AHCCCS' and HSAG's findings from conducting each activity as well as HSAG's analysis and assessment of UHCCP-CRS' performance and, as applicable, recommendations to improve this Contractor's performance.

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

To meet the requirements of 42 CFR 438.358(b), as the EQRO, HSAG must use the information AHCCCS obtained and provided to it, as well as information from the activities HSAG conducted, to prepare and provide to AHCCCS its EQRO annual technical report. The report must include, at a minimum, HSAG's:

- Analysis of the data and information.
- Conclusions drawn from the analysis of the quality and timeliness of, and access to, Medicaid managed care services provided to members by UHCCP-CRS.
- Recommendations for improving UHCCP-CRS service quality, timeliness, and access.

This is the second year that HSAG has prepared the annual report for UHCCP-CRS for AHCCCS. The report complies with requirements set forth at 42 CFR 438.364.

This Executive Summary includes an overview of HSAG's EQR and a high-level summary of the results. The results include a description of HSAG's findings with respect to performance by UHCCP-CRS in complying with AHCCCS contract requirements and the applicable federal 42 CFR 438 requirements for each activity. Additional sections of this EQR annual report include the following:

- Section 2—An overview of the history of the AHCCCS program and a summary of AHCCCS' quality assessment and performance improvement (QAPI) strategy goals and objectives.
- Section 3—A description of the 2015–2016 EQR activities.
- Section 4—An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care programs and those that are specific to the CRS program.
- Section 5—An overview of UHCCP-CRS' best and emerging practices.
- Section 6 (Organizational Assessment and Structure Performance)—A presentation of findings for UHCCP-CRS in complying with select AHCCCS contract requirements, and as applicable, HSAG's recommendations to improve UHCCP-CRS' performance and members' timely access to quality care and services.
- Section 7 (Performance Measure Performance)—A presentation of the AHCCCS-selected performance measure for UHCCP-CRS and HSAG's associated findings and recommendations.
- Section 8 (Performance Improvement Project Performance)—A presentation of UHCCP-CRS' results for its AHCCCS-selected and required PIP and HSAG's associated findings and recommendations.

Overview of the 2015–2016 External Review

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

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

Organizational Assessment and Structure Standards

Contract year ending (CYE) 2013 began a three-year cycle of operational reviews, and within this cycle AHCCCS conducted an operational review (OR) for UHCCP-CRS in CYE 2014. The result of that review was included in the previous EQR annual technical report. For CYE 2015, AHCCCS conducted a focused OR that targeted specific standards for review based on a combination of UHCCP-CRS' 2014 OR results and status of the applicable CAPs. AHCCCS assigned the applicable performance designation to the Contractor's performance:

- *Full Compliance* (FC): Standards scored as 90 through 100 percent compliant
- *Substantial Compliance* (SC): Standards scored as 75 through 89 percent compliant
- *Partial Compliance* (PC): Standards scored as 50 through 74 percent compliant
- *Noncompliance* (NC): Standards scored as 0 through 49 percent compliant

The Contractor was required to develop a CAP, submit it to AHCCCS for review and approval, and implement the corrective actions for any standard for which AHCCCS evaluated performance as less than fully compliant.

Findings

Table 1-1 presents the overall compliance results and the results for each of the four categories of OR standards.

Table 1-1—Overall Compliance Results

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance	Percentage of Full Compliance
Claims and Information Systems	3	0	0	1	2	0
Maternal and Child Health and EPSDT*	3	3	0	0	0	100%
Medical Management	1	0	0	1	0	0
Quality Management	4	4	0	0	0	100%
Totals	**11**	**7**	**0**	**2**	**2**	**64%**
% Totals		**64%**	**0%**	**18%**	**18%**	

* Early and Periodic Screening, Diagnosis, and Treatment.

For this focused OR, AHCCCS reviewed a total of eleven standards within four categories of standards. UHCCP-CRS was in full compliance in seven of the standards—in the four categories or 64 percent of the time—including all of the standards reviewed for Maternal and Child Health and EPSDT and

Quality Management. For both Claims and Information Systems and Medical Management (four standards total) UHCCP-CRS received *Noncompliance* and *Partial Compliance* scores only. UHCCP-CRS has submitted CAPs to AHCCCS for these standards, which will be reevaluated for compliance at the next OR.

Conclusions

UHCCP-CRS was fully compliant in only 64 percent of areas reviewed in the focused OR. The Claims and Information Systems was most problematic, with no standards in substantial or full compliance. The areas of concern were that UHCCP-CRS' remittance advice to providers did not contain the minimum required information and did not pay applicable interest on all claims, including overturned claim disputes. In the Medical Management area, UHCCP-CRS had difficulty with implementation and monitoring of the process for meaningful use of member-specific data supplied by AHCCCS to improve coordination of care and individual outcomes. UHCCP-CRS will need to follow AHCCCS' recommendations to bring these areas into compliance.

Recommendations

AHCCCS had the following recommendations in the Claims and Information Systems and Medical Management areas:

Claims and Information Systems

- The Contractor and its subcontractor's remits must adequately include instructions for the submission of resubmitted claims and the reason for denied or adjusted payments. The Contractor's remits must include the amount billed and adequate description of the reasons for all denials and adjustments.
- The Contractor must ensure it pays applicable interest on all claims, including overturned claim disputes.
- The Contractor must pay the correct contracted rates for its contracted provider and, in the absence of a written negotiated rate, reimburse out-of-network providers pursuant to ARS §36-2903, 2904, and 2905.01.

Medical Management

- The Contractor must enhance the documentation of the care coordination process of the members identified as high-need/high-cost. Specific member interventions and resulting outcomes must be reported to the Health Quality Utilization Management (HQUM) Committee.

Performance Measures

AHCCCS collected data and reported Contractor performance for a set of performance measures selected by AHCCCS. Due to the limited population served under the CRS program, AHCCCS selected

a subset of 21 measures to be reported by UHCCP-CRS. As CYE 2014 performance measure results are still being reviewed by AHCCCS and its Contractor, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.

Findings

Table 1-2 presents UHCCP-CRS' CYE 2014 performance measure rates for each measure with an applicable minimum performance standard (MPS). CYE 2014 was a baseline reporting year for several measures, and no MPS had yet been established for each of these measures. Measure rates for measures without an established MPS are found in the "Performance Measure Performance" section of this report.

Table 1-2—Performance Measurement Review for UHCCP-CRS

Performance Measure	CYE 2014 Performance*	Minimum Performance Standard
Adolescent Well-Care Visits	37.8%	41.0%
Annual Dental Visits—2–21 Years	64.0%	65.0%
Children's Access to Primary Care Practitioners (PCPs)—12–24 Months	97.4%	93.0%
Children's Access to Primary Care Practitioners (PCPs)—25 Months–6 Years	90.3%	84.0%
Children's Access to Primary Care Practitioners (PCPs)—7–11 Years	NA	83.0%
Children's Access to Primary Care Practitioners (PCPs)—12–19 Years	NA	82.0%
Well-Child Visits in the First 15 Months of Life—6+ Visits	NA	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.3%	66.0%
* CYE 2014 performance measure results are still under review by AHCCCS and its Contractors; therefore, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.		

As seen in Table 1-2, comparison to an MPS was only possible for each of five measures in CYE 2014. UHCCP-CRS' performance for the *Children's Access to Primary Care Practitioners—12–24 Months* and *25 Months–6 Years* indicators were demonstrated strengths for the Contractor as these measures each met the corresponding established AHCCCS MPS for CYE 2014.

Of the eight measures with an applicable MPS, three measures (*Adolescent Well-Care Visits; Annual Dental Visits—2–21 Years*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) did not meet the CYE 2014 AHCCCS MPS. The remaining three reported measures with an established CYE 2014 AHCCCS MPS did not meet eligible population requirements for the measure; therefore, rates were not calculated and were reported as "NA." Thirteen measures reported by UHCCP do not yet each have an AHCCCS CYE 2014 MPS; therefore, none of these rates were compared to an established MPS.

Conclusions

CYE 2014 introduced 21 new measures for reporting for the CRS population. Although this is the first year of reporting for these measures, UHCCP-CRS shows potential for positive future performance as most reported rates with a corresponding MPS that did not meet the standard were within 6 percentage points of that MPS.

Recommendations

With three measures each with a rate failing to meet an established AHCCCS MPS, UHCCP-CRS has opportunities for improvement following the CYE 2014 performance measurement period. HSAG recommends that UHCCP-CRS focus efforts on improving well-child visits and well-care visits for adolescents. HSAG also recommends that UHCCP-CRS analyze any improvement strategies that could be linked to the overall success of measures related to children's access to primary care. Further, HSAG suggests that UHCCP-CRS monitor performance with regard to annual dental visits for members ages 2 through 21. Results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Performance Improvement Projects (PIPs)

In CYE 2011, AHCCCS approved a PIP, *Electronic Health Information Performance Improvement Project for Members Receiving Children's Rehabilitative Services*,[1-1] for the Arizona Department of Health Services, the Children's Rehabilitative Services (CRS) Contractor at that time. In CYE 2012, UHCCP-CRS became the CRS Contractor and opted to continue the PIP. The PIP was focused on system development and implementation for the use of electronic health records (EHRs) by CRS providers. Progress was measured by assessing the percentage of CRS members with lab data in the EHR system within 90 days of enrollment into CRS. However, some issues with the provision of data prohibited UHCCP-CRS from reporting data in the second remeasurement period. Consequently, AHCCCS approved a one-year extension of the PIP. Relevance of comparing data to the original baseline period would have become less clear each year however, so the PIP was concluded. Overall, this PIP has been successful in that the percentage of members with lab values transmitted within 90 days of date of service was higher for each measurement period following the baseline, providing the framework for detailed analysis and review of the processes each year. In CYE 2016, UHCCP-CRS will begin deployment of a different web-based interface which, in conjunction with deployments of value-based contracts, will increase the ability and desire for timely lab data for each member.

In CYE 2015, after research noted an opportunity to improve preventable errors occurring through the use of standard, handwritten prescriptions, AHCCCS implemented a new PIP, *E-Prescribing*, for all lines of business, after research noted an opportunity to improve preventable errors in the use of standard handwritten prescription by alternately using an electronic system for communicating between physician and pharmacy about new medications or changes in medications. The purpose of the *E-*

[1-1] This PIP is also referred to as the *Laboratory Data in the Electronic Health Record (EHR)* PIP.

Prescribing PIP is to increase the number of providers electronically prescribing prescriptions 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 electronic prescriptions and the number of electronic prescriptions submitted, followed by increased sustainment for one year.

Findings

The *E-Prescribing* PIP's baseline measurement period covered CYE 2014 (data from October 1, 2013, through September 30, 2014). UHCCP-CRS had a baseline rate of 50.47 percent for Indicator 1, the percentage (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one electronic prescription; and 43.02 percent for Indicator 2, the percentage (overall and by Contractor) of prescriptions prescribed by an AHCCCS-contracted provider sent electronically.

In CYE 2015 UHCCP-CRS participated in an e-prescribing Workgroup (Workgroup) with other Arizona MCOs. The Workgroup discussed barriers to e-prescribing; conducted a survey of 100 providers to gain insight into the barriers to e-prescribing that providers encountered; and, since some surveyed providers had no system that supported controlled substances e-prescribing, surveyed electronic medical record vendors. The surveys identified barriers that demonstrated a need for provider and member education about the benefits of e-prescribing.

UHCCP-CRS initiated two interventions in CYE 2015: developing reports that ranked providers with the greatest volume of prescriptions and the lowest e-prescribing rates and then targeting those physicians for education. In addition, UHCCP-CRS held provider forums and engagement meetings about the benefits of e-prescribing and promoted its use.

Conclusions

This was the baseline reporting period; therefore, no conclusions have been identified in UHCCP-CRS' PIP.

Recommendations

No previous performance data exist with which to compare Contractor performance; therefore, no opportunities for improvement in UHCCP-CRS' performance have been identified. HSAG recommends that UHCCP-CRS continually monitor the PIP to determine whether or not interventions are successful.

2. Background

This section of the report includes a brief history of the AHCCCS Medicaid managed care programs and a description of AHCCCS' QAPI strategy. The description of the QAPI strategy summarizes AHCCCS':

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

History of the AHCCCS Medicaid Managed Care Program

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

AHCCCS operates under a federal 1115 Research and Demonstration Waiver that allows for the operation of a total managed care model that mainstreams members and allows them to select their providers. AHCCCS was the first statewide Medicaid managed care system in the nation and has operated under this waiver since 1982 when its Acute Care program began. In December 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.

Arizona's Children's Rehabilitative Services (CRS) was started in 1929 to serve children with complex healthcare needs who require specialized services. There are specific qualifying conditions that determine whether a child is eligible for CRS. Prior to October 1, 2013, the CRS program was a "carve-out" program and children eligible for AHCCCS were enrolled with an Acute Care or Long-term Care Contractor for their primary healthcare needs and with the CRS Contractor for the care of their CRS-qualifying condition. In addition, behavioral health services were obtained by a third system of care (through the Department of Health Services behavioral health contractor). AHCCCS sought and received approval from CMS in January 2013 to amend the State's 1115 waiver to allow the state to create one single statewide CRS managed care organization. CRS-eligible children are now enrolled into one MCO for their CRS, acute care, and behavioral health needs.

The CRS integrated contract was successfully implemented on October 1, 2013. AHCCCS conducted multiple activities over a six-month period from May to October 2013 to ensure a smooth transition for the Contractor, UnitedHealthcare Community Plan, UHCCP-CRS. After the implementation date, AHCCCS continued to monitor the Contractor via AHCCCS' standard oversight mechanisms.

AHCCCS Strategic Plan

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

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

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

AHCCCS' Strategic Goals and related Strategies are as follows:

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

- Increase transparency by providing relevant financial and quality information.

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

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

AHCCCS must pursue continuous quality improvement.

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

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

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

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

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

AHCCCS Quality Strategy

The U.S. Department of Health and Human Services CMS Medicaid managed care regulations at 42 CFR 438.200 and 438.202 implement Section 1932(c)(1) of the Medicaid managed care act, defining certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of 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 must, in part:

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

AHCCCS has had a formal QAPI plan in place since 1994; established and submitted an initial quality strategy to CMS in 2003; and has continued to update and submit revisions of the strategy as needed to CMS. AHCCCS' QAPI strategy was last revised in October 2012. AHCCCS administration oversees the overall effectiveness of its QAPI strategy with several divisions/offices within the agency sharing management responsibilities. For specific initiatives and issues, AHCCCS frequently involves other internal and/or external collaborations/participants. Due to the anticipated release date of the Final Rule for Medicaid managed care, AHCCCS chose to suspend any further revisions to its Quality Strategy until final guidance was available from CMS. To avoid duplication of effort, AHCCCS anticipates completing a comprehensive review of its Quality Strategy after the Final Rule is released.

Quality Strategy Scope, Goals, and Objectives

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

AHCCCS uses a workgroup model for considering and deciding whether to add new clinical or nonclinical projects for enhancing the well-being of its members. The first step is to review the current components of AHCCCS' quality initiatives and examine the various processes in place to develop, review, and revise quality measures. Following the review, the workgroup reviews AHCCCS' materials that define and illustrate the agency's focus on quality, its approach to quality improvement, and existing quality measurement initiatives and processes. AHCCCS is also diligent in identifying and

incorporating opportunities to improve care coordination through designing new or enhancing current projects and programs that include more than one aspect of a member's healthcare needs.

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

- Facilitating stakeholder involvement through venues such as collaborative relationships with sister agencies, such as the Arizona Department of Health Services and the Arizona Department of Economic Security; task forces, such as the Fetal Alcohol Spectrum Disorder Task Force; and agencies dedicated to specific issues, such as the Behavioral Health Children's Executive Committee.
- Developing and accessing the quality and appropriateness of member care and services, including identifying priority areas for improvement; establishing realistic outcome-based performance measures; identifying, collecting, and assessing relevant data; providing incentives for excellence; imposing sanctions for poor performance; and sharing best practices.
- Including medical quality assessment and quality improvement requirements in AHCCCS contracts (e.g., including all federally required elements in contracts and monitoring related performance).
- Regularly monitoring and evaluating Contractor compliance and performance by conducting desk- and on-site operational and financial reviews; reviewing required Contractor deliverables; and reviewing, analyzing, and validating required Contractor performance measures and PIP results.
- Maintaining an information system that supports initial and ongoing operations and review of the established quality strategy through the use of an automated statewide managed care data system that supports the processing, reporting, research, and project needs of AHCCCS and the Contractors.
- Reviewing, revising, and beginning new projects in any given area of the quality strategy, such as identifying needs for new projects or initiatives based on information from performance results, stakeholder input, and new mandates.
- Involving the public, such as the State Medicaid Advisory Committee, physicians, and others associated with the medical community at large, and other State agencies.
- Frequently evaluating the quality strategy to ensure that it remains aligned with new federal and State regulations/mandates, programs, funding, technologies, and opportunities for improvement.

Operational Performance Standards

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

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

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

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

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

Performance Measure Requirements and Targets

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

For all lines of business, AHCCCS developed new performance measures that became effective October 1, 2014, which aligned with the start of a new contract period. This allowed AHCCCS to align with the CMS measure sets for the Children's Health Insurance Program Reauthorization Act (CHIPRA) Core Measure Set, the Adult Core Measure Set, and Meaningful Use.

It is AHCCCS' goal to continue to develop and implement additional core measures as the data become available. Initial measures were chosen based on a number of criteria that included the greatest need for members, system ability to impact/improve results, alignment with national measure sets, and comparability across lines of business. AHCCCS anticipates that transitioning the measure sets will support the adoption of EHRs and the use of the health information exchange, resulting in efficiencies and data/information that will transform care practices, improve individual member outcomes and population health management, improve member satisfaction, and reduce costs.

AHCCCS has undergone extensive planning efforts, including barrier and risk identification, in its effort to implement the performance measure transition. To assist in the transition and to reduce risks that AHCCCS identified, AHCCCS contracted with HSAG to perform the measurement calculations for the

CYE 2014 measurement period. Contractors will be given data for planning and implementation efforts. Workgroups, new reporting mechanisms, increased opportunities for technical assistance, and a more transparent reporting process are all efforts to assist the plans prior to the end of the measurement period, allowing them to make the necessary adjustments and payment reform initiatives that align with the performance measure thresholds. Finally, AHCCCS has contracted with a vendor that is capable and interested in partnering to develop and implement measures from the CMS Core and other measures sets in addition to maintaining the traditional HEDIS measures.

Performance Improvement Project Requirements and Targets

AHCCCS' QAPI strategy described the agency's requirements and processes to ensure that Contractors conduct PIPs, which the QAPI defined as "a planned process of data gathering, evaluation, and analysis to design and implement interventions or activities that are anticipated to have a positive outcome"—i.e., to improve the quality of care and service delivery. AHCCCS encourages its Contractors to conduct PIPs for topics that they select (e.g., increasing screening of blood lead levels for children, improving timeliness of prenatal care). However, AHCCCS also selects PIPs that the Contractors must conduct.

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

3. Description of EQR Activities

Mandatory Activities

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

- Validate Contractor PIP—Validation performed by AHCCCS.
- Validate Contractor performance measures—Validation performed by AHCCCS.
- Review Contractor performance in complying with the AHCCCS contract requirements and the federal Medicaid managed care regulations cited at 42 CFR 438.358—Review performed by AHCCCS.

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the three mandatory activities for UHCCP-CRS and to prepare this CMS-required 2015–2016 external quality review annual report of findings and recommendations.

Optional Activities

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

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

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

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

AHCCCS Quality Initiatives

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

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

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

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

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

into an agreement with the Health Information Network of Arizona (HINAz) to begin using its Health Information Exchange (HIE) services.

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

Selecting and Initiating New Quality Improvement Initiatives

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

In selecting and initiating new quality improvement initiatives, AHCCCS:

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

Collaboratives/Initiatives

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

- CRS Referral and Care Coordination: AHCCCS has continued to work with UHCCP-CRS and Acute Care Contractors to ensure timely referral and care coordination for children with special healthcare needs. AHCCCS worked with stakeholders to determine how to better serve this special needs population and continues to work with UHCCP-CRS to ensure that timely and appropriate care is delivered to children enrolled in CRS.
- Behavioral Health: Arizona's Children's Executive Committee (ACEC): The ACEC is composed of multiple state and government agencies (including AHCCCS), community organizations, and family members of children/youth with behavioral health needs. These organizations and individuals work together to ensure that behavioral health services are provided to children and families according to the Arizona Vision and 12 Principles of the Children's System of Care regarding behavioral health services. ACEC strives to create and implement a successful system of behavioral health care in Arizona by serving as a State link for local, county, tribal, and regional teams.
- The Arizona Partnership for Immunization (TAPI): AHCCCS Quality Management staff regularly attend TAPI Steering Committee meetings and subcommittee meetings for community awareness, provider issues, and adult immunizations. TAPI regularly communicates immunization trends and best practices to AHCCCS and its Contractors.
- Arizona Diabetes Steering Committee: The Committee is responsible for increasing adherence to evidence-based guidelines, guiding efforts to improve State policy, and implementing the Chronic Disease Self-Management Program. AHCCCS is a member of the Steering Committee and the Diabetes Coalition and works to align Medicaid policy with Statewide efforts.
- Arizona Health-e Connection/Arizona Regional Extension Center: Arizona Health-e Connection (AzHeC) is a public-private community agency geared toward promotion of and provider support for EHR integration into the healthcare system. AzHeC is a key partner with AHCCCS in promoting the use of HIT, as well as Arizona's health information exchange. As a subset of AzHeC, the Arizona Regional Extension Center provides technical assistance and support to Medicare- and Medicaid-eligible professionals working to adopt, implement, or upgrade an EHR in their practices and/or to achieve Meaningful Use in order to receive monetary payments through State (Medicaid) and national (Medicare) EHR incentive programs. The long-term goal is to be able to use this technology for quality improvement purposes and to improve outcomes for AHCCCS members. One of the first steps in using electronic health records occurs with the Childhood Obesity Learning Collaborative, wherein federally qualified health center EHR data will be used to for the initiative.

  Value-Based Purchasing (VBP) Initiatives: AHCCCS is promoting a number of VBP initiatives for both providers and Contractors. Implementation of initiatives is now contractually mandated, with requirements increasing each year. Additionally, AHCCCS leverages VBP strategies with the Contractors on certain performance measures, strengthening the focus on initiatives that AHCCCS deems most meaningful to the populations served.

- ICD-10 implementation—While ICD-10 implementation was a national requirement, AHCCCS conducted extensive testing leading up to the implementation, resulting in a seamless transition. AHCCCS and Contractor technical teams worked closely together to ensure that the implementation was ready, further highlighting the benefit of having strong relationships with Contractors.

5. Contractor Best and Emerging Practices

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

- UHCCP-CRS' Member Advisory Committee (MAC) obtains member input and feedback regarding quality initiatives, findings, program changes, and care provided to members. It also serves as a collaborative forum for members, community representatives, advocacy groups, and community-based providers to address member needs.
- UHCCP-CRS' behavioral health coordinator (BHC), in conjunction with the provider network advocate, assists in educating primary care physicians (PCPs) regarding the PCP's requirement to provide continuity of care and appropriate transition to the RBHA or appropriate CRS behavioral health provider for members that need a referral for a behavioral health assessment and ongoing treatment. UHCCP-CRS educates PCPs about their responsibility in treating attention deficit hyperactivity disorder (ADHD), depression, and anxiety. UHCCP-CRS provides the education through the provider manual, individual provider training/outreach, provider newsletters, provider forums, and other provider communications. In conjunction with the BHC, UHCCP-CRS' Quality Management department conducts medical record reviews (MRRs) in order to ensure that PCPs' treatment of behavioral health disorders is within their scope and coordinates care with the RBHA or CRS behavioral health provider, as appropriate. In addition, UHCCP-CRS conducts MRRs for behavioral health medical professionals in order to monitor care or services provided to members and to meet AHCCCS standards.
- UHCCP-CRS conducts community events promoting healthy living and preventive behaviors for its members and their communities. UHCCP-CRS promotes the events in advance to ensure strong participation, with outreach activities initiated prior to the tour to increase facility visitation by members in need of services. The community events include fun, healthy, physical activities and are open to UHCCP-CRS members and non-members.
- UHCCP-CRS' UnitedHealthcare Oral Health Education Program connects dental department staff with the UHCCP-CRS' Community Outreach Team to provide on-site education for children ages 4 through 17 within targeted school or district settings. Education includes preventive care as well as promotion of yearly visits to the dentist. Children are given toothbrushes, toothpaste, floss, and incentives to visit their dental home or primary care dentists.

6. Organizational Assessment and Structure Performance

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

AHCCCS has extensive experience preparing for, conducting, and reporting findings from its reviews of Contractors' performance in complying with federal and AHCCCS requirements. As permitted by 42 CFR 438.258(a), AHCCCS elected to conduct the functions associated with the federal Medicaid managed care requirements mandatory compliance review activity. 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 AHCCCS obtained from its compliance review activities to prepare this section of the annual EQR report.

CYE 2013 commenced a new, three-year cycle of ORs, and AHCCCS conducted a comprehensive OR for UHCCP-CRS during CYE 2014. During CYE 2015, AHCCCS monitored UHCCP-CRS' progress in implementing its CAPs for the recommendations from the 2014 OR. In addition, AHCCCS conducted a focused OR that targeted specific standards for review based on a combination of the UHCCP-CRS' 2014 OR results. AHCCCS elected not to perform a CAP follow-up process for the CYE 2015 focused OR; however, AHCCCS made it clear to the plans that the expectation was that any issues identified would be addressed and corrected. AHCCCS will follow up at the next full OR.

The results of the focused OR are described in this section of the annual EQR Report.

Conducting the Review

For the CYE 2015-focused OR, AHCCCS reviewed specific standards in the following categories, as indicated below.

- Claims and Information Systems—Three standards
- Maternal and Child Health and EPSDT—Three standards
- Medical Management—One standard
- Quality Management—Four standards

Further details regarding the standards reviewed are listed with the UHCCP-CRS' results.

Objectives for Conducting the Review

AHCCCS' objectives for conducting ORs are to:

- Determine if UHCCP-CRS satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statute, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR Part 438).
- Increase AHCCCS' knowledge of UHCCP-CRS' operational encounter processing procedures.
- Provide technical assistance and identify areas where UHCCP-CRS can improve, as well as areas of noteworthy performance and accomplishments.
- Review UHCCP-CRS' progress in implementing recommendations AHCCCS made during prior ORs.
- Determine if UHCCP-CRS complied with its own policies and evaluate the effectiveness of those policies and procedures.
- Perform oversight of UHCCP-CRS 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 UHCCP-CRS 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.[6-1]

AHCCCS' methodology for conducting the OR included the following:

- Review activities that AHCCCS conducted to assess UHCCP-CRS' performance.
- Reviewing documents and deliverables the Contractor was required to submit to AHCCCS.
- Conducting interviews with key Contractor administrative and program staff.
- Activities AHCCCS conducted following the review, including:
- Documenting and compiling the results of its review, preparing the draft report of findings, and issuing the draft report to UHCCP-CRS for its review and comment. In the report, each standard and substandard was individually listed with the applicable performance designation based on AHCCCS'

[6-1] 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: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: June 28, 2016.

review findings and assessment of the degree to which UHCCP-CRS was in compliance with the standards. Performance designations were as follows:

- Full compliance (FC): 90 percent to 100 percent compliant
- Substantial compliance (SC): 75 percent to 89 percent compliant
- Partial compliance (PC): 50 percent to 74 percent compliant
- Noncompliance (NC): 0 percent to 49 percent compliant

- Compiling a report to send to UHCCP-CRS that included, when applicable, AHCCCS recommendations, which began with one of the following three phrases:
  - UHCCP-CRS must …. This statement indicates a critical noncompliant area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
  - UHCCP-CRS should …. This statement indicates a noncompliant area that must be corrected to be in compliance with the AHCCCS contract but is not critical to the day-to-day operation of UHCCP-CRS.
  - UHCCP-CRS should consider …. This statement is a suggestion by the review team to improve the operations of UHCCP-CRS but is not directly related to contract compliance.
- Reviewing and responding to any UHCCP-CRS challenges to AHCCCS' draft report findings and, as applicable based on AHCCCS' review of the challenges, revising the draft report.
- Issuing the final report to UHCCP-CRS describing the findings, scores, and required Correction Action Plans (CAPs) for each standard AHCCCS reviewed.

AHCCCS' review team members included employees of the Division of Health Care Management (DHCM) in medical and case management, operations, and clinical quality management units.

As needed throughout the preparation of this report, AHCCCS clarified any remaining questions regarding accuracy and completeness of the data and information that HSAG intended to 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 UHCCP-CRS. HSAG then analyzed the data by performance category (e.g., Quality Management).

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

Findings

For CYE 2015, AHCCCS conducted a focused OR that targeted four categories of OR standards. Within these standard categories, AHCCCS chose specific sub-standards to be reviewed. Table 6-1 presents the overall compliance results and results for each standard reviewed.

Table 6-1—Category of Standards and Compliance Scores for UHCCP-CRS

Category of Standards	Total No. of Standards	Full Compliance	Substantial Compliance	Partial Compliance	Non-compliance
Claims and Information Systems	3	0	0	1	2
Maternal and Child Health and EPSDT	3	3	0	0	0
Medical Management	1	0	0	1	0
Quality Management	4	4	0	0	0
Totals	**11**	**7**	**0**	**2**	**2**
% Totals		**64%**	**0%**	**18%**	**18%**

Table 6-1 illustrates the following compliance scores for the 11 standards reviewed for the UHCCP-CRS focused OR:

- Maternal and Child Health and EPSDT: *Full Compliance* for the three standards reviewed.
- Quality Management: *Full Compliance* for the four standards reviewed.
- Claims and Information System: For the three standards reviewed, UHCCP-CRS received one *Partial Compliance* score and two *Noncompliance* scores.
- Medical Management: For the one standard reviewed, UHCCP-CRS received one *Partial Compliance* score.

Strengths

For this focused review AHCCCS reviewed a total of 11 standards in four categories. The Contractor was fully compliant in the four standards reviewed for Quality Management and the three standards reviewed for Maternal and Child Health and EPSDT.

Opportunities for Improvement and Recommendations

The results of the focused OR demonstrated opportunities for improvement as UHCCP-CRS was less than fully compliant in the three standards reviewed for Claims and Information Systems and the one

standard reviewed for Medical Management. In the report generated from UHCCP-CRS' OR, AHCCCS included recommendations for UHCCP-CRS which necessitated that corrective action plans be submitted. AHCCCS included the following recommendations in the final OR report to UHCCP-CRS.

Claims and Information Systems

- The Contractor's and its subcontractors' remits must adequately include instructions for the submission of resubmitted claims and the reason for denied or adjusted payments. The Contractor's remits must include the amount billed and adequate description of the reasons for all denials and adjustments.
- The Contractor must ensure that it pays applicable interest on all claims, including overturned claim disputes.
- The Contractor must pay the correct contracted rates for its contracted provider and, in the absence of a written negotiated rate, reimburse out-of-network providers pursuant to ARS §36-2903, 2904, and 2905.01.

Medical Management

- The Contractor must enhance documentation of the care coordination process of members identified as high-need/high-cost. Specific member interventions and resulting outcomes must be reported to the Health Quality Utilization Management (HQUM) Committee.

Summary

For this focused OR, AHCCCS reviewed a total of eleven standards within four categories of standards. UHCCP-CRS was fully compliant for all standards reviewed for Maternal and Child Health and EPSDT and Quality Management (seven standards). For both Claims and Information Systems and Medical Management (four standards total) UHCCP-CRS received *Partial Compliance* and *Noncompliance* scores only. UHCCP-CRS has submitted corrective action plans to AHCCCS for these standards, which will be reevaluated for compliance at the next OR.

7. Performance Measure Performance

In accordance with 42 CFR 438.240(b), AHCCCS requires Contractors to have a QAPI program that includes measuring and submitting to AHCCCS data related to Contractor performance. Validating MCO and PIHP performance measures is one of the three mandatory EQR activities described at 42 CFR 438.358(b)(2). The requirement at 438.358(a) allows states, their agents that are not MCOs or PIHPs, or an EQRO to conduct the mandatory activities. MCOs/PIHPs can report performance results to a state (as required by the state), or the state can 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 438.258(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 AHCCCS obtained from its performance measure calculation and its data validation activities to prepare this 2015–2016 annual report.

Conducting the Review

AHCCCS contracted with UnitedHealthcare Community Plan-Children's Rehabilitative Services (UHCCP-CRS) to provide Children's Rehabilitative Services (CRS) Program services to eligible Medicaid members. HSAG calculated the measure rates for CYE 2014, and AHCCCS approved the validated rates for inclusion in this report for the following measures for the CRS population:

- *Adolescent Well-Care Visits*
- *Ambulatory Care—Emergency Department (ED) Visits—Total per 1,000 Member Months*
- *Annual Dental Visits—2–21 Years*
- *Children's Access to Primary Care Practitioners (PCPs) (12–24 Months, 25 Months–6 Years, 7–11 Years,* and *12–19 Years)*
- *Developmental Screening in the First Three Years of Life (1 Year, 2 Years, 3 Years,* and *Total)*
- *Inpatient Utilization—General Hospital/Acute Care per 1,000 Member Months (Total Inpatient, Maternity, Surgery,* and *Medicine)*
- *Plan All-Cause Readmissions (18–64 Years of Age, 65+ Years of Age,* and *Total)*
- *Well-Child Visits in the First 15 Months of Life—6+ Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Using results of the Contractor's performance rates provided by AHCCCS, HSAG organized, aggregated, and analyzed the CYE 2014 results. From its analysis, HSAG drew conclusions about

UHCCP-CRS' performance related to the quality and timeliness of care and services as well as access to care and services provided to AHCCCS members.

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 UHCCP-CRS.
- Collected Contractor data for use in evaluating performance measure rates.

Methodology for Conducting the Review

For the review period of CYE 2014 (i.e., measurement year ending September 30, 2014) AHCCCS conducted the following activities:

- Collected Contractor encounter data associated with each State-selected measure and associated Contractor-reported data collected from member medical and/or case management records.
- Performed encounter data validation according to industry standards.
- Reported Contractor performance results by individual Contractor.
- Compared Contractor performance rates with standards defined by AHCCCS' contract.

Corrective action plans (CAPs) are key components of the AHCCCS Quality Strategy and general quality improvement processes used as foundational elements to improve performance rates below contractual minimum performance standards. At the time of the production of this report, AHCCCS had not yet formally placed CAPs on Contractors for CYE 2014 data. As a result, no CAP data are included in the report for this year.

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).

AHCCCS analyzed UHCCP-CRS' performance results for each measure to determine if performance rates met or exceeded AHCCCS' minimum performance standard (MPS). As this was the first year of reporting for these measures, AHCCCS was unable to perform any trending of Contractor performance over time; however, in future years AHCCCS will also analyze the direction of any change in rates from previous measurement periods and whether the change was statistically significant.

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

It is important to note that AHCCCS reports performance measure rates as percentages with one decimal place. While AHCCCS follows mathematical rules in rounding values to obtain a single decimal place, an exception is made when the rounded value results in a different, generally higher, integer percentage. For cases in which rounding would change the integer portion of the percentage, the results are truncated after the first decimal place. As an example of this rule, a calculated rate of 74.37 percent would be reported as 74.4 percent. However, a calculated rate of 74.99 percent would be reported as 74.9 percent because rounding would change the value to 75.0 percent. As a result of this reporting practice, calculations using accepted rounding rules may not align with the performance measure rates reported by AHCCCS.

The following sections describe HSAG's findings, conclusions, and recommendations for UHCCP-CRS.

Results

AHCCCS provided data to HSAG on the CYE 2014 performance measure rates for UHCCP-CRS. CYE 2014 was the first year that UHCCP-CRS reported rates for these measures; therefore, historical rates are not available. As CYE 2014 performance measure results are still being reviewed by AHCCCS and its Contractors, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization. The performance measures reported by the UHCCP-CRS are listed in the "Conducting the Review" section preceding. No CAPs were discussed in the report this year.

Findings

Table 7-1 presents the performance measure rates for UHCCP for members enrolled in the CRS program. The table displays the CYE 2014 performance measure rate and the applicable AHCCCS CYE 2014 MPS. A CYE 2014 performance of "NA" indicates the denominator was too small (<30) to report a valid rate.

Table 7-1—Performance Measurement Review for UHCCP-CRS

Performance Measure	CYE 2014 Performance*	Minimum Performance Standard
Adolescent Well-Care Visits	37.8%	41.0%
Ambulatory Care—ED Visits—Total per 1,000 Member Months	58.0	—
Annual Dental Visits—2–21 Years	64.0%	65.0%
Children's Access to Primary Care Practitioners (PCPs)	91.2%	**
12–24 Months	97.4%	93.0%
25 Months–6 Years	90.3%	84.0%

Performance Measure	CYE 2014 Performance*	Minimum Performance Standard
7–11 Years	NA	83.0%
12–19 Years	NA	82.0%
Developmental Screening in the First Three Years of Life	9.6%	—
1 Year	3.2%	—
2 Years	3.7%	—
3 Years	17.4%	—
Inpatient Utilization—General Hospital/Acute Care—Total Inpatient Discharges per 1,000 Member Months	11.0	—
Inpatient Utilization—General Hospital/Acute Care—Maternity Discharges per 1,000 Member Months	1.0	—
Inpatient Utilization—General Hospital/Acute Care—Surgery Discharges per 1,000 Member Months	5.0	—
Inpatient Utilization—General Hospital/Acute Care—Medicine Discharges per 1,000 Member Months	6.0	—
Plan All-Cause Readmissions	NA	—
18–64 Years of Age	NA	—
65+ Years of Age	NA	—
Well-Child Visits in the First 15 Months of Life—6+ Visits	NA	65.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.3%	66.0%
— CYE 2014 is a baseline reporting year for this measure; therefore, an MPS has not yet been established by AHCCCS.		
* CYE 2014 performance measure results are still under review by AHCCCS and its Contractors; therefore, all performance measure results provided in this report should be considered preliminary and are subject to change prior to finalization.		
** The minimum performance standards for the *Children's Access to Primary Care Practitioners* measure were established for each age group rather than for the aggregate, as in previous years. Aggregated data are presented for informational purposes.		

CAPs

No CAPs were discussed in the report for this year.

Strengths

UHCCP-CRS' performance for the *Children's Access to Primary Care Practitioners—12–24 Months* and *25 Months–6 Years* indicators were demonstrated strengths for the Contractor, as these measures met the AHCCCS MPS for CYE 2014.

Opportunities for Improvement

With three measure rates failing to meet the AHCCCS MPS, UHCCP-CRS has opportunities for improvement following the CYE 2014 performance measurement period. HSAG recommends that UHCCP-CRS focus efforts on improving well-child visits and well-care visits for adolescents. HSAG also recommends that UHCCP-CRS analyze any improvement strategies that could be linked to the overall success of measures related to children's access to primary care physicians as well as interventions implemented to improve the performance in this area and potentially other areas. Further, HSAG suggests that UHCCP-CRS monitor performance with regard to annual dental visits for those ages 2 through 21. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Summary

All measures reported by UHCCP-CRS are new to reporting in CYE 2014, but results for the eight measures each with an established AHCCCS MPS show potential for future positive performance. UHCCP-CRS' rates for the *Children's Access to Primary Care Practitioners—12–24 Months* and *25 Months–6 Years* indicators each exceeded the corresponding AHCCCS MPS, and three measures (*Adolescent Well-Care Visits, Annual Dental Visits—2–21 Years,* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) each did not meet the corresponding CYE 2014 AHCCCS MPS but were within 6 percentage points of the threshold.

8. Performance Improvement Project Performance

In accordance with 42 CFR 438.240(d), and as required by AHCCCS, Contractors must have a Quality Assessment and Performance Improvement (QAPI) program that (1) included an ongoing program of performance improvement projects (PIPs) designed to achieve favorable effects on health outcomes and enrollee satisfaction, and (2) focused on clinical and/or nonclinical areas that involved the following:

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

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

One of the three external review-related activities mandated by the Medicaid managed care requirements and described at 42 CFR 438.358(b)(1) is the annual validation of MCO and PIHP PIPs required by the State and underway during the preceding 12 months. The requirement at 42 CFR 438.358(a) allows a state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory and optional EQR-related activities. AHCCCS elected to conduct the functions associated with the Medicaid managed care act mandatory activity of validating its Contractors' PIPs. In accordance with and satisfying the requirements of 42 CFR 438.364(a)(1), AHCCCS contracted with HSAG as an EQRO to use the information AHCCCS obtained from its PIP data collection, calculation, and validation activities during the contract year ending in 2015 to prepare this section of the annual EQR report.

Conducting the Review

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

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

AHCCCS performs data collection and analysis for baseline and subsequent measurements and reports the performance results of mandated PIPs for each Contractor and across Contractors.

In CYE 2011, AHCCCS approved a PIP, *Electronic Health Information Performance Improvement Project for Members Receiving Children's Rehabilitative Services*,[8-1] for the Arizona Department of Health Services, the children's rehabilitative services Contractor at that time. UnitedHealthcare Community Plan (UHCCP-CRS) opted to continue the PIP when it became the CRS Contractor.

The measurement periods for data collection are as follows:

- Baseline measurement period—October 1, 2010, through September 30, 2011 (CYE 2011)
- Intervention Year—October 1, 2011, through September 30, 2012 (CYE 2012)
- Remeasurement Year 1—October 1, 2012, through September 30, 2013 (CYE 2013)
- Remeasurement Year 2—October 1, 2013, through September 30, 2014 (CYE 2014)

The PIP initially focused on system development and implementation to advance the use of EHRs by CRS providers. Progress toward these goals was measured by assessing the percentage of CRS members with lab data in the EHR system within 90 days of enrollment into CRS. During its four-year existence, however, this PIP has been impacted by advances in EHR technology coupled with contractual changes by CRS (e.g., a transition from multiple lab vendors to a single vendor).

During CYE 2014, the *EHR* PIP was in the second remeasurement phase, and UHCCP-CRS could not provide data for the PIP. While UHCCP-CRS supplied an annual PIP report to AHCCCS, results from the second remeasurement period were not reported; the Contractor explained that two factors contributed to the lack of CYE 2014 data:

1. Following the transition from multiple lab vendors to a single capitated lab vendor in November 2013 the new vendor needed more time than expected to submit data to UHCCP-CRS due to coding needs associated with the AZ 837 companion guide requirements.
2. Once the claims files were available from the lab vendor in the fourth quarter of 2014, UHCCP-CRS required additional processing to enable the lab data to be loaded into the data warehouse.

UHCCP-CRS, unable to submit lab claims for the PIP in 2014, requested a one-year extension of the PIP. This request was granted by AHCCCS, with the expectation that UHCCP-CRS would supply comprehensive data during the next annual PIP submission. However, with the change in the composition of CRS membership following deployment of a more integrated CRS program, the population examined in the early measurement periods changed, resulting in less clarity annually, as to the relevance of comparing data to the original baseline period.

In CYE 2016, UHCCP-CRS will begin deployment of a completely different web-based interface. This fact, in conjunction with deployments of value-based contracts for each of the multi-specialty interdisciplinary clinics, will substantially increase the desire to obtain and ability to procure timely lab data for each member. This PIP represents early steps in the communication of information electronically and timely to providers.

[8-1] This PIP is also referred to as the *Laboratory Data in the Electronic Health Record (EHR)* PIP.

Overall, this PIP has been successful in that percentages of members with lab values transmitted within 90 days of date of service were higher for each measurement period following the baseline. It was also successful in that it provided the framework for detailed analysis and review of the processes each year to identify any issues or errors that prevented timely lab data transmission.

In CYE 2015 (10/1/14–9/30/15), AHCCCS implemented a new PIP, *E-Prescribing*, for all lines of business, including UHCCP-CRS. The baseline measurement period covered CYE 2014 (data from October 1, 2013, through September 30, 2014), to be followed by two remeasurement periods, October 1, 2015, through September 30, 2016, and October 1, 2016, through September 30, 2017. Only baseline measurement data and baseline interventions will be included for the purposes of this annual report.

AHCCCS implemented this PIP because research indicated that an opportunity existed to improve preventable errors in using the standard, handwritten paper method to communicate a medication between a prescriber and a pharmacy. Research found 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.[8-2] 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 can assist pharmacies in identifying potential problems related to medication management and potential reactions members may encounter, especially for those taking multiple medications.

The purpose of the *E-Prescribing* PIP is to increase the number of prescribers electronically prescribing prescriptions 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 electronic prescriptions and the number of electronic prescriptions submitted, followed by increased sustainment for one year.

Objectives for Conducting the Review

When evaluating Contractor PIPs, AHCCCS:

- Ensures that each Contractor has an ongoing performance improvement program of projects that focuses on clinical and/or nonclinical areas for the services it furnishes to members.
- Ensured that each Contractor measures performance using objective and quantifiable quality indicators.
- Ensures that each Contractor implements system wide interventions to achieve improvement in quality.
- Evaluates the effectiveness of each Contractor's interventions.
- Ensures that each Contractor plans and initiates activities to increase or sustain its improvement.

[8-2] Electronic prescribing improves medication safety in community-based office practices. Kaushal R, et al. 6, Alexandria: Springer, 2010, Journal of General Internal Medicine, Vol. 25, pp. 530-536.

- Ensures that each Contractor reports to the State data/information it collects for each project in a reasonable period to allow timely information on the status of PIPs.
- Calculates and validates the PIP results from Contractor data/information.
- Reviews the impact and effectiveness of each Contractor's performance improvement program.
- Requires each Contractor to have an ongoing process to evaluate the impact and effectiveness of its performance improvement program.

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

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

Methodology for Conducting the Review

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

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

To successfully complete the PIP, Contractors need to show sustained improvement from the baseline measurement through two remeasurement periods, without statistically significant declines between the

remeasurement periods. If the Contractor's performance was not improved or the improvement was not sustained, the PIP will remain open and continue for another remeasurement cycle.

When a PIP is considered closed for a Contractor, the Contractor's final report and any follow-up or ongoing activities are due 180 days after the end of the project (typically the end of the contract year). AHCCCS uses a standardized format for documenting PIP activities (i.e., Performance Improvement Project Reporting Format). AHCCCS encourages Contractors to use the PIP reporting format to document their analyses of baseline and remeasurement results, implementation of interventions, and assessment of improvement.

AHCCCS conducted its review and assessment of Contractor performance using the applicable criteria found in CMS' PIP protocol.[8-3] The protocol includes 10 distinct steps:

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

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

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

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

[8-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: April 15, 2013.

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

AHCCCS provided the overall annual plan submissions and plan-specific results to HSAG for its review and analysis for the 2015–2016 annual report.

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

For the 2015–2016 annual report, the following sections have been updated to include UHCCP-CRS - specific activities and interventions during CYE 2015 (October 1, 2014, through September 30, 2015) as submitted to AHCCCS.

The following sections describe HSAG's findings, conclusions, and recommendations for UHCCP-CRS.

Results

AHCCCS provided HSAG with its CYE 2015 Contractor PIP results for UHCCP-CRS. The PIP conducted during CYE 2015 for UHCCP-CRS was *E-Prescribing*, which focused on increasing both the number of providers ordering prescriptions electronically and increasing the percentage of prescriptions submitted electronically rather than via paper or other method in order to improve patient safety.

During CYE 2015, the *E-Prescribing* PIP was in the baseline measurement phase. Baseline data were used to assist UHCCP-CRS in identifying and/or implementing strategies to increase the number of providers ordering prescriptions electronically and increase the percentage of prescriptions submitted electronically. It is expected that UHCCP-CRS, provider, and member education efforts during this intervention period will result in a greater percentage of AHCCCS members being prescribed prescriptions electronically.

This section includes UHCCP-CRS' PIP remeasurement results as submitted to AHCCCS along with specific activities and interventions during the baseline measurement period from October 1, 2013, through September 30, 2014, and CYE 2015. Though the results were not validated by AHCCCS, an assessment of UHCCP-CRS' strengths was performed.

Findings

Table 8-1 presents the baseline results for the *E-Prescribing* PIP for UHCCP-CRS' members, including those members from 0 through 20 years of age and those members 21 years of age and over.

Table 8-1—UHCCP-CRS *E-Prescribing

PIP Measure	Baseline Period Oct. 1, 2013, to Sept. 30, 2014	Remeasurement Period 1 Oct. 1, 2015, to Sept. 30, 2016	Remeasurement Period 2 Oct. 1, 2016, to Sept. 30, 2017	Relative Percentage Change From Baseline
Indicator 1: The percent (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one electronic prescription.	50.47%	NA	NA	NA
Indicator 2: The percent (overall and by Contractor) of prescriptions prescribed by an AHCCCS contracted provider sent electronically.	43.02%	NA	NA	NA

*Percentages reflect a combination of members 0-21 years of age and 21 years of age and over.

CYE 2014 was the baseline measurement period for the statewide *E-Prescribing* PIP. Table 8-1 shows that 50.47 percent of UHCCP-CRS' providers prescribed at least one prescription electronically and that 43.02 percent of prescriptions ordered by an AHCCCS-contracted provider were sent electronically.

UHCCP-CRS completed the following quantitative analyses:

- UHCCP-CRS participated in the completion of two surveys as part of an e-prescribing workgroup (workgroup) formed with other Arizona MCOs. One survey asked providers to identify contributing factors to e-prescribing rates to identify best practices or barriers, while another asked Arizona EHR vendors to determine their particular system capabilities for e-prescribing controlled substances.
- UHCCP-CRS found that the most commonly perceived barriers to e-prescriptions of any kind were that providers mostly prescribe controlled substances, not using e-prescribing for those prescriptions; and that providers listed technical difficulties in using and transmitting e-prescriptions. More than 50 percent of providers identified a barrier to e-prescribing controlled substances, with the most commonly perceived barriers to adoption of e-prescriptions for controlled substances (EPCS) being that the provider was not aware it was legal, the provider preferred to handwrite controlled substance prescriptions, or the provider's EHR system did not support controlled substance e-prescription.
- UHCCP-CRS surveyed the EHR vendors to see if their systems were capable of supporting EPCS e-prescriptions. Nine vendors were surveyed, and all responded. Four of the nine did not support EPCS in Arizona. Two of the four stated that their EHR systems were targeted to support EPCS by the end of 2015. Prescribers using EHR systems that do not support EPCS would not be able to increase their EPCS rates.
- The workgroup also compiled prescriber data considering e-prescribing rates and which providers in each MCO had the lowest rates.

- UHCCP-CRS identified several opportunities from the surveys, including the need for further education on e-prescribing, the need to evaluate the ability for current EHR systems to support ECPS, and identification and ranking of providers' e-prescribing practices.

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

- Reported on the rankings of providers with greatest volume of prescriptions and lowest e-prescribing rates.
- Educated prescribers on advantages of e-prescribing and offered assistance in connecting with e-prescribing vendors.
- Incorporated e-prescribing into provider forums and provider engagement meetings.

Strengths

UHCCP-CRS analyzed the data from the surveys conducted and developed interventions to address the education barrier to e-prescribing. UHCCP-CRS has educated prescribers on the advantages of e-prescribing, offered assistance in connecting with e-prescribing vendors, and incorporated e-prescribing into provider forums and provider engagement meetings.

Opportunities for Improvement and Recommendations

UHCCP-CRS has an opportunity for improvement for the indicators related to both the rate of providers prescribing prescriptions electronically and the rate of prescriptions sent electronically. HSAG recommends that UHCCP-CRS continue to monitor the outcomes associated with the reported interventions. In addition, HSAG recommends that AHCCCS continue the collaboration among contractors in the workgroup to improve these indicators.

Summary

UHCCP-CRS' baseline rate for the *E-Prescribing* PIP Indicator 1 (percentage of AHCCCS-contracted providers who prescribed at least one prescription electronically) was 50.47 percent, and for Indicator 2 (percentage of prescriptions ordered by an AHCCCS-contracted provider and sent electronically) the rate was 43.02 percent. UHCCP-CRS is encouraged to monitor the progress of the PIP interventions employed to increase providers prescribing electronically and sending prescriptions electronically, adjusting interventions as needed to ensure that the rates increase by a statistically significant amount during the first remeasurement period.