

**Arizona Health Care Cost Containment System  
Arizona Department of Health Services**

**Behavioral Health Services**

**Annual External Quality Review Report  
*for*  
Contract Year Ending 2010**

HCE QualityQuest



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## **EXECUTIVE SUMMARY**

### **Introduction**

The Arizona Health Care Cost Containment System (AHCCCS) is the Single State Agency for Medicaid in Arizona. AHCCCS administers the services under Title XIX Medicaid and Title XXI State Children's Health Insurance Program (CHIP) (called KidsCare) in accordance with the Social Security Act. AHCCCS contracts with the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) for provision of behavioral health services to Title XIX and Title XXI enrollees in medical acute care managed care organizations (MCOs). AHCCCS' administrative oversight roles for behavioral health services are outlined in its contract with ADHS/DBHS and include the standards for access to care, structure and operations, and quality measurement and improvement. ADHS/DBHS has a subcontract with a Regional Behavioral Health Authority (RBHA) for each of Arizona's six Geographic Service Areas (GSAs) to provide behavioral health services directly, or to secure a network of providers, clinics, and other appropriate facilities and services to deliver behavioral health services to Title XIX and Title XXI enrollees within their contracted area. ADHS/DBHS additionally has Intergovernmental Agreements with Tribal RBHAs (TRBHAs) for the provision of behavioral health services to eligible members of some of Arizona's American Indian Tribes.

The federal Balanced Budget Act of 1997 (BBA) and associated rules and regulations directed that states monitor access to care, timeliness, and quality of services provided by state-contracted MCOs and Prepaid Inpatient Health Plans (PIHPs) serving Title XIX and Title XXI enrollees. The BBA also requires an annual external quality review (EQR) of these MCOs and PIHPs. The three mandatory EQR activities are monitoring compliance with federal managed care regulations one or more times during a three-year cycle, validation of one or more performance measures, and validation of one or more performance improvement projects (PIPs).<sup>1</sup> The federal Centers for Medicare and Medicaid Services (CMS) published protocols for conducting the mandatory and optional EQR activities.<sup>2</sup> All EQR activities must be consistent with the CMS protocols, and they may be completed by one or more than one entity. A single external quality review organization (EQRO) is required to consolidate the EQR findings and prepare an annual report for submission through AHCCCS to CMS.

ADHS/DBHS is the single state authority for planning, administration, regulation, coordination, and monitoring of all aspects of Arizona's public managed care behavioral health system. ADHS/DBHS meets the CMS definition of a PIHP (rather than the T/RBHAs or subcontracted behavioral health provider organizations); thus, ADHS/DBHS is the focus of the EQR process for Title XIX and Title XXI behavioral health managed care services in Arizona. AHCCCS monitors and evaluates compliance with state and federal regulations through program-specific performance measures, PIPs, comprehensive Operational and Financial Reviews (OFRs), and reviews and analyses of periodic reports required by its contract with ADHS/DBHS.

## Summary of External Quality Review Process, Activities, and Major Findings

AHCCCS contracted with HCE QualityQuest (QQ) as the EQRO to analyze findings and prepare the annual EQR report for Contract Year Ending (CYE) 2010, July 1, 2009 through June 30, 2010. In compliance with CMS' policies and regulations, this CYE 2010 EQR Annual Report includes the AHCCCS OFR findings related to compliance with federal, state, and contractual requirements, quality monitoring of the ADHS/DBHS PIHP behavioral health services system, and a review of the Performance Measure and PIP selected by AHCCCS for validation. No optional EQR services, over and above the mandatory activities, are included in this report.

The AHCCCS OFR reviewed eight ADHS/DBHS program areas in CYE 2010 including Claims and Information Systems, Delivery Systems, Encounters, General Administration, Grievance System, Medical Management, Member Information, and Quality Management. The OFR included 109 Standards and, of these, 40 (37%) were rated in Full Compliance, five (5) (5%) in Substantial Compliance, seven (7) (6%) in Partial Compliance, 22 (20%) in Non-Compliance, 6 (6%) rated for Information Only, and 29 (27%) Not Applicable. The large number of Standards that were Not Applicable to ADHS/DBHS were because AHCCCS used the same comprehensive OFR tool to rate MCOs that provide medical services as was used to evaluate the ADHS/DBHS behavioral health care PIHP. There were 74 Standards if the six (6) that were for Information Only and 29 that were Not Applicable were disregarded, and ADHS/DBHS was rated in Full Compliance for 54% of these 74. Five (5) (7%) of the 74 Standards received a Substantial Compliance rating, and seven (7) (9%) were found in Partial Compliance. Of the 22 (30%) Non-Compliance ratings, three (3) were in Claims and Information Systems, one (1) in Encounters, one (1) in General Administration, seven (7) in Member Information, and 10 in Quality Management.

Any OFR recommendation that some action must or should be taken to improve compliance required a Corrective Action Plan (CAP) to be submitted by ADHS/DBHS and approved by AHCCCS. Disregarding Standards that were for Information Only or Not Applicable, there were 76 AHCCCS recommendations requiring ADHS/DBHS CAPs across 43 (58%) of the 74 Standards. Of the 109 total Standards, 39% required one or more CAPs.

The Access to Care Performance Measure selected by AHCCCS for EQRO review was defined as the percent of AHCCCS Title XIX and Title XXI enrollees, including children, adolescents, and adults, referred for or requesting behavioral health services for whom the first behavioral health service was provided within 23 days of the initial assessment. The measurement period was April 1, 2009 through March 31, 2010. Electronic source data were collected by DBHS from its Client Information System. Encounter data, allowing for a 90-day claims lag from the end of the measurement period, were used to identify the date of assessment and first behavioral health service. ADHS/DBHS calculated the number of days between the assessment date and the first service for each Title XIX and Title XXI AHCCCS enrollee. The overall rate for this Access to Care measure was calculated by dividing the number of Title XIX and Title XXI AHCCCS-enrollees who received clinical behavioral health services 23 days or less from an initial assessment

date during the study period by the total number of Title XIX and Title XXI AHCCCS enrollees who had an initial assessment during the study period. The AHCCCS Minimum Performance Standard (MPS) for this Performance Measure was 85%, as specified in its contract with ADHS/DBHS, and the Goal was 95%.

ADHS/DBHS reported that it exceeded the MPS on the Access to Care 23-day measure in CYE 2010 but did not meet the Goal, with 92% of adults and 86% of children and adolescents statewide receiving behavioral health services within 23 days of their initial assessments. The EQRO repeated these calculations as a part of performance measure validation, also computing the 23-day standard as having been achieved 89% of the time statewide for CYE 2010. ADHS/DBHS reported aggregated statewide data for CYE 2010 on the Access to Care performance measure of clients that received a behavioral health service within 23 days of initial assessment. Of the 78.00% of enrollments usable for calculation of this measure, 89.19% of the total statewide usable cases received behavioral health services within 23 days of initial assessment, exceeding the minimum performance standard of 85%. When the total usable cases were divided into child and adult population groups, 91.66% of adults and 85.99% of children received behavioral health services within 23 days of initial assessment. EQRO validation of these data resulted in the same results as the ADHS/DBHS reported data.

The ADHS/DBHS *Recovery Through Employment for Individuals with Serious Mental Illness (SMI)* PIP was recognized by AHCCCS in January 2011 as having demonstrated significant and sustained improvement and selected for EQRO review. The study question was whether specific interventions such as increased education regarding disability benefits, enhanced rehabilitation network development, and technical assistance provision would result in an increase in the number of Medicaid Title XIX adult enrollees with serious mental illness who received psycho-educational services such as pre-job training and job development. Baseline data collection in 2008 found 14% of the study population received psycho-educational services at least once during the study period. After various interventions designed to address barriers to employment were implemented, the first remeasurement found 25% received the desired psycho-educational services, a statistically significant increase compared to baseline. This performance improvement was enhanced during the second remeasurement cycle, with 29% of the study population receiving psycho-educational services at least once. This sustained performance improvement fulfilled the requirements for completion of the PIP.

### **Conclusions and Recommendations for ADHS/DBHS Related to Timeliness, Access, and Quality of Care of Behavioral Health Services**

Access, timeliness, and quality are examined as they relate to the three required EQR activities. Access to care and timeliness of services are critical aspects of the process of care. ADHS/DBHS tracks statewide access data through multiple mechanisms including customer satisfaction surveys; performance measure and performance improvement monitoring initiatives; complaint data; and network sufficiency analyses. The timeliness of services for enrollees entering the behavioral health

services system and for those utilizing higher levels of care is documented by ADHS/DBHS through comparative analyses.

The 2009 Behavioral Health Services Consumer Satisfaction Surveys' domains that were relevant to access, timeliness, and quality of care were Access to Services, Service Quality/Appropriateness, and General Satisfaction. Eighty-nine percent (89%) of adults and 90% of respondents to the Youth Services Survey for Families (YSS-F) provided a positive response when evaluating Service Quality and Appropriateness. Eighty-four percent (84%) of adults rated General Satisfaction domain positively, as did 80% of YSS-F responders. Access to Services had a 78% positive response rate for adults and 76% positive for YSS-F respondents. Adults and families reported that both the location and times available for service provision were convenient. Adults noted that improvements could be made in timeliness of staff returning enrollees' phone calls, informing the enrollee of the array of services available to them, and providing more scheduling time to see a psychiatrist.

Additional data contributing to the Access category include the Access to Care 23-Day Performance Measure discussed above and Access to Care complaint data. Complaints are categorized according to enrollment, timely access to the behavioral health system, and accessing routine covered services. The timely access sub-category contained more of the Access to Services complaints in CYE 2010 than any other subcategory for both adults and youth. As recommended, Quality of Care data related to access will be triangulated with the data sets above to improve analyses related to access to care in the coming year. Triangulation has the potential to enable ADHS/DBHS to more accurately and effectively evaluate system-wide data to develop quality management activities that apply to all behavioral health recipients and to improve functional and treatment outcomes. Moreover, AHCCCS and ADHS/DBHS are implementing a new enrollment process to eliminate potential administrative barriers to accessing behavioral health services for Title XIX and Title XXI enrollees by automatically providing every AHCCCS enrollee with a home RBHA based on area of residence.

There were 14 OFR standards rated in Full or Substantial Compliance that were relevant to timeliness, access, and quality of care, indicative of ADHS/DBHS' strengths in these specific areas. The compliance review of the Quality Management domain also generated numerous recommendations that must be resolved through the corrective action plan process. AHCCCS and ADHS/DBHS collaborated to completely revamp the selection and technical specifications of performance measures, resulting in data that are more meaningful and reliable in informing stakeholders of the accessibility, availability, and quality of behavioral health services received. CYE 2010 was the baseline year for this new core set of measures. Person-centered care has continued to be a guiding principle, and assessing functional outcomes is a priority, consistent with the recommendations in this and previous EQR Annual Reports. Adoption of nationally standardized, valid, and reliable measures being developed for access, timeliness, and quality of care is also recommended, with the added potential of benchmarking with Title XIX and Title XXI behavioral health managed care programs in other states and trending results over time.

<sup>1</sup>*Department of Health and Human Services, Centers for Medicare & Medicaid Services, Code of Federal Regulations, Title 42, Chapter IV, Part 438 – Managed Care. <http://www.gpoaccess.gov/cfr/index.html>*

<sup>2</sup>*Centers for Medicare & Medicaid Services, Protocols for External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans. February 11, 2003.*

## **I. BACKGROUND**

### **A. History of Arizona's Medicaid Managed Care Programs**

The Medicaid program was established in the United States (US) in 1965, under Title XIX of the Social Security Act, as a joint federal and state program for financing medical, long-term care, and optional services for eligible low-income US residents. The Social Security Act was further amended in 1997 to add Title XXI, the State Children's Health Insurance Program (SCHIP, now CHIP). CHIP is the largest expansion of health assistance for youth since Medicaid was established. It makes health insurance available to uninsured children under 19 whose family incomes are too high to be eligible for Medicaid but low enough to be at or below 200 percent of the federal poverty level. The CMS administers both the Title XIX Medicaid program and the Title XXI CHIP program at the federal level. CMS has the authority to approve waivers of certain federal requirements on a state-by-state basis. Waivers allow states to structure Medicaid programs to better meet local needs, such as offering additional services, setting different eligibility criteria, or limiting the choice of providers. Section 1115 Research and Demonstration Waivers allow the most extensive departures from federal requirements, including comprehensive restructuring of health care delivery systems and the terms and conditions of federal funding.

In 1982 Arizona's Title XIX Medicaid program became the first statewide Medicaid managed care system in the US. It was implemented and continues to operate under a Section 1115 Research and Demonstration Waiver, due for renewal in October 2011. In 1998 Arizona's CHIP Title XXI managed care program, known as KidsCare, was structured to provide more eligible Arizona low-income families the opportunity to have affordable health care coverage for children. Parents pay a monthly premium to obtain KidsCare coverage, except for American Indians who are exempt from premiums by federal law.

Medicaid managed care programs typically require enrollees to sign up with a specific MCO that has a contract with the state to accept responsibility for providing and authorizing medically necessary covered services, except for American Indians who may elect to receive their care through the Indian Health Service. MCOs accept a predetermined and prepaid level of funding on a per-person per-month basis, and agree to provide all medically necessary covered services to their members without regard for the volume of services they receive.

Arizona's State Medicaid Agency, AHCCCS, is a model public-private collaboration that involves the federal government, the state and its counties, health plans and providers from both public and private sectors, and families and individuals eligible for Medicaid and KidsCare services. AHCCCS contracts with acute-care MCOs to provide a comprehensive array of health services to eligible Arizona residents, including those enrolled in the Title XIX and Title XXI programs. Children enrolled under KidsCare receive the same package of health care benefits through the same MCOs contracted to provide services to children

and adults enrolled under Title XIX Medicaid. This provides a seamless system of delivering services, since eligibility for children may change between Title XIX Medicaid and Title XXI KidsCare programs based on changes in family income.

While federal Title XIX and Title XXI regulations require participating states to cover medically necessary acute-care physical health services, states are given the option of whether to cover behavioral health services. Arizona does provide behavioral health coverage for eligible residents of the State for the continuum of services from less to more restrictive. In October 1990 Arizona began offering coverage to eligible seriously emotionally disabled children under age 18 who required residential care. Behavioral health coverage was extended to all Medicaid enrollees over the next five years.<sup>1</sup>

AHCCCS has carved behavioral health services out of MCO contracts, providing them through a contract with the ADHS/DBHS under an arrangement designated by CMS as a PIHP. ADHS/DBHS is the PIHP that plans, administers, and monitors behavioral health services funded through Titles XIX/XXI in Arizona. ADHS/DBHS oversees the behavioral health services available to all state-supported programs, not just Medicaid, but most recipients gain access to these programs through Title XIX and Title XXI eligibility.

Early in FY 2010, there were approximately 1.4 million enrollees statewide in the AHCCCS managed care system.<sup>1</sup> ADHS/DBHS provided behavioral health services to 214,557 persons in FY 2010, 81.8 percent of whom were Medicaid Title XIX enrollees, and 1.7 percent of whom were enrolled under Title XXI.<sup>2</sup> Of the 182,011 Title XIX and Title XXI enrollees in ADHS/DBHS behavioral health services programs in FY 2009, 163,567 had at least one encounter during which behavioral health services were provided in FY 2009.<sup>3</sup>

ADHS/DBHS subcontracts with RBHAs and TRBHAs to provide covered behavioral health services directly or to secure a network of providers, clinics, and other appropriate facilities and services to deliver managed behavioral health services to Title XIX and Title XXI-enrolled acute-care members within each GSA in Arizona. The T/RBHAs function for the provision of behavioral health services similar to the manner in which MCOs function to provide medical care. The T/RBHAs are responsible for behavioral health evaluation and diagnosis; service and treatment; planning; case management; and coordination of care with the MCOs. Arizona's Medicaid program provides coverage for a broad range of behavioral health care services, including prevention programs for children and adults and the continuum of services for adults with general mental health and substance abuse disorders, children with serious emotional disturbances, and adults with serious mental illness.

Each Arizona Medicaid enrollee either chooses or is assigned an acute-care MCO for medical and preventive health care services. If the enrollee requires behavioral health services, he or she is typically referred by an acute-care plan to the appropriate T/RBHA. The enrollee goes through the behavioral health intake evaluation process and then receives covered behavioral health services through the T/RBHA system of contracted providers.

Medicaid enrollees alternatively may self-refer directly to a T/RBHA or its contracted providers for behavioral health services.

Arizona is divided into six GSAs served by four RBHAs for the provision of behavioral health services. During CYE 2010, the four RBHAs and the counties they served were as follows.

- Magellan of Arizona for Maricopa County (Effective 09/01/2007)
- Community Partnership of Southern Arizona (CPSA) for Pima, Graham, Greenlee, Santa Cruz, and Cochise Counties (Effective 07/01/2005)
- Northern Arizona Regional Behavioral Health Authority (NARBHA) for Mohave, Coconino, Apache, Navajo, and Yavapai Counties (Effective 07/01/2005)
- Cenpatico Behavioral Health of Arizona (Cenpatico) for Pinal, Gila, Yuma, and La Paz Counties (Effective 07/01/2005)

In addition to these RBHAs, ADHS/DBHS currently has Inter-Governmental Agreements (IGAs) for TRBHAs with five of Arizona's American Indian Tribes to provide covered behavioral health services for American Indians on reservations. Gila River Indian Community, Navajo Nation, and Pascua Yaqui Tribe each have an IGA for Title XIX and Title XXI and State Subvention Services. Colorado River Indian Tribe has an IGA for State Subvention Services, and covered behavioral health services to other Native American Indian Tribes not identified here are through the local RBHA in which the tribal reservation is located. A CYE 2010 map showing the area served by each of Arizona's behavioral health T/RBHAs is included in the Appendix.

## **B. Arizona's Quality Strategy Objectives, Performance Measures, Performance Improvement Requirements, and Operational System Standards for Behavioral Health Services**

Federal regulations mandate that states ensure the delivery of health care of high quality by all their Medicaid managed care contractors. CMS published the finalized BBA regulations (42 CFR 438 et. seq.) on June 14, 2002<sup>5</sup> that included QAPI strategy specifications with which each state must comply.

AHCCCS has an established reputation as an innovative leader in Medicaid managed care. The AHCCCS Quality Strategy specific to Medicaid managed care was established in 2003, and the QAPI Strategy has continued to be reviewed and revised as appropriate. Arizona's quality strategies and deliverables are set forth in Attachment II, "Quality Assurance/Monitoring Activity" of the AHCCCS Medicaid 1115 Waiver Report. Strategy effectiveness, progress, and updates for the QAPI Strategy are reported in the Section 1115 Quarterly Reports posted on the AHCCCS website, along with a rolling Five-Year Strategic

Plan.<sup>6</sup> The AHCCCS Quality Strategy is founded on AHCCCS' mission of "reaching across Arizona to provide comprehensive, quality health care for those in need."<sup>1</sup>

The AHCCCS Quality Strategy is a coordinated, comprehensive, and proactive approach to facilitate quality throughout the AHCCCS system by utilizing innovative initiatives, monitoring, assessment, and outcome-based performance improvement. It is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. In addition, it leads to identification and documentation of issues related to those standards, and encourages improvement through incentives, or where necessary, through corrective actions.<sup>1</sup> AHCCCS' Quality Strategy objectives include the following.

- Rewarding quality of care, member safety, and member satisfaction outcomes
- Supporting best practices in disease management, chronic care, and preventive health
- Providing feedback on quality and outcomes to Contractors and Providers
- Providing comparative information to consumers

Data timeliness, accuracy, and completeness are assessed, and AHCCCS performs extensive data validation as a condition of its 1115 Waiver. For purposes of BBA compliance, AHCCCS contracts with an EQRO to review its behavioral health quality monitoring activities and to write an independent report identifying strengths and opportunities for improvement for the ADHS/DBHS PIHP for behavioral health services.<sup>1</sup>

AHCCCS includes in its contract with ADHS/DBHS those elements that are required to monitor and measure quality, timeliness, and access to care in accordance with federal and state regulations. These elements include certain program-specific performance measures; PIPs; an OFR that monitors compliance with federal, state, and contractual requirements of managed care systems; and periodic reports as required in the contract. The contract between AHCCCS and ADHS/DBHS stipulates the standards for access; structure and operations; and quality measurement and improvement. The AHCCCS Medical Policy Manual (AMPM), as well as other AHCCCS policies and manuals, are incorporated by reference as a part of the ADHS/DBHS contract and provide more detailed information and requirements.

The ADHS/DBHS vision states: All Arizona residents touched by the public behavioral health system are easily able to access high quality prevention, support, rehabilitation, and treatment services that have resiliency and recovery principles at their core, which assist them in achieving their unique goals for a desired quality of life in their homes and communities.<sup>4</sup> The mission of ADHS/DBHS is to provide strong clinical and administrative leadership for Arizona that accomplishes the following.

- Improves the quality of care provided to all behavioral health recipients
- Improves behavioral health recipient satisfaction with services received

- Improves outcomes for all behavioral health recipients<sup>4</sup>

AHCCCS and ADHS/DBHS identify areas on which to focus performance improvement efforts through quality management activities, including data collection. In CYE 2010, ADHS/DBHS tracked the following measures with benchmarks for performance.<sup>4,7</sup>

- Access to Care
- Behavioral Health Service Plan
- Behavioral Health Service Provision
- Coordination of Care 1 (Disposition of Referral)
- Coordination of Care 2 (Communication)
- Follow Up After Hospitalization for Mental Illness Within 7 Days
- Follow Up After Hospitalization for Mental Illness Within 30 Days
- Treatment of Depression

Specific target areas were determined through data collection that indicated either a clinical or non-clinical opportunity for improvement. ADHS/DBHS CYE 2010 PIPs included the following.

- Child and Family Team
- Recovery Through Employment

A major source of behavioral health outcome measurement is the two annual satisfaction surveys for children/families and adults based on the Substance Abuse and Mental Health Administration's (SAMSHA's) Mental Health Statistics Improvement Program (MHSIP) Consumer Surveys. ADHS/DBHS participates in these surveys to determine consumer satisfaction in relation to the behavioral health care system. Results are analyzed and compared to other monitoring mechanisms to identify areas needing improvement. The Consumer Surveys provide National Outcomes Measures (NOMs) data for the annual AHCCCS deliverable and for submission to SAMSHA's MHSIP.<sup>4</sup>

Outcome measures collected for behavioral health service enrollees, other than those from the MHSIP Consumer Survey, are as follows.

- Educational Status
- Employment Status
- Substance Use
- Living Situation
- Criminal Justice Involvement

AHCCCS has mechanisms to ensure that ADHS/DBHS maintains information systems that collect, analyze, integrate, and report data to achieve AHCCCS objectives. ADHS/DBHS and its subcontractors are required to have claims processing and management information

systems to collect service-specific procedures and diagnosis data, encounters, and records of remittances to providers.

<sup>1</sup>Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, Revised as of March 1, 2010

<sup>2</sup>Arizona Department of Health Services, Division of Behavioral Health Services, An Introduction to Arizona's Public Behavioral Health System, January, 2011

<sup>3</sup>Arizona Department of Health Services, Division of Behavioral Health Services, Annual Report, Fiscal Year 2009, <http://www.azdhs.gov/bhs/annualrpt.htm>

<sup>4</sup>Arizona Department of Health Services, Division of Behavioral Health Services, 2010 Annual Quality Management Plan (AHCCCS Contract Year October 1, 2009 - September 30, 2010)

<sup>5</sup>Department of Health and Human Services, Centers for Medicare & Medicaid Services, Code of Federal Regulations, Title 42, Chapter IV, Part 438 – Managed Care <http://www.gpoaccess.gov/cfr/index.html>

<sup>6</sup>Arizona Health Care Cost Containment System, Five-Year Strategic Plan Fiscal Year 2011-2015, <http://azahcccs.gov/reporting/Downloads/StrategicPlan.pdf>

<sup>7</sup>Arizona Health Care Cost Containment System Administration, Division of Business and Finance, Contract Amendment 35 with Arizona Department of Health Services, Contract #YH8-0002, ADHS #832007, Effective July 1, 2009

## II. DESCRIPTION OF EXTERNAL QUALITY REVIEW ACTIVITIES

When states provide health services using managed care arrangements, including behavioral health care, to Medicaid and CHIP Title XIX and Title XXI enrollees, the federal government requires an annual, external, independent review of access to, timeliness of, and the quality outcomes of services provided by the managed care entities, whether they are MCOs or PIHPs. In Arizona, AHCCCS contracts with ADHS/DBHS as the PIHP to plan, administer, and monitor Title XIX and Title XXI managed behavioral health care services, and this is the focus of this EQR.

The applicable federal CMS Final Rule requires an annual EQR report that must include three mandatory activities, consistent with associated published protocols, as follows.<sup>1,2</sup>

- Validation of Performance Improvement Project(s)
- Validation of Performance Measure(s)
- Determination of MCO/PIHP Compliance with Federal Medicaid Managed Care Regulations

These EQR activities can be performed by one or more organizations, but each of the three required activities must be incorporated into a single annual report by one EQRO. AHCCCS has developed significant in-house resources, processes, and expertise for many years in monitoring its managed care contractors and, thus, performs most of the EQR functions itself, rather than relying on external organizations for these services. AHCCCS has contracted with HCE QualityQuest (QQ) to serve as the EQRO to review AHCCCS' quality monitoring activities and prepare the independent report mandated annually by CMS. This report summarizes for AHCCCS review and follow-up the strengths, weaknesses, and required compliance of ADHS/DBHS in administering Title XIX and Title XXI public managed care programs for provision of behavioral health services.

AHCCCS conducted the EQR activities related to documenting compliance with federal, state, and contractual obligations and provided a draft of the CYE 2010 OFR to the EQRO to summarize and incorporate in the EQR Annual Report to CMS.

The Performance Measure selected by AHCCCS in CYE 2010 was Access to Care, or the percent of AHCCCS members referred for or requesting behavioral health services for whom the first behavioral health service was provided within 23 days of the initial behavioral health assessment. This measure is based on electronic data which ADHS/DBHS provided through AHCCCS to the EQRO for validation of the reported results.

AHCCCS selected the *Recovery Through Employment* PIP for EQR. The AHCCCS contract with ADHS/DBHS stipulates that AHCCCS must review and approve PIP plans and interim and final reports. AHCCCS provided ongoing technical assistance to ADHS/DBHS for complying with the CMS protocol activities and guidelines for conducting

this PIP, approved the *Recovery Through Employment* PIP Final Report in January 2011, and gave the EQRO copies of documentation for use in the required PIP validation.

AHCCCS will submit the EQR findings and recommendations to ADHS/DBHS and CMS. AHCCCS uses the EQR Annual Report to contribute to ongoing QAPI strategy development and to quality improvement activities of ADHS/DBHS. The Arizona EQR Annual Reports are posted online on the AHCCCS web site, accessible for review by behavioral health care recipients and their families, Arizona stakeholders, other state Medicaid and CHIP programs, and the community at large.

<sup>1</sup>*Centers for Medicare & Medicaid Services, Medicaid Program; External Quality Review of Medicaid Managed Care Organizations (Final Rule. Federal Register, 68(16): 3585-638), January 24, 2003.*

<sup>2</sup>*Centers for Medicare & Medicaid Services, Protocols for External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans. February 11, 2003.*

### III. STATE QUALITY INITIATIVES

The AHCCCS Quality Strategy was established in 2003 in accordance with the federal regulations specific to Medicaid Managed Care, and it has been reviewed and revised as appropriate since that time. The 2010 revision includes requirements under Section 401(c)(1) of the CHIP.<sup>1,2</sup> In addition to including both the Medicaid and CHIP programs, it encompasses the acute and long-term care MCOs as well as the ADHS/DBHS, the PIHP overseeing the public behavioral health services managed care system in Arizona. The AHCCCS Quality Strategy is intended to facilitate and monitor services provided to enrollees that meet or exceed established standards for access to care, clinical quality of care, and quality of service. It fosters identification and documentation of issues related to those standards, and encourages improvement through incentives or, where necessary, corrective actions.

The AHCCCS program has grown substantially as a result of rapid increases in the population of Arizona, prevalence of low-wage jobs, high unemployment, and increasing health insurance costs. AHCCCS' rolling five-year strategic plans serve as a framework for ongoing planning, prioritizing, and budgeting in this challenging environment. Health care quality is one of four major issues addressed in the AHCCCS Strategic Plan for State Fiscal Years (SFY) 2010-2014, the remaining three being health care costs, the uninsured, and organizational capacity.<sup>3</sup> Strategies intended to lead to improvements in quality and result in an overall reduction in costs include the following.

- Use of centers of excellence
- Use of evidence-based treatment guidelines
- Support of graduate education, particularly in rural areas
- Continued emphasis on preventive care
- Facilitation of telemedicine networks

AHCCCS' QAPI Strategy<sup>1</sup> objectives are a component of the five-year strategic goals and objectives. The AHCCCS QAPI plan closely aligns and interfaces with the AHCCCS 1115 Waiver Quarterly Report and the EQR Annual Report. The EQR report includes details of the assessment, results, and recommendations related to the goals and strategies in the QAPI document. The information provided by the EQRO is used by AHCCCS to assess the effectiveness of the currently stated goals and strategies and provide a roadmap for new goals and strategies or potential changes.<sup>1</sup>

The specific components of the AHCCCS Quality Strategy are as follows.

- Facilitating stakeholder involvement
- Developing and assessing the quality and appropriateness of care/services for members

- Including medical quality assessment and performance improvement requirements in the AHCCCS contracts
- Monitoring and evaluating contractor compliance and performance
- Maintaining an information system that supports initial and ongoing operations and review of the established quality strategy
- Reviewing, revising, and beginning new projects in any given area of the quality strategy
- Soliciting public involvement
- Frequently evaluating strategy

The ADHS/DBHS Five-Year Strategic Plan for 2010-2014<sup>4</sup> parallels the focus of the AHCCCS Strategic Plan. The ADHS/DBHS guiding principles are as follows.

- Investing in prevention and health promotion
- Improving access to healthcare
- Reducing disparities in health
- Being prepared to respond to health threats and emergencies
- Building partnerships among a diverse group of stakeholders including education, transportation, air quality, and housing
- Measuring results, essential for maintaining a standard of excellence and innovation

ADHS/DBHS designated behavioral health as one of its priority areas of work, "a cornerstone to overall health and wellness with promotion of recovery, resiliency, psychosocial rehabilitation, safety, and hope."<sup>4</sup> The following four goals guide the work of ADHS/DBHS.<sup>4</sup>

- Implementing a population-based public health system
- Ensuring a comprehensive, easy to access, recovery-oriented behavioral health system of care that is outcomes-driven and accountable to its numerous stakeholders
- Ensuring the health and safety of all Arizonans through a comprehensive system for licensing, monitoring, and technical assistance
- Delivering courteous, efficient, responsive, and cost-effective service to the Department's external and internal customers, stakeholders, and key policymakers

There is a specific Quality Management (QM) subsection in the Program Requirements Section of the AHCCCS contract with ADHS/DBHS<sup>5</sup> that contractually mandates a Quality Management Plan consistent with strategic objectives. Quality Management requirements in the contract include, but are not limited to, performance measures, PIPs, participation in the operational review process, ensuring the completeness and accuracy of quality management data reported to AHCCCS, and investigation, analysis, tracking, and trending of quality-of-care issues, abuse, and/or complaints. These ADHS/DBHS goals, objectives, and quality strategies are included in the annual ADHS/DBHS Quality Management Plan and associated

Work Plan.<sup>6</sup> For each goal, there is a detailed list of goals, tasks, data sources, and target dates that are the responsibility of ADHS/DBHS' Bureau of Quality Management Operations (BQMO) and other stakeholders.

The BQMO Quality Management Plan and Work Plan for AHCCCS Contract Year October 1, 2009 through September 30, 2010 contained many changes that were planned in 2009 and implemented in 2010. The scope of the 2010 QM Plan covered all behavioral health recipients and included task items applicable to all behavioral health program types and levels of need. The array of monitoring and oversight activities was narrowed to focus on the requirements of the AHCCCS Medical Policy Manual in order to improve the core business activities and enable ADHS/DBHS to systematically review data and prioritize QM activities as informed by data analysis. The collection and analysis of prevention data was conducted by the ADHS/DBHS Prevention Office and reported annually as a data feed to the QM Committee. The monitoring, evaluation, and improvement of functional and treatment outcomes for behavioral health recipients was given high priority, and that expectation was incorporated into the day-to-day functions of ADHS/DBHS. The Annual Consumer Surveys were used as another means of capturing outcomes data. Finally, morbidity and mortality data were used as data feeds in the ADHS/DBHS monitoring, oversight, and review activities instead of being treated as stand-alone work plan items.

ADHS/DBHS also prepared a Quality Management Program Evaluation Summary that reported on the strategic direction of the QM program for CYE 2010. Forty-seven (47) steps were specified as integral to six goals relating to performance measures, monitoring and oversight activities, PIPs, peer review, quality of care, and reporting requirements. It was reported that 44 of the 47 steps were completed during 2010. Goals for three of the performance measures were met, and work will continue in 2011 toward meeting and exceeding the MPS for the Behavioral Health Service Plan and Behavioral Health Service Provision Performance Measures. CYE 2010 was considered a baseline year for these indicators with new measurement methodologies.<sup>7</sup>

Additional changes in performance measures evaluated by ADHS/DBHS were planned in 2010. In CYE 2011, AHCCCS members seeking behavioral health services will no longer need to enroll with a RBHA. On October 1, 2010, AHCCCS began automatically assigning all enrolled acute care physical health members to a RBHA based on the enrollee's zip code rather than county of residence. This eliminated the need for the Coordination of Care 1 Performance Measure that monitored whether the disposition of the referral was communicated to the Primary Care Provider/Health Plan within 30 days of the initial assessment. Thus, in CYE 2011, there will be only one Coordination of Care Measure, previously called Coordination of Care 2 - Communication. It tracks all enrollees receiving behavioral health services and requires evidence of communication between the RBHA and the acute physical health plan regarding diagnoses, medications, laboratory, and other pertinent treatment information.<sup>7</sup>

<sup>1</sup>Arizona Health Care Cost Containment System, Quality Assessment & Performance Improvement Strategy, March 2009, revised as of March 1, 2010. <http://www.azahcccs.gov/reporting/quality/strategy.aspx>

<sup>2</sup>Centers for Medicare & Medicaid Services, Medicaid/SCHIP Quality Strategy. <http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/>.

<sup>3</sup>Arizona Health Care Cost Containment System, Five Year Strategic Plan, State Fiscal Year 2010-2014, <http://www.azahcccs.gov/Publications/StrategicPlanning/>

<sup>4</sup>Arizona Department of Health Services, Division of Behavioral Health Services, Five Year Strategic Plan, Fiscal Years 2010-2014. [http://www.azdhs.gov/bhs/bh\\_topics.htm](http://www.azdhs.gov/bhs/bh_topics.htm)

<sup>5</sup>Arizona Health Care Cost Containment System Administration, Division of Business and Finance, Contract Number YH8-0002 ADHS #832007, Amendment Number 35, Effective July 1, 2009. <http://www.azahcccs.gov/Contracting/ContractAmend.asp>

<sup>6</sup>Arizona Department of Health Services, Division of Behavioral Health Services, Quality Management and Utilization Management Plan and Work Plan. [http://www.azdhs.gov/bhs/qm\\_plan.htm](http://www.azdhs.gov/bhs/qm_plan.htm)

<sup>7</sup>Arizona Department of Health Services, Division of Behavioral Health Services, Quality Management Program Evaluation Summary, AHCCCS Contract Year October 1, 2009 - September 30, 2010.

#### **IV. BEST AND EMERGING PRACTICES FOR IMPROVING QUALITY OF CARE AND SERVICES**

ADHS/DBHS' best and emerging practices implemented in CYE 2010 included initiatives to incorporate behavioral health information in the Arizona Medical Information Exchange (AMIE), develop and disseminate evidence-based guidelines, continue the focus on promoting patient-centered therapeutic approaches, and increase network development and coordination of care.

The AMIE Behavioral Health Expansion began in 2009 as a collaboration between AHCCCS, ADHS/DBHS, and the RBHAs. Behavioral health medication information was added to the AMIE medication histories, and approximately 30 behavioral health care providers were allowed access to AMIE information using a web-based viewer. In CYE 2010 a non-profit organization was formed to transfer the operation of AMIE outside AHCCCS with a vision of achieving interoperable statewide health care information technology. The CMS has approved planning efforts to support a state Medicaid health information technology plan and associated incentive program.<sup>1</sup>

ADHS/DBHS has researched and published four Clinical Practice Protocols with Required Elements to assist behavioral health providers in implementing and monitoring the following evidence-based best practices.<sup>2</sup>

- Child and Family Team Practice
- Substance Use Disorders in Children and Adolescents
- Out-of-Home Services for Children and Adolescents
- Psychiatric Medication Guidelines for Children from Birth to Five Years of Age

System-development efforts in CYE 2010 continued the focus on creating a person- and family-centered strengths-based system that allows individual choice, values clinical experience, and focuses on recovery and resiliency. Priority was placed on behavioral health network development and enhancement in the support and rehabilitation services, housing resources, substance abuse services, individual and family involvement, crisis system and services, community-based and home-based services with natural supports, rehabilitation services, culturally competent services, and improving access to care for Arizona's tribes and rural communities. The key highlights in statewide development and expansion centered on residential/housing services for adults, substance abuse services, specialty category services, and peer and family support services.

ADHS/DBHS facilitated the development and implementation of a Best Practices Advisory Committee with the goal of identifying and adopting promising models for mental health and substance abuse care and prevention services. One initiative was promoting Child and Family Team (CFT) expansion toward the goal of having all children served with CFTs.

ADHS/DBHS continues to focus on promoting patient-centered treatment and ensuring the quality of services provided to children and families through CFT practice.

In CYE 2010 ADHS/DBHS, in collaboration with AHCCCS, has made significant changes to the ADHS/DBHS contractually-required performance measures, developing and refining several measures. These measures are designed to collect more meaningful data on access, availability, and quality of behavioral health services while improving data validity. The new measures include the following.

- Access to Care - The percent of AHCCCS members referred for or requesting behavioral health services for whom the first service was provided within 23 days of the initial assessment
- Behavioral Health Service Plan - The percent of AHCCCS members with current service plans that incorporate the needs and service recommendations identified in their assessments
- Behavioral Health Service Provision - The percent of AHCCCS members who received the services that were recommended in their service plans
- Coordination of Care 1 (Disposition of Referral) - The percent of AHCCCS members for whom disposition of the referral is communicated to the Primary Care Physician (PCP) or Health Plan within 45 days of initial assessment, or, if behavioral health services are declined, within 45 days of the referral
- Coordination of Care 2 (Communication) - The percent of AHCCCS members for whom behavioral health service providers communicate behavioral health clinical and contact information with the member's PCP and/or Health Plan
- Follow Up After Hospitalization for Mental Illness - The percent of discharges for members age six (6) years and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit or partial hospitalization with a behavioral health practitioner, based on Healthcare Effectiveness Data and Information Set (HEDIS) criteria. Two rates are reported:
  - Members who received follow up within 30 days of discharge
  - Members who received follow up within seven (7) days of discharge
- Treatment of Depression - The percent of continuously enrolled AHCCCS members diagnosed with major depressive disorder of mild subtype who received an antidepressant medication or psychotherapy during the measurement period

The ADHS/DBHS CYE 2010 Semiannual and Annual Performance Improvement Reports for the Children's and Adult's Systems of Care included results for five of these measures. It is anticipated the remaining measures will begin to be collected through the AHCCCS recipient and encounter systems and reported in CYE 2011.

Another best and emerging practice is the increasing proportion of the measures tracked over time that are outcome measures, such as those incorporated in the annual consumer

surveys and other nationally recognized functional outcome measures in the areas of employment, educational participation, abstinence from alcohol and illegal drugs, criminal activity, and homelessness. In CYE 2010 ADHS/DBHS also planned the launch of an Outcomes Dashboard on its website to reflect statewide and RBHA performance in access to care, coordination of care, service delivery, and enrollee outcomes.

<sup>1</sup>Arizona Health Care Cost Containment System, *Quality Assessment and Performance Improvement Strategy*, Revised March 1, 2010.

<sup>2</sup>ADHS/DBHS *Clinical Practice Protocols with Required Elements*, <http://www.azdhs.gov/bhs/guidance/guidance.htm>

## V. ORGANIZATIONAL ASSESSMENT AND STRUCTURE PERFORMANCE

The organizational structure and operations of ADHS/DBHS, the PIHP responsible for administering public behavioral health services in Arizona, are monitored and evaluated by AHCCCS through an annual Operational and Financial Review (OFR). AHCCCS uses the OFR process for determining ADHS/DBHS compliance with federal Medicaid Managed Care Regulations at 42 Code of Federal Regulations (CFR) 438.364 and to determine the extent to which ADHS/DBHS met the AHCCCS contract requirements, AHCCCS policies, and additional federal and state requirements. The AHCCCS OFR of ADHS/DBHS is consistent with the mandatory protocol for monitoring MCOs and PIHPs<sup>1</sup> as required by the CMS Final Rule on EQR of MCOs.<sup>2</sup> AHCCCS uses a comprehensive OFR tool that includes standards that rate MCOs/PIHPs that provide medical services, as well as behavioral health services. The AHCCCS OFR process includes an extensive crosswalk to ensure ADHS/DBHS compliance is monitored in the following areas a minimum of once every three years, sometimes annually, for each individual federal, state, and contractual obligation.

- Behavioral Health
- Case Management
- Claims System
- Corporate Compliance
- Cultural Competency
- Delegated Agreements
- Delivery System
- General Administration
- Grievance System
- Maternal and Child Health
- Medical Management
- Quality Management
- Reinsurance
- Third Party Liability

The primary objectives of the ADHS/DBHS CYE 2010 OFR were as follows.

- Increase AHCCCS knowledge of ADHS/DBHS operational and financial procedures
- Provide technical assistance and identify areas where improvements can be made, as well as identify areas of noteworthy performance and accomplishments
- Review progress in implementing recommendations made during prior reviews
- Determine if ADHS/DBHS is in compliance with its own policies, and evaluate the effectiveness of those policies and procedures
- Perform ADHS/DBHS oversight as required by CMS in accordance with AHCCCS' Medicaid 1115 Waiver

- Provide information to the EQRO for its use as described in 42 CFR 438.364
- Determine if ADHS/DBHS satisfactorily met AHCCCS' requirements as specified in the Contract YH8-0002, AHCCCS policies, Arizona Administrative Code, and 42 CFR Part 438 Managed Care Regulations

The CYE 2010 OFR for July 1, 2009, through June 30, 2010, was conducted by AHCCCS in October 2010. AHCCCS transmitted the draft OFR report to ADHS/DBHS on December 14, 2010.<sup>3</sup> The AHCCCS findings related to ADHS/DBHS organizational assessment and structure performance in the CYE 2010 Annual EQR Report are based on the December 14, 2010 draft report.

The nine-member AHCCCS OFR review team included employees of the Division of Health Care Management in Acute Care Operations, Data Analysis and Research, Medical Management, Clinical Quality Management, and the Office of Administrative Legal Services. Nineteen staff from ADHS/DBHS participated in the review. The OFR tool contained 109 Standards from eight (8) domains or program areas. However, not all of the standards on the comprehensive review tool are applicable to ADHS/DBHS. There were 74 OFR Standards when those for information only and not applicable are excluded. The eight (8) program areas reviewed in CYE 2010 included Claims and Information Systems, Delivery Systems, Encounters, General Administration, Grievance System, Medical Management, Member Information, and Quality Management.<sup>3</sup>

The OFR standards/substandards were rated based on the findings using the following thresholds.

- Full Compliance: ADHS/DBHS was 90-100% in compliance with the standard requirements based on weighted findings
- Substantial Compliance: ADHS/DBHS was 75-89% in compliance with the standard requirement based on weighted findings
- Partial Compliance: ADHS/DBHS was 50-74% in compliance with the standard requirements based on weighted findings
- Non-Compliance: ADHS/DBHS was 0-49% in compliance with the standard requirements based on weighted findings
- Not Applicable: The standard did not apply to ADHS/DBHS and/or the standard was not a contractual requirement and/or there had been no instances in which the requirement applied
- Information Only: The standard was reviewed only to gather information in CYE 2010

Based on the findings of the OFR review, one of three recommendations was made for each standard that was scored:

- "The Contractor (ADHS/DBHS) must" indicated critical non-compliance in an area that must be corrected as soon as possible to be in compliance with the AHCCCS contract
- "The Contractor (ADHS/DBHS) should" indicated non-compliance in an area that must be corrected to be in compliance with the AHCCCS contract, but is not critical to the everyday operation of the Contractor
- "The Contractor (ADHS/DBHS) should consider" was a suggestion by the review team to improve the operation of the contractor, although the operation is not directly related to contract compliance

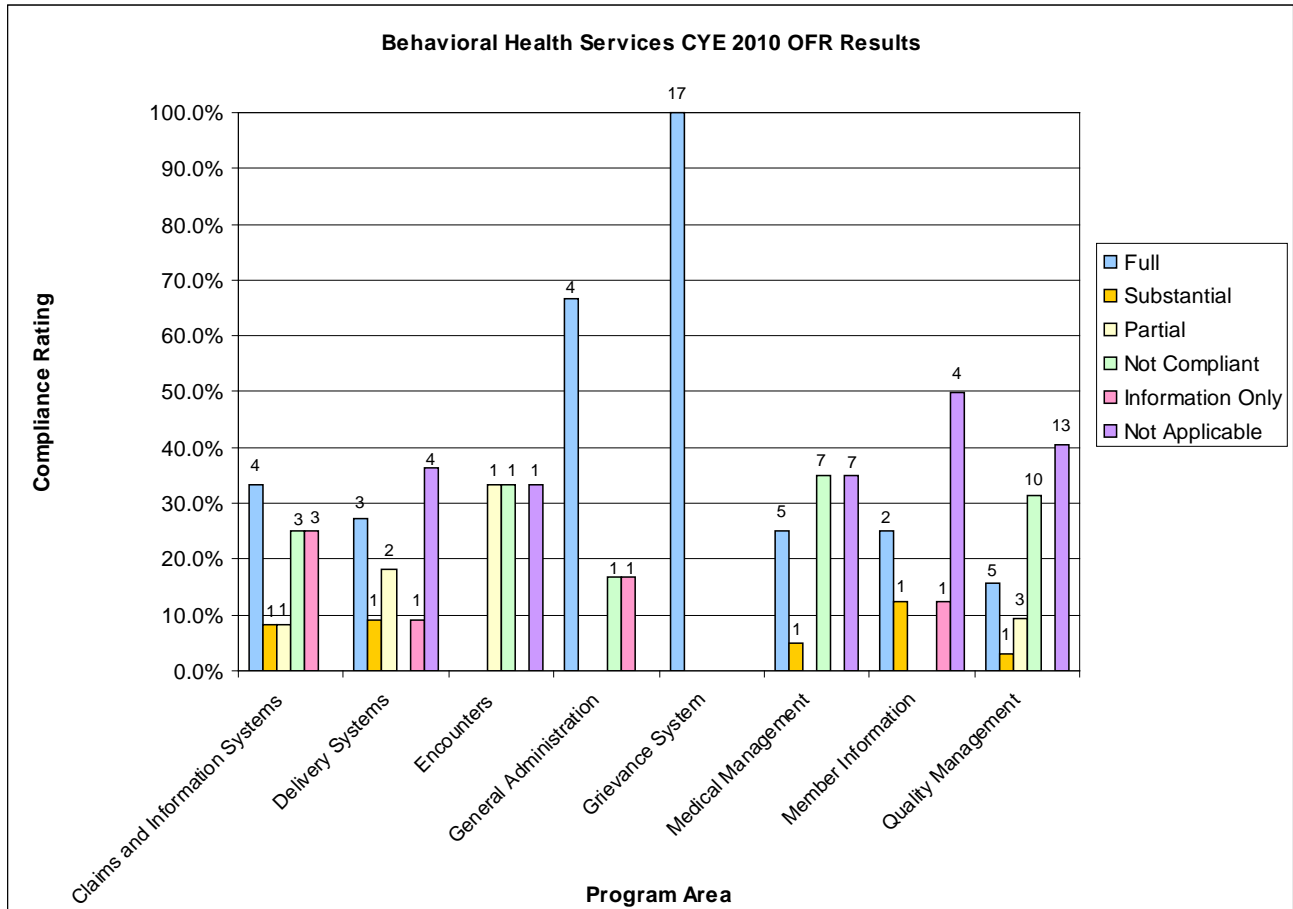
AHCCCS required ADHS/DBHS to develop a Corrective Action Plan (CAP) for standards where there were recommendations that some action must or should be taken. These CAPs were due to AHCCCS for approval within 30 days of the final OFR report. All previous CAPs were reviewed with one of three possible outcomes: (1) Found to be in Full or Substantial Compliance, (2) Carried over with a specific focus in the CYE 2010 OFR, or (3) Addressed through another performance monitoring mechanism.

**Table 1, Chart 1, and Chart 2** illustrate the results of the behavioral health services CYE 2010 OFR across the eight program areas reviewed.

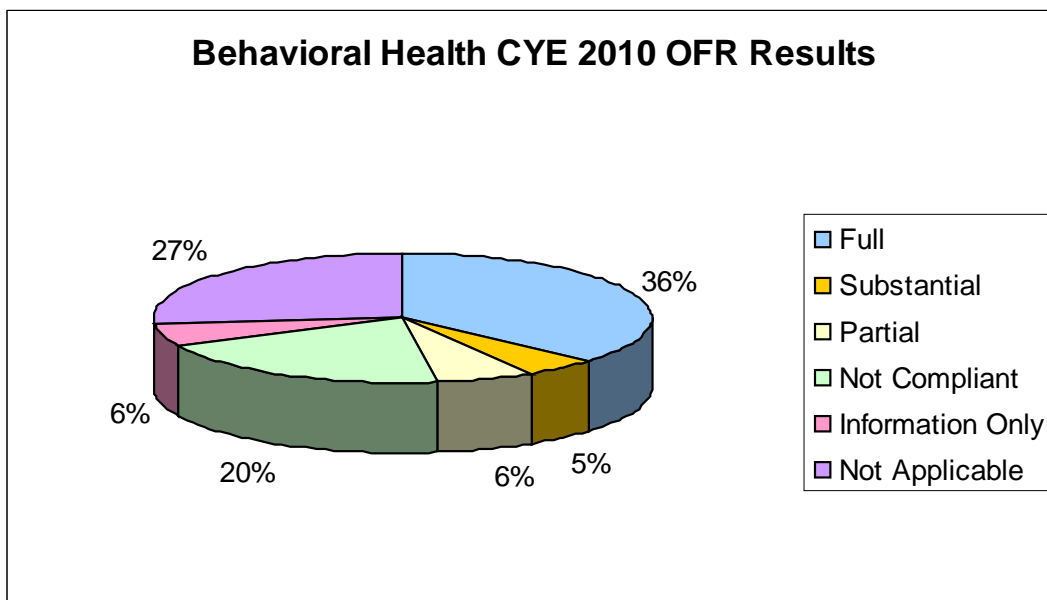
**Table 1**  
**Behavioral Health Services CYE 2010**  
**Operational and Financial Review (OFR) Results**

Program Area	Total Number of Standards	Compliance Rating for Standard					
		Full	Substantial	Partial	Not Compliant	Information Only	Not Applicable
Claims and Information Systems	12	(4) 33.3%	(1) 8.3%	(1) 8.3%	(3) 25%	(3) 25%	(0) 0%
Delivery Systems	11	(3) 27.3%	(1) 9%	(2) 18.2%	(0) 0%	(1) 9%	(4) 36.4%
Encounters	3	(0) 0%	(0) 0%	(1) 33.3%	(1) 33.3%	(0) 0%	(1) 33.3%
General Administration	6	(4) 66.7%	(0) 0%	(0) 0%	(1) 16.7%	(1) 16.7%	(0) 0%
Grievance System	17	(17) 100%	(0) 0%	(0) 0%	(0) 0%	(0) 0%	(0) 0%
Medical Management	20	(5) 25%	(1) 5%	(0) 0%	(7) 35%	(0) 0%	(7) 35%
Member Information	8	(2) 25%	(1) 12.5%	(0) 0%	(0) 0%	(1) 12.5%	(4) 50%
Quality Management	32	(5) 15.6%	(1) 3.1%	(3) 9.4%	(10) 31.3%	(0) 0%	(13) 40.6%
<b>TOTAL</b>	<b>109</b>	<b>(40) 36.7%</b>	<b>(5) 4.6%</b>	<b>(7) 6.4%</b>	<b>(22) 20.2%</b>	<b>(6) 5.5%</b>	<b>(29) 26.6%</b>

**Chart 1**



**Chart 2**



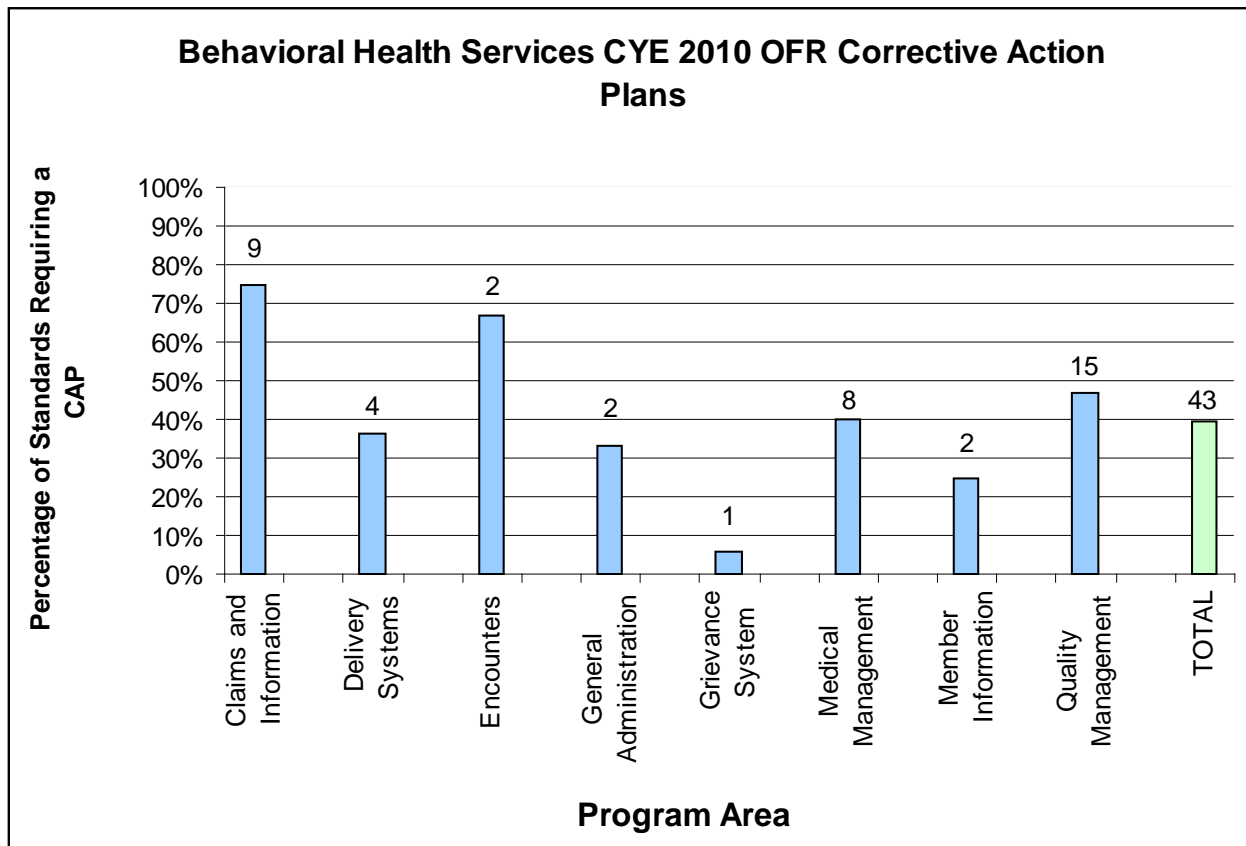
As shown in **Table 1** and **Charts 1** and **2**, ADHS/DBHS was rated in Full Compliance in CYE 2010 for 40 of the 109 Standards or 36.7%. Six Standards were for Information Only, and 29 were Not Applicable. Disregarding the Information Only and Not Applicable standards, ADHS/DBHS was rated in Full Compliance for 54% of those 74 Standards. Five (5) Standards or 4.6% received a Substantial Compliance rating, and seven (7) or 6.4% were rated Partially Compliant. Standards were rated Not Compliant in 22 instances (20.2%), or 29.7% of the time when Standards that were for Information Only or Not Applicable were disregarded. Of the 22 Non-Compliance ratings, three (3) were in Claims and Information Systems, one (1) in Encounters, one (1) in General Administration, seven (7) in Member Information, and 10 in Quality Management.

The number of Standards receiving recommendations requiring a CAP is shown across the eight OFR program areas in **Table 2**.

**Table 2**  
**Behavioral Health Services CYE 2010**  
**Operational and Financial Review (OFR) Recommendations**

Program Area	Total Number of Standards	Number of Recommendations Requiring a CAP	Number of Standards Requiring a CAP	Percentage of Standards Requiring a CAP
Claims and Information Systems	12	9	9	75%
Delivery Systems	11	4	4	36.4%
Encounters	3	2	2	66.7%
General Administration	6	2	2	33.3%
Grievance System	17	1	1	5.9%
Medical Management	20	17	8	40%
Member Information	8	2	2	25%
Quality Management	32	39	15	46.9%
<b>TOTAL</b>	<b>109</b>	<b>76</b>	<b>43</b>	<b>39.4%</b>

**Chart 3**



The percentage of standards requiring a CAP is graphically presented in **Chart 3**. Disregarding standards that were Not Applicable or for Information Only, there were 76 OFR recommendations requiring CAPs across 43 of those 74 Standards (58.1%). Of the 109 total Standards, 39.4% required one or more CAPS.

Trending CYE 2010 OFR performance compared to previous OFR results is not methodologically appropriate, as the number, content, weighting, and rating systems of standards have changed over time.

<sup>1</sup>Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at CFR Parts 400, 430, et al, (Final Protocol, Version 1.0), February 11, 2003.*

<sup>2</sup>Centers for Medicare & Medicaid Services, Medicaid Program; *External Quality Review of Medicaid Managed Care Organizations. Final Rule, (Federal Register, 68 (16): 585-638), January 24, 2003.*

<sup>3</sup>AHCCCS, *CYE 2010 Draft Report of the AHCCCS Operational and Financial Review of ADHS/DBHS, December 14, 2010.*

## **VI. PERFORMANCE MEASUREMENT PERFORMANCE**

### **A. Background**

AHCCCS selected an access to care measure for validation activities comparable to the CMS protocol for performance measure validation. The measure is as follows.

- The percent of AHCCCS members referred for or requesting behavioral health services for whom the first service was provided within 23 days of the initial assessment.

The Access to Care 23 Day measure monitors ADHS/DBHS' compliance with providing a routine service to newly enrolled behavioral health recipients within 23 days of their initial assessments. This measure is encounter-based and a 90-day lag time was observed to provide the RBHAs the opportunity to submit service encounters to the ADHS/DBHS Client Information System (CIS). Reporting frequency was quarterly.

The Minimum Performance Standard (MPS) was 85%, the Goal was 90%, and the Benchmark was 95% for the measure of access to care.

### **B. Provision of a Behavioral Health Service within 23 Days of the Behavioral Health Recipient's Initial Assessment**

The study population was all Medicaid Title XIX and Title XXI eligible children/adolescents and adults with a behavioral health intake date during the reporting period. Validation for the measure included the performance of RBHAs only. The data source was electronic snapshot data from the ADHS CIS. The assessment date was obtained from encounter data, with a list of CPT and HCPCS codes provided for use in identifying an assessment.

For inclusion in this performance measure, the assessment must have occurred within 45 days of the intake date. Thus, usable data were those for behavioral health recipients with an intake date during the study period with a corresponding assessment encounter that must have occurred within 45 days of the intake date. Data were unusable for behavioral health recipients with an intake date during the reporting period but no corresponding assessment encounter data or when the assessment occurred more than 45 days after the intake date. There were a total of 20,740 cases that were unusable. 3,288 (16%) of these cases had an assessment that occurred more than 45 days after the intake date; 17,452 (84%) had no assessment encounter data following the intake date.

An assessment was defined as the ongoing collection and analysis of a person's medical, psychological, psychiatric, and social condition in order to initially determine if a behavioral health disorder existed, if there was a need for behavioral health services, and ensure on an

ongoing basis that the person's service plan was designed to meet the person's (and family's) current needs and long-term goals.

An encounter was defined as a record of a service rendered by a registered AHCCCS provider to an AHCCCS behavioral health recipient enrolled with a contracted RBHA on the date of service. RBHAs had 210 days to submit encounter data to ADHS/DBHS and 120 days to process pending encounter data. Lag time allowed for the provider to submit encounter data to the RBHA and, in turn, for the RBHA to submit the data to ADHS/DBHS.

An intake was defined as the collection by appropriately trained RBHA/Provider staff of basic demographic information about a person in order to enroll him/her in the ADHS/DBHS system, to screen for Title XIX or Title XXI AHCCCS eligibility, and to determine the need for any co-payments.

First service was defined as the earliest service provided to the behavioral health recipient on or after the date of the initial assessment and was obtained from encounter data, with a group of included/excluded procedure codes that identify an assessment. There were limitations on the type of billable service rendered within 23 days of assessment that qualified as a first service. A specified list of behavioral health service categories were excluded as a first service if they occurred on the same day as the assessment. Behavioral health recipients could have received any covered service on the same day as the initial assessment, but only included services were considered in calculating the performance measure. An assessment provided a minimum of one day after the initial assessment met the requirements to qualify as a first service.

Crisis services are excluded from this performance measure, as the measure is designed to evaluate access to routine behavioral health services.

### **C. Description of the Data for CYE 2010**

Calculation of this measure involved the following steps.

1. ADHS/DBHS received the behavioral health recipient enrollment data from the RBHAs by the ADHS/DBHS CIS Intake/Disenrollment tables.
2. The minimum encounter data submission requirements and minimum performance standards for usable data were applied.
3. The percentage of Usable Enrollments was calculated.
  - Numerator: Number of behavioral health recipients with an intake date (excluding crisis encounters) during the review quarter and an encounter for a corresponding initial assessment within 45 days of the encounter date
  - Denominator: Number of behavioral health recipients with a new encounter date (excluding crisis encounters) during the review quarter

4. The percentage compliant with providing a service within 23 days of assessment was calculated.
  - Numerator: Number of behavioral health recipients with an intake date (excluding crisis encounters) during the reporting period with a corresponding assessment encounter within 45 days of the intake date and with an ongoing service encounter within 23 days of the assessment
  - Denominator: Number of behavioral health recipients with an intake date (excluding crisis encounters) during the reporting period with a corresponding assessment encounter within 45 days of the intake date

The accuracy and completeness of data submitted by the RBHAs to the ADHS/DBHS CIS was ensured through pre-processor edits and random data validation review of behavioral health recipient medical charts. ADHS/DBHS may identify a statistically significant random sample of behavioral health recipients who meet the numerator criteria and require the RBHAs to submit documentation for validation purposes or perform validation through on-site visits.

This performance measure was calculated for each reporting quarter 30 days after the end of the subsequent quarter, allowing a 90-day lag time for encounter submission (e.g., January - March 2010 quarter was calculated in July 2010). Compliance was calculated on cumulative performance for the current reporting quarter and rerun of the previous three quarters to capture additional encounter submissions. Data were reported by population (child/adolescent, adult).

Aggregated data for CYE 2010 (based on the measurement period of April 1, 2009 – March 31, 2010) showed 78.00% of 94,277 enrollments were usable for calculation of this measure. Of these, 89.19% of the total statewide usable cases received behavioral health services within 23 days of initial assessment. This result is just short of the Goal of 90%. This was based on a total statewide number of usable cases of 73,537, of which 41,574 were adults and 31,963 were children. For adults, 91.66%, exceeding the Goal of 90%, received behavioral health services within the 23-day standard, while this rate for children was 85.99%, exceeding the Minimum Performance Standard of 85%.

ADHS/DBHS, through AHCCCS, provided the EQRO with the following to use in the performance measure validation process.

- Original raw source data from the ADHS/DBHS CIS processed in August 2010
- A copy of the ADHS/DBHS BQMO Specifications Manual, which includes a description, methodology, operational definitions, and quality control measures used to calculate performance for each CYE 2010 quarter

- A copy of the October 1, 2010, ADHS/DBHS BQMO Annual Performance Improvement Report submitted to AHCCCS, including the access to care standards and the most recently reported aggregated CYE 2010 performance on the 23-day standard
- Field definitions for Access to Care 23 Day Performance Measure tables

Using the information available as listed above, the following variables or fields were examined by the EQRO to verify data collection and arrive at reportable numbers.

- Reporting quarter
- Client's intake date
- Qualifying behavioral health services occurring within 23 days of initial assessment
- Indication of whether the record is "usable" based on the presence of Assessment within 45 days of Intake date in CIS
- Indication of Child or Adult

Quarterly usable denominator data were analyzed by SAS FREQ procedure; the results were 100% matched with the source data. Quarterly numerator data for service within 23 days were analyzed by SAS Table Analysis procedure; the results were 100% matched with the source data.

**Table 3** displays the aggregated statewide data reported by ADHS/DBHS based on August 2010 CIS source data, compared to recalculations performed by the EQRO using the source data provided by ADHS/DBHS through AHCCCS.

**Table 3**  
**Quarter 1 through Quarter 4, CYE 2010**  
**Dates of Enrollment Reported for July 1, 2009 through June 30, 2010**  
**Title XIX and Title XXI Only**

Total Enrollments	Total Usable Enrollments	Percentage of Usable Enrollments	Of Usable Cases - The Number Within 23 Days	Of Usable Cases - The Percentage Within 23 Days
<b>Aggregate Statewide Results for All Populations</b>				
<b>ADHS/DBHS</b>				
94,277	73,537	78.00%	65,594	89.19%
<b>EQRO</b>				
94,277	73,537	78.00%	65,594	89.19%
<b>Aggregate Statewide Results for Adults</b>				
<b>ADHS/DBHS</b>				
57,396	41,574	72.43%	38,106	91.66%
<b>EQRO</b>				
57,396	41,574	72.43%	38,106	91.66%
<b>Aggregate Statewide Results for Children</b>				
<b>ADHS/DBHS</b>				
36,881	31,963	86.67%	27,488	85.99%
<b>EQRO</b>				
36,881	31,963	86.67%	27,488	85.99%

**D. Conclusions**

As shown in **Table 3**, the EQRO calculations produced the same results as the comparable ADHS/DBHS calculations. The EQRO findings confirm that the adult population group exceeded the Goal of 90% and child population group exceeded the 85% MPS for this measure. The total statewide percentage of usable cases receiving behavioral health services within 23 days of initial assessment exceeded the MPS and fell just short of the 90% goal.

Evaluation of the aggregate statewide results for all populations reveals that of 94,277 Title XIX and Title XXI total enrollments, only 73,537 or 78% met the criteria for usable enrollments for the Access to Care 23 Day Performance Measure. There were a total of 20,740 cases that were unusable. 3,288 (16%) of these cases had an assessment that occurred more than 45 days after the intake date; 17,452 (84%) had no assessment encounter data following the intake date. This raises concerns about the enrollees who were referred for or had an intake assessment and did not receive behavioral health services timely, but of greater concern is the number of enrollees with no evidence of whether behavioral health services were received following enrollment.

The Access to Care 23 Day Standard performance measure was last evaluated by the EQRO for the CYE 2007 Annual EQR Report. The same statistical methodology was used to evaluate both the CYE 2007 and CYE 2010 access to care performance measure data. **Table 4** shows the comparison of the performance measurement performance for the Access to Care measure CYE 2010 to CYE 2007 findings.

**Table 4**  
**Access to Care 23 Day Standard**  
**Statewide RBHAs Title XIX and Title XXI**  
**Comparison of CYE 2010 to CYE 2007 Findings**

CYE 2010 Findings			
ADHS/DBHS Usable Enrollments	ADHS/DBHS CY 2010 Reported Percentage Compliance	EQRO Validated Usable Enrollments	EQRO CY 2010 Validated Percentage Compliance
73,537	89.2%	73,537	89.2%
CYE 2007 Findings			
ADHS/DBHS Total Usable Enrollments	ADHS/DBHS CY 2007 Reported Percentage Compliance	EQRO Validated Usable Enrollments	EQRO CY 2007 Validated Percentage Compliance
53,055	87.91%	53,055	86.75%

## VII. PERFORMANCE IMPROVEMENT PROJECT PERFORMANCE

The ADHS/DBHS *Recovery Through Employment for Individuals with Serious Mental Illness (SMI)* PIP was chosen by AHCCCS for validation and inclusion in the CYE 2010 EQR Annual Report for behavioral health services.

ADHS/DBHS resubmitted the *Recovery Through Employment* PIP proposal to AHCCCS in February 2009, successfully responding to AHCCCS' recommendations. In March 2009, AHCCCS accepted the PIP proposal and revised baseline report. The final report for the *Recovery Through Employment* PIP was submitted by ADHS/DBHS in December 2010. On January 6, 2011, AHCCCS acknowledged that significant and sustained improvement had been demonstrated as required for PIP completion,<sup>1</sup> but required corrections to percentage change values reported in the results. ADHS/DBHS revised the PIP data in its resubmission dated January 18, 2011, and the PIP was recognized by AHCCCS as complete, consistent with the 10 CMS protocol activities for conducting and validating performance improvement projects.<sup>2,3</sup> Those activities are as follows.

1. Appropriate study topic
2. Clearly defined and answerable study question
3. Clearly defined study indicator(s)
4. Unambiguously defined study population
5. Valid sampling techniques, if sampling is used
6. Accurate and complete data collection
7. Targeted performance improvement strategies
8. Appropriate analysis and interpretation of data
9. Real performance improvement achieved
10. Real performance improvement sustained

The study topic was selected to demonstrate a statistically significant and sustained statewide increase in the utilization of psycho-educational services by Medicaid Title XIX adults with SMI. Psycho-educational services, coded H2027 for pre-job training and job development, are services designed to assist enrollees with SMI in choosing and acquiring a job or other meaningful community activity, such as volunteer work. The review of extensive published research spanning several decades concluded that supported employment for the severely mentally ill is an evidence-based practice that is an important part of psychosocial rehabilitation and recovery.<sup>4</sup> The PIP as first proposed had used employment rate as the indicator, but it was decided that too many uncontrolled variables affect employment rate. The decision was made to have the PIP goal be an increase in utilization of psycho-educational services instead, as a proxy for increased employment rate. Research was cited demonstrating that employment increased when psycho-educational services were provided, and evidence-based practices in supported employment were upheld through the provision of such rehabilitation services. This was an appropriate study topic, clearly stated, with details provided concerning how and why it was selected. The gold standard for PIPs

involves having the study indicator measure an outcome such as employment, but a process measure or valid proxy of an outcome is acceptable.

The study indicator was well defined, objective, and measurable and allowed the study question to be answered. Electronic data were available and already being collected on the study indicator. Rationale was provided for why the indicator was selected, and it measured an important aspect of care.

The study question was whether specific interventions that included increased education regarding disability benefits, development of an online benefits calculator, technical assistance provision, and enhanced rehabilitation network development would result in an increase in the number of the study population who received psycho-educational services such as pre-job training and job development. The study question was stated in clear simple terms and was answerable. The intervention strategies were related to barriers identified through data analysis and quality improvement processes. Different RBHAs implemented different intervention strategies, and the specific interventions and related timeframes were carefully tracked and monitored.

The study population was all Medicaid Title XIX AHCCCS mental health program enrollees with a serious mental illness who were 18 years of age or older, regardless of the length of enrollment or types of services received. The study population was appropriate, complete, and well defined. Inclusion and exclusion criteria were specified, and the study population captured all enrollees to whom the study question applied. Electronic data were available for the entire study population, making sampling unnecessary. Analyzing data for each person included in the study population is preferable to sampling, as this ensures that the results are representative and generalizable.

Data collection procedures were provided, including the data sources used and how and when baseline and remeasurement data were collected. The 2008 baseline data showed there were 27,867 study participants statewide in the denominator, with a numerator of 3,847 who received the psycho-educational service code (H2027) at least one time during the measurement period, for a rate of 13.5%. Federal Rehabilitation Services Administration data were cited, suggesting a successful rehabilitation target of 58%. Given how much greater this target was compared to baseline, it was determined that demonstrating and sustaining a statistically significant increase in receipt of psycho-educational services would be a realistic goal. The study indicator was the utilization rate of psycho-educational services, calculated by determining the numerator (the number of Title XIX adult behavioral health services enrollees with SMI who received the psycho-educational service code H2027 at least one time during the measurement period), and dividing the numerator by the denominator (the total number of adult Title XIX behavioral health enrollees with SMI).

Remeasurement methodology was consistent with baseline measurement methodology. The data supported a clear determination of statistically significant increases in statewide receipt of psycho-educational services.

The statewide percent of the SMI study population who received psycho-educational services at least once during the measurement period was 13.5% during Baseline, 24.7% during Remeasurement I, and 28.6% during Remeasurement II. The performance improvement rate observed during Remeasurement I was a statistically significant increase compared to baseline. Evidence was provided for why this documented improvement in the process of care was the result of the implemented interventions, and there was statistical evidence that the observed improvement was real improvement. Further increases were found during Remeasurement II, satisfying the requirement of demonstrating sustained real performance improvement for PIP completion.<sup>1,2,3</sup>

<sup>1</sup>*Arizona Health Care Cost Containment System Administration, Division of Business and Finance, Contract Amendment 35 with Arizona Department of Health Services, Contract #YH8-0002, ADHS #832007, Effective July 1, 2009, page 82*

<sup>4</sup>*Bond, GR et.al. Implementing Supported Employment as an Evidence-Based Practice, *Psychiatric Services* 52:313-322, March 2001*

<sup>2</sup>*Conducting Performance Improvement Projects, A Protocol for Use in Conducting Medicaid External Quality Review Activities, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002*

<sup>3</sup>*Validating Performance Improvement Projects, A Protocol for Use in Conducting Medicaid External Quality Review Activities, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002*

## **VIII. CONCLUSIONS AND RECOMMENDATIONS FOR THE BEHAVIORAL HEALTH PIHP**

Conclusions and recommendations are provided for each domain or program area reviewed in the CYE 2010 OFR. When the draft CYE 2010 OFR is finalized, ADHS/DBHS will be required to submit CAPs that address all CYE 2010 OFR recommendations where some action must or should be taken. These, in addition to any other standards requiring corrective action, must be reviewed for appropriate implementation during the CYE 2011 OFR. All OFR CAPs for years prior to CYE 2009 are closed.

### **Claims and Information Systems**

ADHS/DBHS was found to be in Full Compliance with a number of established standards for its Claims and Information Systems. There is a mechanism in place to inform behavioral health providers of the appropriate place to send claims for services rendered. ADHS/DBHS ensures that those responsible for claims processing have been trained on AHCCCS' relevant and specific rules and methodology, and pays all overturned claim disputes in a consistent manner within 15 business days of the decision. There is a process to identify resubmitted claims and to adjust claims for data corrections or revised payment. The Claims and Information Systems recommendations for ADHS/DBHS that required a Corrective Action Plan (CAP) were as follows.

- Must include provider rights for claims disputes and instructions for the submission of claims disputes or corrected claims
- Should put a hold on any claim for a limited period of time when the possibility of another liable party exists in order to further review the available coverage prior to denial
- Should develop policies and procedures for the recoupment and refund of overpayments and the adjustment of underpayments
- Should pay applicable interest or penalty on all claims, including claims disputes
- Should accurately apply quick-pay payments
- Should monitor each RBHA to determine if they are in compliance with the contract standard to process and pay all overturned claims disputes in a manner consistent with the decision within 15 business days of the decision
- Should develop policies and procedures for the acceptance and integration of eligibility and enrollment data provided by AHCCCS into its claims and information systems
- Should develop procedures for the acceptance and integration of provider registration data provided by AHCCCS into its claims and information systems
- Must develop policies and procedures for the reimbursement of services provided during the prior coverage period

## **Delivery Systems**

AHCCCS contracts with ADHS/DBHS for the administration of behavioral health services, and ADHS/DBHS then delegates the operational functions of the delivery systems for the provision of therapeutic services. ADHS/DBHS, therefore, acts as an oversight and regulatory agency for the subcontracted entities. As such, ADHS/DBHS provides written or electronic information to service providers including policy and/or procedure changes, subcontract updates, chronic care and disease management information, termination of contract, and exclusion from the network. ADHS/DBHS has a provider selection policy and procedure that prohibits discrimination against those who serve high-risk populations or that specialize in conditions that result in costly treatment. ADHS/DBHS does not prohibit or otherwise restrict a provider from advising or advocating on behalf of an enrollee who is his/her patient.

The Delivery Systems recommendations for ADHS/DBHS that required a CAP were as follows.

- Should ensure Provider Services Representatives are adequately trained on provider inquiry handling and tracking
- Should develop a policy for tracking and trending provider inquiries that includes timely acknowledgement and resolution and taking systemic action as appropriate
- Must ensure out-of-network referrals are made in accordance with appointment standards

## **Encounters**

ADHS/DBHS is required to have integrated electronic systems in place to track and audit encounter data. However, there have been longstanding issues with ensuring timely, accurate, and complete submission of encounters. The recommendations for ADHS/DBHS that required Encounters CAPs were as follows.

- Must provide sufficient documentation in order to compare paid claims data with encounter submissions
- Must provide agenda(s), training material(s), attendee or distribution lists to comply with tracking provider education and training

## **General Administration**

ADHS/DBHS has policies and procedures for the maintenance of records and can provide those records when requested. Training is provided to all staff on AHCCCS guidelines. Staff and the provider network are provided education on fraud and abuse. ADHS/DBHS maintains a policy and procedure for the development and approval of policies for the

AHCCCS line of business. A record of all current policies is maintained, including the last revision date, with provisions for annual review.

The General Administration recommendations for ADHS/DBHS that required a CAP were as follows.

- Must implement a process to ensure all contracts/agreements are loaded accurately and timely
- Should develop a policy and procedure for the auditing of the claims payment/health information system to identify inconsistencies and potential fraud. The audit processes should include pre-payment audits as well as reviewing for the accuracy of payment against the provider's contract terms

### **Grievance System**

ADHS/DBHS has written policies delineating the Grievance System. Appeal decisions are issued and carried out within required timeframes. Provider claim disputes are confirmed with a written acknowledgement of receipt. There is a process for internal communication and coordination when an appeal or claim dispute decision is reversed. ADHS/DBHS ensures that the individuals who make decisions on appeals are appropriately qualified and were not involved in any previous level of review or decision-making. Claim disputes are resolved and written Notices of Decision are mailed no later than 30 days after receipt of the dispute unless an extension is requested or approved by the provider. Notices of Decision that are issued include all information required by AHCCCS. Claim dispute records are maintained as required. Logs, registries, or other written records include all the contractually required information. ADHS/DBHS continues or reinstates an enrollee's benefits when an appeal is pending under the appropriate circumstances as required by Federal Regulation 42 CFR 438.420. If an ADHS/DBHS or Director's decision reverses a decision to deny, limit, or delay services that were not furnished while an appeal or hearing was pending, ADHS/DBHS authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires. If an appeal is upheld, ADHS/DBHS may recover the cost of services received by the enrollee during the appeal process.

ADHS/DBHS has policies that require assisting the enrollee with the appeal filing process, including toll-free number(s) that can be used to file an appeal. The enrollee is given reasonable opportunity to present, in person as well as in writing, evidence and allegations of fact or law. The enrollee and/or their representative is given the opportunity before and during the appeal process to review the case file, including medical records and any other documentation considered during the appeal process. The enrollee and/or representative or legal representative(s) are included as a party to the appeal. ADHS/DBHS' grievance process follows the timeframe and written notice requirements. Policies allow providers to

file for appeal on behalf of an enrollee with the enrollee's written consent. A process exists for the intake and handling of enrollee appeals to be filed orally. Requests for hearing received by the ADHS/DBHS are handled following AHCCCS timeframe and notice requirements. There were no Grievance System recommendations for ADHS/DBHS that required a CAP.

### **Medical Management**

ADHS/DBHS acts as an oversight and regulatory agency for subcontracted entities that manage the operational functions of behavioral health services provision. ADHS/DBHS was found in Full Compliance with numerous standards monitored by AHCCCS in 2010. ADHS/DBHS adopts, disseminates, and monitors compliance with practice guidelines that are consistent with Federal Regulations and are based on national and/or local standards of practice. Payment is not denied for emergency services. Written policies and procedures are in place and followed for the processing of prior authorization requests. A structure is in place to approve and reimburse for the provision of services to enrollees who have liable third party coverage, and authorization or reimbursement is not denied when ADHS/DBHS is aware that the liable third party will not cover the condition or service. Written notice is provided to enrollees, facilities, and providers at least two working days before a continued inpatient stay authorization is set to expire.

ADHS/DBHS must develop CAPs for the following recommendations, consistent with Medical Management standards, and submit them for AHCCCS approval.

- Must develop a policy that outlines the variance criteria that would identify members and providers who require intervention in order to correct patterns of abuse or misuse
- Must demonstrate the use of processes for monitoring and evaluating utilization of services, both for under- and over-utilization
- Must document in the Medical Management/Utilization Management (MM/UM) Committee minutes the review of utilization data that demonstrates having a health information system that collects, analyzes, integrates and reports data over time so that trends are identified
- Must document, through the MM/UM Committee minutes, outcomes based on previous meeting minutes' recommendations and document the analysis of these interventions and make changes to interventions based on the recommendations
- Must document identified MM/UM patterns and any interventions taken as a result of the quality review based on the variances
- Must provide ongoing oversight for the over- and under-utilization patterns
- Must develop a process for oversight of subcontractors' inter-rater reliability program(s)

- Must develop policies regarding inter-rater reliability for staff involved with the application of clinical criteria for decision making up to and including the Medical Director
- Must develop a policy and procedure for members who transition back to the Acute Care Contractor for the management of depression, anxiety, and attention deficit hyperactivity disorder
- Must develop a process for oversight of the subcontractors' transition activity
- Must develop a process for monitoring the effectiveness of the care coordination/case management of special health care needs members
- Must amend the policy for addressing the review of new technology based on authorization requests that may be time-dependent
- Must describe in the policy the relevant clinical information that is to be obtained when making hospital length of stay decisions or level of care determinations
- Must develop criteria to describe services requiring retrospective review
- Must report to the Medical Management or appropriate committee any identified utilization issues for analysis and intervention
- Must amend the policy to document protocols to assist homeless clinics with the prior authorization process
- Must develop a process for monitoring and reporting the oversight of timeliness of prior authorization decisions within 14 days for a standard request and within three (3) days for an urgent (expedited) request

### **Member Information**

ADHS/DBHS' new member information packets are tracked to ensure mailing within 10 days of receiving AHCCCS notification and were found to contain the most current Member Handbook. Affected enrollees are notified of material changes to the network and operations at least 30 days before the effective date of the change. Affected enrollees are also notified on a timely basis when a frequently utilized provider leaves the network.

The Member Information recommendations for ADHS/DBHS that required a CAP were as follows.

- Must review the New Member Information Packets distributed by its subcontractors to ensure all material has been approved by ADHS
- Should notify members, in a notice separate from the handbook, that they can receive a new Member Handbook annually

### **Quality Management**

ADHS/DBHS and its governing body are accountable for all Quality Management/Quality Improvement (QM/QI) program functions, and has the appropriate staff employed to carry

out the related administrative requirements. A Quality Management Program structure is in place that includes administrative requirements related to policy development and the peer review process. The ADHS/DBHS health information system includes data collection requirements such as member demographics, services provided, and other information necessary for engaging in quality improvement.

The Quality Management recommendations for ADHS/DBHS that required a CAP were as follows.

- Must indicate the level of substantiation on all quality-of-care cases
- Should include the determination of level of substantiation in written correspondence to AHCCCS regarding the findings on individual cases
- During the CYE 2011 OFR, must provide documentation as specified of the level of severity assigned to the quality-of-care cases selected for review for the OFR
- Must include ADHS/DBHS analysis of the documentation submitted by its sub-contractors and identify any additional issues that need to be addressed
- Must identify why the sub-contractor initiated a change if the sub-contractor determines the allegation is not substantiated but also makes a change in policy, implements staff training, or takes other action
- Must improve its individual and systemic intervention and resolution processes and determine the effectiveness of the interventions implemented
- Must communicate with members and families who make a complaint to advise them that the issue is being reviewed
- Must afford closing communication to the enrollee/family member that made the original complaint
- Must continue to "systemically extract and bucket quality-of-care data" for evaluation by the QM Committee to identify potential performance improvement opportunities based on system-wide data
- Must analyze and evaluate the data from its system to determine any trends related to the quality of the Contractor's service delivery system or provider network
- Must utilize trends referred to and reviewed by the QM Committee to design and implement interventions to improve the care provided to members
- Must monitor the success of interventions developed as a result of enrollee complaint issues (including clinical and non-clinical interventions)
- Must incorporate successful interventions into the QM program or assign new interventions/approaches when necessary
- Should update the Credentialing and Re-credentialing policy to include all AHCCCS requirements
- Must revise its policy to incorporate all the requirements for ensuring credentialing, re-credentialing, and provisional credentialing of the providers in its contracted provider network as noted in the AHCCCS Medical Policy Manual (AMPM) Chapter 900

- Must address in policy the role of the Credentialing Committee; the Medical Director's oversight of the credentialing, re-credentialing and provisional credentialing decisions; the need for participation of Arizona Medicaid network providers in making the credentialing decisions; and use of the performance monitoring data and tracking and trending of the provider as part of the decision-making process
- Should annually review its policy and Administrative Review standards and tools against revisions made to the AMPM Chapter 900 to ensure compliance with all requirements
- Should review thirty of each of the initial, re-credentialing, and provisional credentialing files to ensure an adequate sample
- Should review 100 percent of all eligible charts and note it as such if a sub-contractor has less than 30 charts for review
- Should include completed tools for provider files reviewed with ADHS/DBHS documentation during the next AHCCCS OFR
- Must review Provider Manual Policy Section 3.20, Credentialing and Re-credentialing to include all requirements for provisional credentialing, including the timeframe for the Medical Director's signed approval/denial within 14 days of receipt of a completed application
- Must measure all required elements, including timeliness of decisions, for provisional credentialing during the Administrative Reviews of its sub-contractors
- Must ensure that its sub-contractors are compliant with all the initial and re-credentialing elements as specified in the AMPM Chapter 900
- Should indicate for completed audit tools that the sub-contractor's files have been reviewed for all AHCCCS-required elements, and not just indicate that the data element is Not Applicable
- Must develop and implement a process for oversight and audit to ensure that sub-contractors verify the credentials of all organizational providers in compliance with AMPM Chapter 900, Section 950 requirements
- Must formally monitor delegated entities on an ongoing basis at least annually to ensure the delegated entity meets or exceeds the AHCCCS requirements for all functions that they are delegated to perform
- Should clearly document its health information system review and evaluation processes, such as by describing in a policy and procedure how it ensures the accuracy, completeness, timeliness, logic, and consistency of all data necessary to implement its QM/QI Program
- Must calculate and report to AHCCCS all Performance Measure data according to the methodologies specified in its contract with AHCCCS
- Must request any changes to Performance Measure methodology through the formal contract amendment process and have it formally approved by AHCCCS in advance

- Must monitor its sub-contractors, including delegated functions, for compliance with all required elements regarding behavioral health professionals maintaining comprehensive records as identified in the AMPM Chapter 900, Policy 940
- Must monitor its sub-contractors for compliance with all required elements for behavioral health professionals maintaining comprehensive records that include, at a minimum, identification information, demographic information, and member initial and past medical history as identified in the AMPM Chapter 900, Policy 940
- Must monitor its sub-contractors for compliance with all required elements for behavioral health professionals maintaining comprehensive records that include, at a minimum, current problem listing, current medications, documentation of coordination of care, and information releases as identified in the AMPM Chapter 900, Policy 940
- Must monitor its sub-contractors for compliance with all required elements for providers documenting in the enrollee's medical record whether or not the adult member has been provided information on advance directives and whether an advance directive has been executed as identified in the AMPM Chapter 900, Policy 940
- Must revise the QM Medical Record Review Tool to include elements in the tool that review the medical file to determine if there is appropriate supervision by a licensed professional documented in the medical chart, and to check that the enrollee's medical record information is confidential and protected per federal and state law
- Must monitor sub-contractors for compliance with all required elements identified in the AMPM Chapter 900, Policy 940
- Should document the qualifications of staff that collect and analyze data for performance improvement projects, as well document, such as in a policy and procedure, the inter-rater reliability processes if more than one person are collecting and entering data

A number of Quality Management Standards in the CYE 2009 OFR were revisited in the CYE 2010 OFR, and one was monitored through another mechanism—the ADHS/DBHS Semiannual Performance Improvement Reports. For three QM Standards rated Non-Compliant in 2009, two of these were rated in Full Compliance in 2010 and one in Substantial Compliance. Two rated in Partial Compliance in 2009 were rated in Full Compliance in 2010. However, in eight instances where QM Standards were rated in Non-Compliance in the CYE 2009 OFR, ADHS/DBHS continued to be rated in Non-Compliance in the CYE 2010 OFR for comparable Standards. One CYE 2009 Medical Management CAP was challenged, and the challenge was rejected with the finding remaining Non-Compliance. Another Medical Management CAP was not accepted and required amendment.

ADHS/DBHS strengths related to timeliness, access, and/or quality of care are highlighted by the following Standards, each of which received a rating of Full Compliance or Substantial Compliance in the CYE 2010 OFR.

- Adopting, disseminating, and monitoring compliance with practice guidelines that are compliant with the Federal Regulations and based on national and/or local standards of practice
- Having an effective concurrent review process which includes a component for reviewing the medical necessity of inpatient stays
- Not denying payment for emergency services
- Having in place and following written policies and procedures for processing prior authorization requests
- Providing written notice to enrollees, facilities, and providers at least two working days before a continued inpatient stay authorization is set to expire
- Meeting AHCCCS standards for the content and distribution of New Member Information Packets
- Notifying affected enrollees timely when a frequently utilized provider leaves the network
- Notifying affected enrollees of material changes to network and operations at least 30 days before the effective date of the change
- Having a structure and process in place for quality-of-care and abuse/complaint tracking and trending for enrollee/system resolution
- Holding ADHS/DBHS and its governing body accountable for all QM/QI program functions
- Having the appropriate staff employed to carry out QM administrative requirements
- Having a structure in place for a QM program that includes administrative requirements related to policy development
- Having a structure in place for a QM program that includes administrative requirements related to the peer review process
- Having health information system data elements that facilitate meeting quality improvement requirements

For all RBHAs combined statewide, ADHS/DBHS reported that the Access to Care performance measure showed 89.2% of the total usable cases received behavioral health services within 23 days of initial assessment, which exceeded the Minimum Performance Standard of 85% and fell just short of the Goal of 90% for CYE 2010 as a whole. The same results were found by the EQRO as a part of performance measure validation activities. Performance on this measure was 86.8% in CYE 2007 based on electronic data calculated for the entire population of referrals. The Access to Care 23 Day standard is useful for assessing the sufficiency of the provider network, and provides a measure of the actual receipt of behavioral health services. The measure addresses access from the vantage point

of new clients seeking initial behavioral health services rather than clients farther along in their treatment plans.

However, there were a total of 20,740 cases that were unusable. 3,288 (16%) of these cases had an assessment that occurred more than 45 days after the intake date; 17,452 (84%) had no assessment encounter data following the intake date. There is potential concern about the enrollees who were referred for or had an intake assessment and did not receive behavioral health services timely, but of greater concern is the number of enrollees with no evidence of whether behavioral health services were received following enrollment. Consideration should be given to documentation that responds directly and completely to the outcomes for these enrollees.

The CYE 2009 Behavioral Health Services Consumer Satisfaction Survey found 78% of adults statewide and 76% of children or their family members reported positively about service access, suggesting a need for improvement in service access more than the findings related to the Access to Care performance measure validated in CYE 2010 might suggest. A recommendation to the PIHP is that additional nationally standardized process measures of access should be considered that focus on access during the longer-term treatment process, including measures of utilization.

The *Recovery Through Employment* PIP analyzed the number of severely mentally ill adults who received psycho-educational services at least once during the measurement cycle. The Baseline rate was 13.5%, increasing to 24.7% during Remeasurement I, and 28.6% during Remeasurement II, sustaining this performance improvement. QQ has confidence in these results. While the PIP was successful, the rates were still less than the rehabilitation target of 58% suggested by the Federal Rehabilitation Services Administration. ADHS/DBHS should consider continuing interventions to increase the number of severely mentally ill who receive psycho-educational services, and should simultaneously track changes in employment that accompany this initiative.

The PIP reporting format has continued to evolve with technical assistance from AHCCCS, including a matrix outlining PIP requirements, a Road Map to a PIP, and a PIP Methodology Template. In CYE 2010, the issue remained that the evolution of the PIP plan and the information needed to assess each of the 10 activities and sub-activities required for PIP validation were not contained in a single document. Consideration should be given to documentation that responds directly and completely to each of the PIP validation protocol elements. Attention should also continue be paid to complete and accurate presentation of data. Finally, a mechanism must be found to inform what action is taken by ADHS/DBHS in response to recommendations made in the EQRO Annual Report over and above the OFR recommendations requiring CAPs.

ADHS/DBHS effectively addressed the recommendations in previous EQR reports regarding the selection, calculation, and reporting of measures, including utilizing electronic data sources and nationally standardized measurement approaches. The evaluation of the behavioral health services quality management program by AHCCCS and ADHS/DBHS in CYE 2009 resulted in sweeping revisions initiated in CYE 2010, and additional changes are slated for CYE 2011. Performance measures were revised to produce data that will be more meaningful and reliable in informing AHCCCS of the accessibility, availability, and quality of services received. Many of the changes were consistent with the recommendations in previous EQR Annual Reports. The changes to the scope of the Quality Management Plan will enable ADHS/DBHS to more accurately and effectively evaluate system-wide data to improve functional and treatment outcomes. Consistency with quality measures being developed nationally continues to be recommended due to the inherent advantages of using vetted, valid, and reliable measures that enable benchmarking with Title XIX and Title XXI enrollees in other states.

**APPENDIX**  
**ADHS/DBHS Behavioral Health Services**  
**CYE 2010**  
**Map of GSAs and T/RBHAs**

