

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

Children's Rehabilitative Services

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

HCE QualityQuest



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EXECUTIVE SUMMARY

Introduction

The Children's Rehabilitative Services (CRS) program is administered through the Arizona Department of Health Services (ADHS), Division of Public Health Services/Office for Children with Special Health Care Needs (DPHS/OCSHCN). Children's Rehabilitative Services Administration (CRSA) provides a limited scope of services to children who have specific medical, disabling, or potentially disabling conditions which have the potential for functional improvement. The most common conditions are cerebral palsy, congenital circulatory problems, and congenital musculoskeletal deformities. Arizona Health Care Cost Containment System (AHCCCS) eligible CRS children are concurrently enrolled in an AHCCCS Acute Care or Arizona Long Term Care System (ALTCS) Contractor for their primary health care needs.

AHCCCS has a written Quality Assessment and Performance Improvement (QAPI) Strategy to comply with the Balanced Budget Act (BBA) requirements. AHCCCS regularly monitors and evaluates access to care; organizational structure and operations; clinical and non-clinical quality measures; and performance improvement outcomes for all Medicaid managed care contractors in Arizona, including CRSA. Monitoring is accomplished through ongoing report and document review, regular meetings with CRSA staff, and an annual onsite Operational and Financial Review (OFR).

AHCCCS contracted with HCE QualityQuest (QQ) as the External Quality Review Organization (EQRO) to analyze findings and write the annual External Quality Review (EQR) report of the CRS program for Contract Year Ending (CYE) 2010. This review is limited to the three areas required in the Federal regulations: organizational assessment and structure performance, performance measurement performance, and performance improvement project performance. No optional EQR services are included in this report. AHCCCS uses the results of this EQR report to assist in the identification of strengths and opportunities for improvement. The information is used to assess the effectiveness of its current goals and strategies and provides a roadmap for potential change. EQR reports are a driving force in assessing the effectiveness of the Quality Assessment and Performance Improvement (QAPI) Strategy.

Summary of Findings

CRSA has written policies and procedures in place to support organizational assessment and structure performance. With minor exceptions, policies comply with federal and state requirements. However, many policies have not been fully implemented. The percent of standards rated at full compliance has declined from 82.6% in CYE 2009 to 58% in CYE 2010.

CRSA demonstrated full compliance with Member Information, Reinsurance, and Third Party Liability standards in CYE 2010. Performance on Grievance standards improved 16 percentage points and is at full compliance with 94% of the standards reviewed this year.

Delivery Systems, Medical Management, and Quality Management are the program areas with

significant declines in CYE 2010. CRSA demonstrated full compliance with less than 40% of the standards reviewed in these program areas. Failure to implement and monitor critical policies and using an inadequate sample size in the review of delegated functions are the main reasons for poor performance in these program areas.

CRS recipients are included in the AHCCCS Acute Care or ALTCS population from which samples are drawn for Acute Care or ALTCS plan performance measures. Therefore, the standard performance measurement process established for Acute Care or ALTCS Contractors is not applicable to CRSA. As a result, AHCCCS created performance measures that are unique to the CRS program and are reflective of the services provided by CRSA. The following four performance measures were included in the CRS contract for CYE 2010:

- Timeliness of Eligibility Determination #1
- Timeliness of Eligibility Determination #2
- Timeliness of Initial Service Plan Development
- First CRS Service

CRSA exceeds both the minimum performance standard and the goal for three of the four required performance measures; timeliness of eligibility determinations #1, #2, and timeliness of an initial service plan development. The percent of children who receive their first CRS service by the date specified in their service plan or within 90 calendar days of eligibility is the only performance measure below the minimum standard and lower than the rate reported in 2009. CRSA believes that the findings do not accurately reflect their performance because system limitations and data reporting difficulties may have caused an underreporting of this measure.

CRSA developed a corrective action plan to improve the timeliness of the first CRS service. Interventions are aimed at improving the accuracy of the information used to report the measures; identifying the barriers to timeliness of the first CRS service; and ongoing monitoring for compliance. Work on identifying the barriers to providing the first CRS service in accordance with established timeframes should continue.

In contract year 2010, CRSA completed its work on the Eligibility and Enrollment Performance Improvement Project (PIP). The purpose of this PIP is to increase the proportion of applications with definitive eligibility determinations of either eligible or ineligible within 14 days of receipt of the original application by reducing the number of applications that are pended for needing more information.

CRSA demonstrated a statistically significant improvement in the proportion of CRS initial applications definitively determined as eligible or ineligible within 14 days. CRSA reported that the proportion of applications determined eligible or ineligible within 14 days of the original application increased from 49% at baseline to 83% at the second remeasurement. QQ validated these findings and found the improvement to be greater than that reported by CRSA.

QQ identified that 91% of the applications in its sample were determined eligible or ineligible within 14 days. On average CRSA made a definitive eligibility determination within nine days of receiving the initial application. In addition, CRSA reduced the number of applications

pending for needing additional information from 26% at baseline to 9% in the sample reviewed by QQ.

Overall, in CYE 2010 CRSA improved its performance on performance measures; demonstrated significant improvement on its PIP; and did not perform well in organizational assessment and structure performance. Effective January 1, 2011, AHCCCS will assume direct responsibility for oversight of the CRS program. AHCCCS entered into a contract agreement with Arizona Physicians IPA, which also has an acute-care contract, to assume administration of CRS services from ADHS. This contract change will streamline administration of the CRS program and ensure a seamless and transparent transition for CRS members, their families and providers. The goal remains to ensure timely referral and care coordination with Acute-care contractors for children with special health needs.

I. BACKGROUND

Arizona's Medicaid program, known as AHCCCS, was established in 1982 and was the first Medicaid program in the United States to be granted an 1115 waiver. The waiver allows Arizona to operate a demonstration project using a managed care model for the delivery of health care services.

Prior to the implementation of the AHCCCS program, CRS was known as the Society for Crippled Children. This society was founded in 1929 as a private charitable organization caring for poor children suffering from the effects of poliomyelitis and other conditions, such as club foot.

In 1935 the Social Security Act provided federal money to be used for the operation of this program. Today the program is known as Children's Rehabilitative Services. The CRS program is currently administered by the Arizona Department of Health Services, Office for Children with Special Health Care Needs (OCSHCN). In Arizona the Medicaid program and CRS are managed by separate state agencies.

It is important to note that all Medicaid eligible children including those eligible under the State Children's Health Insurance Program (SCHIP) are assigned to an AHCCCS Acute Care or ALTCS Contractor for their acute, long term, and preventative health care needs. When a child is identified with a CRS covered condition, the child is referred to CRSA. A child may be referred by a provider, parent, caregiver, or anyone involved with the child. If CRSA determines that a child's condition qualifies for CRS coverage, the child is enrolled in the CRS program and must receive all care for that condition from the CRS contracted provider network. Medicaid children with a CRS qualifying condition are enrolled in both health care systems.

Each Medicaid eligible child in CRS is included in the Acute Care or ALTCS Contractor's PIPs and performance measures. Most of the PIPs and performance measures mandated by AHCCCS for the Acute Care/ALTCS Contractors are based on Healthcare Effectiveness Data and Information Set (HEDIS[®]) measures, such as immunization rates and well-child visits. These services are not provided by CRSA. AHCCCS has identified performance measures for CRSA and requires CRSA to conduct PIPs relevant to the CRS program. CRS members are considered a special needs population and are included in the AHCCCS Quality Strategy.

AHCCCS has had a formal Quality Initiative and Performance Improvement Plan since 1994 and a Quality Strategy since 2003. It is reviewed annually and revised as appropriate. The 2010 revision includes the CHIPRA requirements. The Quality Strategy encompasses AHCCCS acute and long term Contractors, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and the ADHS Children's Rehabilitative Services (CRS).

The scope of the Quality Strategy as outlined by AHCCCS includes the following tenets.

- Enhance current performance measures, performance improvement projects, and best practices activities by creating a comprehensive quality of care assessment and

improvement plan across AHCCCS Medicaid programs including CHIPRA that serves as a roadmap for driving the improvement of member-centered outcomes

- Build upon prevention efforts and health maintenance/management to improve AHCCCS members' health status through targeted medical management to include planning patient care for the special needs population
- Develop collaborative strategies and initiatives with state agencies and other external partners to include effective medical management of at risk and vulnerable populations
- Enhance customer service and improve information retrieval and reporting capability by establishing new and upgrading existing information technologies and thereby increasing responsiveness and productivity

II. DESCRIPTION OF EXTERNAL QUALITY REVIEW ACTIVITIES

Medicaid is a joint federal and state program that provides medical assistance to low-income groups including children, senior citizens, and people with disabilities. Since its inception in 1982, Arizona has operated its Medicaid program under an 1115 waiver. This waiver allows Arizona to use a managed care model to deliver health care services to its Medicaid population.

The BBA requires states to implement a quality assessment and improvement strategy and as part of that strategy, provide an annual external independent review of the quality, outcomes, timeliness of, and access to the services covered under each managed care contract.

Federal regulations require that the EQR include the following activities.

- Validation of PIPs required by the state to comply with requirements set forth in 42 CFR 438.240(b)(1) and that were underway during the preceding 12 months
- Validation of performance measures reported to the state or performance measures calculated by the state during the preceding 12 months to comply with requirements set forth in 438.240(b)(2)
- Reviews every three years to determine the Prepaid Inpatient Health Plans' (PIHPs') compliance with standards required by the state to comply with 42 CFR 438.204(g), that are related to access to care, structure and operations, and quality measurement and improvement

These EQR activities may be performed by one or more organizations, but the findings must be incorporated into a single annual report prepared by one EQRO. AHCCCS contracted with QQ to prepare this CRS EQR Annual Report for Contract Year Ending (CYE) 2010. The annual report must include the following components.

- A detailed technical report describing the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to care
- An assessment of each health plan's strengths and weaknesses with respect to quality, timeliness, and access to care
- As the state determines, methodologically appropriate, comparative information about all health plans
- Recommendations for improving the quality of health care services furnished by the health plans
- An assessment of the degree to which each health plan has addressed effectively the quality improvement recommendations made by an EQRO during the prior year's EQR

QQ based its review of the Organizational Assessment and Structure Performance on the information provided in the Annual Operational and Financial Review (OFR) for CYE 2010 conducted by AHCCCS on March 29-31, 2010. QQ analyzed the findings and the corrective actions implemented by CRSA as a result of the review. A description of the process used by AHCCCS is included in the Organizational Assessment and Structure Performance section of this report.

The performance measurement review is based on the rates submitted by CRSA. A statistically significant random sample of recipient records to validate CRSA reported findings was not performed this contract year. QQ analyzed the findings and compared them to findings from the previous year. Corrective actions implemented by CRSA to improve performance measures were reviewed and evaluated as part of the review process.

QQ reviewed the Eligibility and Enrollment PIP. The information reviewed was provided by CRSA as part of an annual report of its progress submitted to AHCCCS. QQ performed an independent data validation on a random sample of 36 records as part of its review. The process used by QQ is described in the PIP section later in this report.

AHCCCS uses the results of this EQR report to assist in the identification of strengths and opportunities for improvement. EQR reports are a driving force in assessing the effectiveness of the QAPI Strategy. The information is used to assess the effectiveness of its current goals and strategies and provides a roadmap for potential change.

III. STATE QUALITY INITIATIVES

In compliance with federal regulations, AHCCCS has a written QAPI Strategy 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. This section of the report highlights the quality initiatives implemented by the state to support Contractor efforts to improve the quality of care and service provided to members, including those enrolled in the State Children's Health Insurance Program (SCHIP), known as KidsCare in Arizona.

As part of its QAPI Strategy, AHCCCS has identified specific goals and objectives as the focus of its strategy over the next five years. Many of the activities impact the CRS population. Highlights of the QAPI Strategy include the following.

- Enhance current performance measures, PIPs, and best practices activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS Medicaid programs that serves as a roadmap for driving the improvement of member-centered outcomes
- Improving functionality in activities of daily living
- Planning patient care for the special needs population
- Developing collaborative strategies and initiatives with state agencies and other external partners. Objectives include continuing use of:
 - Strategic partnerships to improve access to health care services and affordable health care coverage;
 - Effective medical management of at risk and vulnerable populations; and
 - Capacity building in rural and underserved areas to address both professional and paraprofessional shortages.
- Enhance customer service and improve information retrieval and reporting capability by establishing new and upgrading existing information technologies and thereby increasing responsiveness and productivity.

AHCCCS strives for optimal member health outcomes and member satisfaction. This is evidenced by the significant quality improvements that have already been achieved. The following examples highlight the major accomplishments to date.

- **Performance Measures** – AHCCCS was among the first to utilize HEDIS[®] measures or HEDIS[®]-like measures for Medicaid managed care. Minimum Performance Standards (MPS) are based on the most recent national NCQA HEDIS[®] Medicaid means available. If the Medicaid mean for any measure is met, the MPS is based on a target to narrow the gap between the current AHCCCS statewide mean and a national goal such as Healthy People 2020. AHCCCS also participated in the CHIP Measure review process and is reviewing the measures for implementation.

All Performance Measures apply to all member populations, but AHCCCS may analyze and report results by line of business/program, geographic services area (GSA) or county, and/or applicable demographic factors to identify opportunities for improvement. For example, rates

for several child and adolescent members are analyzed and reported separately for Medicaid and KidsCare members, and further stratified by race/ethnicity.

This system has helped achieve a high level of overall performance in several areas of preventive health, as measured by HEDIS[®] specifications. For example, the overall average of AHCCCS Contractors for annual dental visits by children and adolescents is in the top 10 percent of Medicaid health plans nationally. Other measures in which the AHCCCS program outperforms the national average for Medicaid health plans are most measures of childhood immunizations and well-child visits in the first 15 months of life.

AHCCCS continues to explore new ways to drive further improvements in performance, including possible Contractor, member, and/or provider incentives. The Agency also continues to raise expectations for Contractor performance; for example, by increasing Minimum Performance Standards, enforcing corrective action plans, and implementing sanctions to ensure that members receive preventive health care services.

- **Performance Improvement Projects** – The Agency has a well-developed process for identifying and conducting projects to improve performance in key areas of clinical care and non-clinical services that affect health outcomes and enrollee satisfaction. PIPs may be focused on specific populations or programs, and measurements for these projects also may stratify members by line of business/program, GSA or county, and/or applicable demographic factors to identify opportunities for improvement.

In 2005, AHCCCS implemented a PIP to improve the completeness of vaccination data recorded in the Arizona State Immunization Information System (ASIIS) for children and adolescents covered by AHCCCS. By ensuring that more complete data are contained in the state's electronic immunization registry, health care providers can determine whether their patients are up to date on vaccinations and take advantage of opportunities to complete immunizations, thus protecting children and the community at large from preventable infectious diseases. Under the PIP, the percent of AHCCCS primary care providers reporting vaccination data to ASIIS on a monthly basis increased significantly, from 74.2 percent in 2005 to 88.2 percent in 2008. AHCCCS has also initiated PIPs to improve testing and management of blood-glucose levels among people with diabetes, children's annual dental visits, management of co-morbid (coexisting) and chronic conditions, management of asthma through use of appropriate medications, documentation of advance directives, annual influenza vaccination among adults, and adolescent well-care visits.

- **Spouse as Paid Caregiver** – To continue to expand the Home and Community Based Services (HCBS) network within ALTCS and allow more choice for ALTCS members, AHCCCS requested and received a waiver from CMS to allow members to select their spouse to be their paid caregiver. The Spouse as Paid Caregiver Policy became effective in October, 2007. In Contract Year 2009, approximately 625 members received paid services from their spouse. Allowing the spouse to be a paid caregiver has also expanded the availability of caregivers for other members by making non-spouse caregivers available to other HCBS members.

- **Self Directed Attendant Care** – Consumers and advocates had been requesting that AHCCCS develop a Self Directed Attendant Care (SDAC) Program so that members may have more control and management of their needs. Led by an ALTCS Program Contractor, the development work teams have included members, providers, advocates and AHCCCS Contractors. SDAC encourages members to make decisions that will more likely result in positive outcomes. Stakeholder input has been an integral part of the planning and development of SDAC. The SDAC Program was implemented as of 8/1/2008. In Contract Year 2009, approximately 60 ALTCS members utilized this service.
- **Collaborative Oversight of Nursing Facilities** – AHCCCS has worked with ALTCS Contractors to coordinate the monitoring and oversight of nursing facilities and Assisted Living Homes/Facilities throughout Arizona. This process has reduced the burden on these provider types by reducing the number of AHCCCS Contractors scheduling and conducting quality management reviews allowing them more time for member care and quality improvement activities. In addition, this process has freed time for Contractor resources to evaluate and improve monitoring and oversight of the HCBS program, much of which has far less state licensure oversight.
- **AHCCCS Data Decision Support System** – In 2005, the Agency implemented a “data warehouse,” known as the AHCCCS Data Decision Support System (ADDS), which provides a more timely and flexible way to monitor performance measures data, as well as analyze utilization data by type of treatment or provider, and run specialized queries. When ADDS was developed, the Agency incorporated HEDIS[®] measures, including many that had not been previously used, into the data warehouse. There are now more than 100 separate measures, ranging from Adolescent Well Care Visits to Use of Imaging Studies for Low Back Pain that can be selected to monitor and improve quality. Results for these measures can be analyzed by individual Contractor, GSA, race/ethnicity, and specific beneficiary categories. This allows the Agency and its Contractors to target efforts where improvement is needed and likely to be most beneficial.
- **Health Information Technology** – The Agency has been a strong leader in developing health information technology and exchange efforts since 2005, coordinating the first e-health summits, serving on the state roadmap development committees, and serving on the board of directors of the Arizona Health-e Connection, an e-health coordinating body that started in January of 2007.

The Agency was successful in receiving Medicaid Transformation grants to deploy a statewide federated health information exchange (HIE) utility. Known as the Arizona Medical Information Exchange or AMIE, it used a simple web-based viewer application that provides clinicians timely access to health information without requiring an electronic health record (EHR). After a successful proof of concept phase, AMIE has expanded data partners, the types of patient information available to clinicians, and the number of AMIE certified users.

Another important project funded under the Medicaid Transformation Grant was the creation of an organization that would provide affordable, standards-based EHR systems that targeted

small practice providers. Known as the Arizona Purchasing and Assistance Collaborative for Electronic Health Records (PACeHR), it selected two different web-based EHR systems and services available through group purchasing arrangements. The organization will be working closely with AHCCCS to support eligible providers adopt and demonstrate they are meaningfully using certified EHRs in order to receive Medicaid incentive payments.

Funding for the Medicaid Transformation grant projects was exhausted at the end of 2009. AMIE was able to demonstrate the value of HIE for participating hospitals, clinicians and members. AHCCCS is continuing to work with other state and federal partners to identify and apply for funding opportunities that could support the development of a statewide HIE infrastructure.

Through these efforts, all AHCCCS providers will have easy access to beneficiaries' health records via electronic connection at the point of service. Providing timely member health information at the point of service will improve the quality, efficiency and effectiveness of the AHCCCS program. Real-time health information access will result in improved member care through reduction of medical errors, reduction of redundant testing and procedures, better coordination of care for chronic diseases, increased preventive interventions, reduction in the inappropriate use of the emergency room, and lower administrative costs.

Starting in 2008, AHCCCS worked toward developing initiatives that would improve patient safety, enhance the quality of care, and reduce health care costs across all lines of business. In partnership with several acute care partners, the Agency developed a use case for e-prescribing. The original vision of the workgroup was to evaluate marketed products, identify knowledge and system gaps, develop user groups, establish and monitor implementation progress, develop outcome measures, develop incentives and make recommendations for other AHCCCS providers and plans.

- **Increased Contractual Performance Standards** – AHCCCS realigned the reporting of targeted information to the contractual Performance Standards that would better align minimum performance levels and benchmarks with the most current HEDIS[®] means and percentiles for Medicaid managed care organizations, as reported by the National Committee for Quality Assurance. This mechanism is designed to ensure that, overall, measures of quality meet or exceed national averages for Medicaid and CHIP enrollees.

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

AHCCCS regularly shares best practices with, and provides technical assistance to, its Contractors and encourages them to share evidence-based best practices with each other and their providers. This is accomplished through sharing successful interventions during AHCCCS Contractor Quality Management/Maternal and Child Health; Medical Management; Medical Director; and Administrator meetings of which CRSA is included. The following are examples of information shared at these meetings.

- CRSA streamlined the eligibility and enrollment process for children enrolled with AHCCCS by eliminating the need for the applicant to see a CRS provider to confirm the qualifying diagnosis before enrollment. This allows children in need of CRS services to obtain them sooner. Earlier access to care may result in better outcomes.

To further streamline the process, CRSA initiated an outgoing call program to provide immediate feedback to referring providers when an application is incomplete or submitted with inadequate documentation.

- CRSA successfully implemented a telemedicine program for orthopedic, neurology, and neurosurgery services. Ninety percent of the families that used the service in CY 2010 rated the experience as very good or excellent. Families reported that the wait time to see a doctor was shorter, and that on average they traveled 150 fewer miles, missed 10 fewer hours of work, and saved \$166 by using the service.
- CRSA has established a Family Centered Cultural Competence Committee comprised of members/parents of diverse cultures; community advocacy groups; stakeholders and CRSA staff that meet on a regular basis. This forum allows the entire community to have a voice in shaping relevant policy and programs.
- At an onsite review, AHCCCS and CRSA staff became aware of a subcontractor incorporating information on where to send claims for payment directly on its prior authorization form. This practice ensures that non-contracted providers are informed of where to send claims for payment and reduces a common source of provider frustration. No other contractors were using this approach. This was shared with other contractors as a best practice.

V. ORGANIZATIONAL ASSESSMENT AND STRUCTURE PERFORMANCE

A. Introduction and Objectives

The BBA requires Medicaid agencies that contract with Medicaid Managed Care Organizations (MCOs) and PIHPs “to develop a state quality assessment and improvement strategy that is consistent with standards established by the Department of Health and Human Services (DHHS).” AHCCCS has a written QAPI Strategy to comply with BBA requirements. The document was developed with input from AHCCCS members, the public, and other stakeholders. It is reviewed annually based on the CMS Quality Strategy Tool Kit and/or when a significant change is proposed and implemented. “The Quality Strategy 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.” Federal requirements are broadly defined under the following categories.

- Enrollee Rights and Protections
- Quality Assessment and Performance Improvement
- Access Standards
- Structure and Operations Standards
- Measurement and Improvement Standards
- Grievance System

Federal regulations dictate that states perform a review of plan compliance with these standards at least once every three years. The objectives of this EQR are to determine to what extent CRSA is in compliance with federal and state standards related to organizational assessment and structure and to identify areas where improvement and/or changes are needed.

AHCCCS reports Quality Strategy activities, findings, and actions to AHCCCS members, other stakeholders, contractors, the governor, legislators, and CMS.

B. Description of Data and Information Collection Methodology

AHCCCS uses a combination of methods designed to monitor and oversee CRSA operations. On a regularly scheduled basis AHCCCS monitors and evaluates CRSA compliance with access to care; organizational structure and operations; clinical and non-clinical quality measurements; and performance improvement outcomes through the following activities.

- Annual onsite Operational and Financial Review (OFR)
- Review and analysis of periodic reports
- Review and analysis of program specific performance indicators and PIPs

The contract between AHCCCS and CRSA contains a detailed list of periodic reporting requirements. In addition to required reports, the contract requires CRSA to submit

the following documents to AHCCCS for review or approval.

- A CRSA Policy Manual with copies of final policies submitted to AHCCCS at least ten business days prior to implementation
- Physician Incentive Plan disclosures
- All subcontracts for the provision of AHCCCS covered services
- Requests for proposals to provide AHCCCS covered services
- Legislative proposals and initiatives

Upon receipt by AHCCCS, the documents listed above are forwarded to the specific department within AHCCCS that has the expertise needed to analyze the content of the document. Where applicable, checklists have been developed for staff to use in the review process, ensuring that all required federal and state requirements are addressed. AHCCCS responds in writing, and either approves the document or requests revisions.

In addition to reviewing the deliverables described above, AHCCCS conducts an operations and finance review annually. The review provides the opportunity to validate CRSA compliance with contract requirements. AHCCCS refers to these reviews as OFRs. The process used for these reviews has been refined over several years. A uniform tool is used to review each Contractor, although the tool used for CRSA has been modified to reflect its unique scope of services. The format of the review follows nationally recognized processes and is modeled after NCQA guidelines.

The activities include document review, staff interviews, and observations of operations. This process is consistent with the protocol developed by CMS that includes the following recommended activities.

- Planning for the review
- Obtaining background information
- Document review
- Conducting interviews
- Collecting accessory information
- Reporting results

For CYE 2010, AHCCCS identified the following as the primary objectives for the CRSA OFR.

- Determine if CRSA satisfactorily meets AHCCCS' requirements as specified in the contract, AHCCCS policies, Arizona Revised Statute, Arizona Administrative Code, and 42 CFR Part 438, Managed Care.
- Increase AHCCCS' knowledge of CRSA's operational and financial procedures.
- Provide technical assistance and identify areas where improvements can be made as well as identifying areas of noteworthy performance and accomplishments.
- Review progress in implementing recommendations made during prior OFRs.
- Determine if CRSA is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures.

- Perform oversight of CRSA as required by CMS in accordance with the AHCCCS 1115 waiver.
- Provide information to an EQRO for its use as described in 42 CFR Part 438.364.

Upon completion of the OFR, key program areas are scored according to the following scale.

Full Compliance	90-100% agreement with standard(s)
Substantial Compliance	75-89% agreement with standard(s)
Partial Compliance	50-74% agreement with standard(s)
Noncompliance	0-49% agreement with standard(s)

A written report that includes findings and recommendations is produced. Recommendations are made based on the following definitions.

- “CRSA must” – This indicates a critical noncompliance area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
- “CRSA should” – This indicates a noncompliance area that must be corrected to be in compliance with the AHCCCS contract, but it is not critical to the everyday operation of CRSA.
- “CRSA should consider” – This is a suggestion by the review team to improve operations of CRSA, although it is not directly related to contract compliance.

In addition, AHCCCS regularly obtains feedback from the Acute Care/ALTCS Contractors on CRSA issues. The Acute Care/ALTCS Contractors are likely to be the first to know if CRS recipients or providers are having difficulty navigating the CRS system. These issues are reported to AHCCCS on an ongoing basis. A monthly meeting with Medical Directors from the state’s contracted health plans provides a forum to keep this dialogue open. The CRSA Medical Director attends these meetings. In combination, these oversight activities provide AHCCCS with an accurate assessment of CRSA compliance with state and federal requirements.

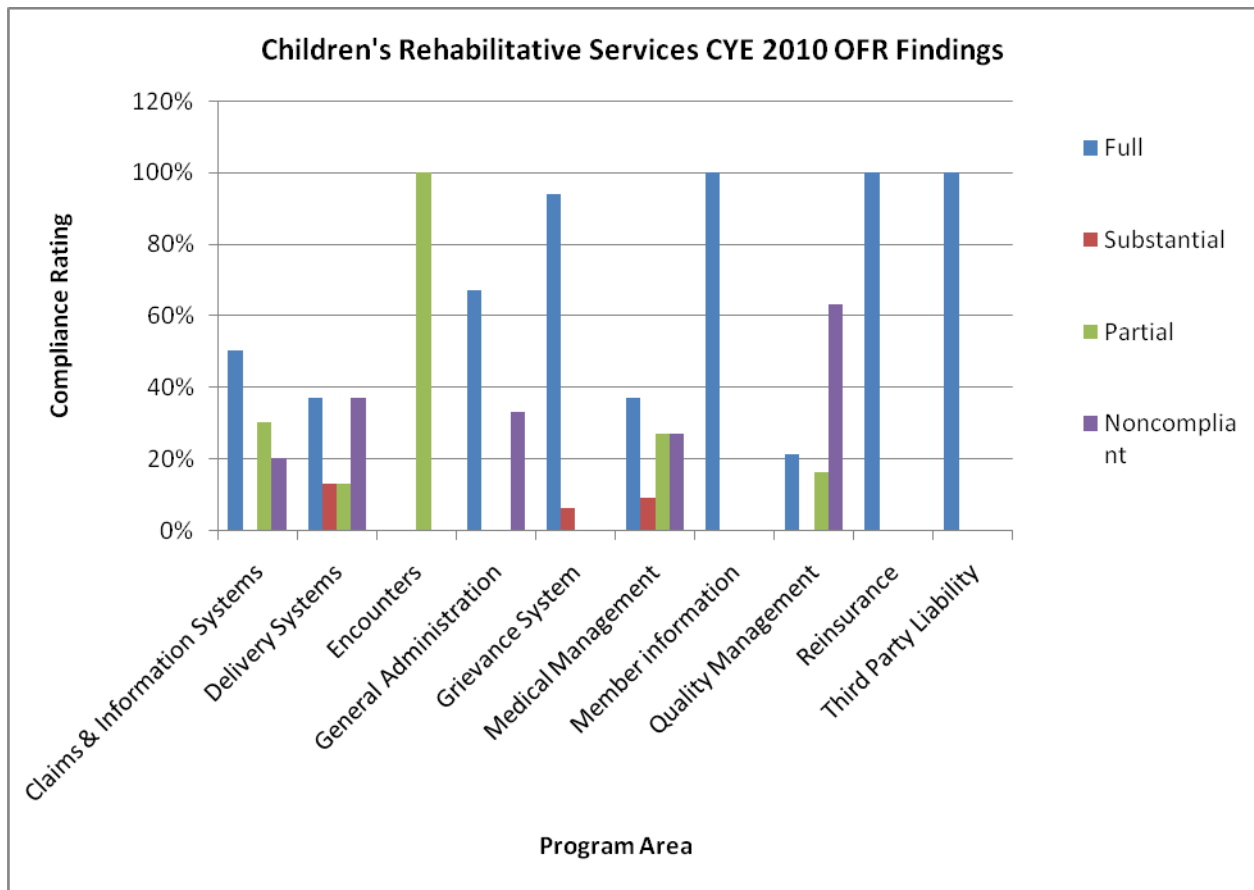
C. Description of the Data for CYE 2010

The overall findings of the compliance review are presented in **Table 1** and **Chart 1** followed by a narrative summarizing the findings by program area. Overall, 86 standards were reviewed and scored. CRSA demonstrated full compliance with 58% of the standards, substantial compliance with 3%, partial compliance with 13%, and noncompliance with 26% of the standards.

**Table 1: Summary of Children’s Rehabilitative Services
 CYE 2010 Operational and Financial Review Findings**

Program Area	Number of Standards Reviewed	Compliance Rating for Standard			
		Full	Substantial	Partial	Noncompliant
Claims and Information Systems	10	5 50%	0 0%	3 30%	2 20%
Delivery Systems	8	3 37%	1 13%	1 13%	3 37%
Encounters	1	0 0%	0 0%	1 100%	0 0%
General Administration	6	4 67%	0 0%	0 0%	2 33%
Grievance System	17	16 94%	1 6%	0 0%	0 0%
Medical Management	11	4 37%	1 9%	3 27%	3 27%
Member Information	4	4 100%	0 0%	0 0%	0 0%
Quality Management	19	4 21%	0 0%	3 16%	12 63%
Reinsurance	2	2 100%	0 0%	0 0%	0 0%
Third Party Liability	8	8 100%	0 0%	0 0%	0 0%
Overall	86	50 58%	3 3%	11 13%	22 26%

**Chart 1: Summary of Children’s Rehabilitative Services
 CYE 2010 Operational and Financial Review Findings**



Claims and Information System

Ten standards were reviewed to evaluate compliance with claims and information systems requirements. CRSA demonstrated full compliance with 5 (50%) of the standards, partial compliance with 3 (30%) of the standards, and noncompliance with 2 (20%) of the standards.

CRSA maintains policies and procedures to process claims timely and appropriately. The claims system is configured to identify resubmitted claims and process adjustments for corrections and revised payments. Contracted providers are informed of the appropriate place to send claims, both paper and electronic, and remittance advices contain all required information. Staff is trained to process claims specific to the AHCCCS line of business.

The problems identified in this area are primarily due to inadequate or missing documentation. CRSA was unable to provide adequate documentation of slow-payment penalties on claims disputes or that overturned claims disputes are processed within 15 business days. In addition, CRSA does not have a written policy and procedures for the

recoupment of overpayments or the integration of provider registration data, provided by AHCCCS, into its claims and information system.

Delivery Systems

Eight standards were reviewed to evaluate compliance with delivery system requirements. CRSA demonstrated full compliance with 3 (37%) standards; substantial compliance with 1 (13%) standard; partial compliance with 1 (13%) standard; and noncompliance with 3 (37%) standards.

CRSA has a written policy and procedure manual that guides the operation of its delivery system. The manual includes policies on critical management activities such as eligibility, coordinating medically necessary non-emergency transportation, provider communication, and out-of-network referrals. A provider manual is available to providers on the website and in hardcopy if requested. The manual includes all necessary information including the provider's right to advise or advocate on behalf of a member without restriction. The manual is updated as necessary.

CRSA's policy on provider inquiries is not complete and does not accurately document its process. The training for provider services representatives is missing key components and consultation reports to referring physicians and AHCCCS contractors are not sent within 30 days of the visit. Not sending consultation reports was noted in the CYE 2009 review and was not corrected this contract year.

Encounters

One standard was reviewed to evaluate compliance with encounter requirements. CRSA demonstrated partial compliance with the standard.

Encounter findings are based on statistical measures applied to adjudicated encounters. If the ratio is within one standard deviation of the mean, the contractor receives 100% of the compliance points. If the ratio is greater than one standard deviation, but does not exceed two standard deviations, the contractor receives 50% of the compliance points. If the ratio exceeds two standard deviations, no compliance points are awarded. Compliance points are totaled and multiplied by a weighting factor to determine the compliance score. Sixty percent (60%) of the claims paid by CRSA were successfully matched with complete, accurate, and timely encounters. Multiple errors and omissions were identified.

General Administration

Six General Administration standards were reviewed. CRSA demonstrated full compliance with 4 (67%) standards, and noncompliance with 2 (33%) standards.

CRSA has written policies and procedures in place for the maintenance of records; staff qualifications and training; and policy development, review, and approval that comply with federal and state guidelines. CRSA has a process to input contract information into its

system and performs periodic audits to ensure the information is timely and accurately loaded. However, CRSA does not compare how the contract was loaded in the system to the hardcopy of the contract to determine if claims are paid correctly, nor do they regularly audit for potential fraud and abuse. These deficiencies were identified in the CYE 2009 review and were not corrected this contract year.

Grievance System

Seventeen standards were reviewed to evaluate compliance with grievance system requirements. CRSA demonstrated full compliance with 16 (94%) standards, and substantial compliance with 1 (13%) standard.

CRSA maintains written policies and procedures that include all federal and state requirements for members and providers to file an appeal. Written information is appropriately distributed to both members and providers and includes procedures for filing a standard appeal, an expedited appeal, and requesting a state fair hearing. Members are allowed to file an appeal orally and providers are allowed to file an appeal on behalf of a recipient with their written consent. Member benefits are appropriately continued or reinstated pending an appeal when a decision to deny is reversed. Provider claim disputes are managed correctly and timely including when an appeal or claim dispute is reversed. Individuals who make decisions on grievances and appeals meet standards, required timeframes are monitored, and written notices are sent as required.

Logs and files related to grievances contain all required information and are properly maintained. The only minor deficiency identified related to untimely member appeals. The Notice of Decision in response to an untimely request for an appeal by a member did not contain the right to request a State Fair Hearing and how to do so. This omission resulted in a substantial compliance rating for one standard.

Medical Management

Eleven standards were reviewed to evaluate compliance with medical management requirements. CRSA demonstrated full compliance with 4 (37%) of the standards, substantial compliance with 1 (9%) standard, partial compliance with 3 (27%) of the standards, and noncompliance with 3 (27%) of the standards.

CRSA has documented policies and procedures in place to guide the prior authorization process. The policy includes that only qualified health care professionals can make a decision to deny, reduce, or terminate a medical service; ensures appropriate communication with providers in accordance with standards; and does not deny authorization or reimbursement when a known liable third party does not cover the requested service. Utilization patterns are monitored and care is coordinated. However, the criteria used to identify under- and over- utilization and the outcomes of interventions aimed at improving utilization are not documented. Medical records do not accompany members transitioning to another contractor; and a process for downgrading an expedited request to a standard request is not documented in policy. These deficiencies resulted in a partial compliance rating for three standards.

Three standards were rated as noncompliant because of the following:

- CRSA did not evaluate staff consistency with its practice guidelines and did not document actions taken when inconsistency is identified.
- CRSA did not implement a process for the review of new technology based on an authorization request that may be time-dependent.
- CRSA did not conduct retrospective reviews of high-dollar and/or potential over-utilized CRS covered services.

Member Information

Four standards were reviewed to evaluate compliance with member information requirements. CRSA demonstrated full compliance with all of the standards.

CRSA has a written policy and procedure that accurately describes the content, distribution, and approval of the New Recipient Orientation Packet. A quarterly mailing report is generated and reviewed to ensure packets are mailed timely. Members are notified annually that they may request a copy of the most recent member handbook and are notified timely when significant program and provider changes occur.

Quality Management

Nineteen quality management standards were reviewed to evaluate compliance with requirements. CRSA demonstrated full compliance with 4 (21%) standards, partial compliance with 3 (16%) standards, and noncompliance with 12 (63%) standards.

CRSA has a written Quality Management program that includes all required components such as PIPs, performance measures, peer review, quality of care/abuse complaints, credentialing, re-credentialing and delegated activities. Quality Management policies are approved and signed by the Medical Director and Executive Management. CRSA employs an appropriate staff to manage its program and trains staff on quality management at the time of hire.

CRSA maintains a health information system that collects, integrates, analyzes, and reports the data necessary to manage its QM/QI program. An appropriate governing body is responsible for oversight of the program.

An annual refresher training on appropriate quality of care referrals and an annual review of policies were not completed this contract year. In addition, a review of quality of care case files identified inadequate documentation, poor communication, and that staff were not consistently following the approved policy. These omissions and inconsistencies resulted in partial compliance for three standards.

Ten of the twelve standards rated as noncompliant are related to CRSA's oversight of its subcontractor. In its annual administrative review of APIPA, CRSA reviewed a sample of 10 cases or files. The AHCCCS standard is 30 therefore all of the standards related to oversight of delegated activities were rated as noncompliant regardless of the actual findings.

Reinsurance

Two standards were reviewed to evaluate compliance with reinsurance requirements. CRSA demonstrated full compliance with both standards.

CRSA maintains written policies and procedures that describe the process for monitoring the appropriateness of the reinsurance revenue received against paid claims data. The AHCCCS Reinsurance unit is notified within 30 days of identifying an overpayment on reinsurance cases regardless of the contract year in which the overpayment occurred.

Third Party Liability

Eight standards were reviewed to evaluate compliance with third party liability requirements. CRSA demonstrated full compliance with all third party liability standards.

CRSA has a written process for identifying claims and services that are subject to third party payment and cost-avoids claims where appropriate. Trauma codes and other appropriate diagnostic code edits are used to identify potential third party claims. CRSA policy includes all required activities including notifying AHCCCS when other insurance coverage for Title XXI (Kids Care) HIFA Parents, BCCTP, and SOBRA Family Planning members is identified. The policy correctly outlines the payment of copayments, coinsurance, and deductibles regardless of the place of service. Liens on total plan casualty cases that exceed \$250 are filed and AHCCCS is contacted to determine if reinsurance or fee-for-service payments were made by AHCCCS before negotiating a settlement. CRSA uses the AHCCCS approved Casualty Settlement Notification form to notify AHCCCS within 10 business day of the settlement.

D. Conclusions: Strengths and Opportunities for Improvement

CRSA has written policies and procedures in place to appropriately manage program operations. With minor exceptions, policies comply with federal and state requirements. However, many policies have not been fully implemented. The percent of standards rated at full compliance has declined from 82.6% in CYE 2009 to 58% in CYE 2010.

Four program areas demonstrated noteworthy performance. Member Information, Reinsurance, and Third Party Liability are in full compliance with the standards reviewed. The Grievance System improved 16 percentage points compared to the previous review and is in full compliance with 94% of the standards reviewed this contract year.

Delivery Systems, Medical Management, and Quality Management demonstrated full compliance with less than 40% of the standards reviewed. Performance in these program areas significantly declined compared to the findings reporting in CYE 2009. Failure to implement and monitor critical policies and an inadequate review of delegated functions are the primary reasons for poor performance in these areas.

Effective January 1, 2011 the responsibility for oversight of the CRS program will transition from CRSA to AHCCCS.

VI. PERFORMANCE MEASUREMENT PERFORMANCE

A. Introduction and Objectives

As described in its QAPI Strategy, AHCCCS recognizes the need for identifying, tracking, and trending performance measures as a component of assessing the overall quality of care delivered to its members. AHCCCS recognizes that for these measures to be reliable and valid, the methodology must be sound and based on nationally recognized standards. AHCCCS uses HEDIS[®] to evaluate performance in its acute care plans. HEDIS[®] was developed by NCQA and is considered the national standard for measuring and reporting health plan performance.

In addition to identifying the performance measures, AHCCCS identifies a Minimum Performance Standard (MPS) and a Goal for each measure. The MPS and Goal for each measure are based on an objective methodology designed to “narrow the gap” between the current statewide average and a longer-range goal. If the MPS is not achieved, the contractor is required to develop and submit a corrective action plan with interventions aimed at meeting the MPS.

Medicaid eligible CRS members are dually enrolled in AHCCCS and primary health care needs are provided by an Acute Care or ALTCS Contractor. CRS members are included in the Acute Care or ALTCS Contractor population from which samples are drawn for the Contractor’s performance measures. For example, when measuring immunization rates for two-year-old children, all of the two-year-olds are eligible to be included in the sample, including those receiving specialized services through CRS.

Since primary care performance is monitored for the Acute and ALTCS plans via HEDIS[®], which focuses on preventive health care measures, HEDIS[®] is not applicable to CRS. Therefore, AHCCCS requires CRS to report performance on measures specific to the services provided by CRS. The performance measures and methodology used to measure performance are specified in the contract and must be reported and evaluated on an annual basis.

In CYE 2010, the following four access to care measures were required for CRS.

- Timeliness of Eligibility Determination #1
- Timeliness of Eligibility Determination #2
- Timeliness of Initial Service Plan Development
- First CRS Service

These measures are reflective of the services provided by CRS. Due to the unique nature of these performance measures, there are no national standards or benchmarks that can be used for comparison. The purpose of these performance measures is to ensure that enrollees have access to care in a timely manner. Timely access to care is a proxy for

network adequacy and is used as a way to evaluate if a health plan has enough providers to meet the needs of its members in a reasonable amount of time. AHCCCS has delineated the methodology to be used and established MPS and a Goal for each measure. **Table 2** identifies these requirements.

**Table 2: Children’s Rehabilitative Services Performance Measures
 Minimum Performance Standards and Goals**

Performance Measure	Minimum Performance Standard	Goal
Timeliness of Eligibility Determination #1	75%	90%
Timeliness of Eligibility Determination #2	75%	90%
Timeliness of Initial Service Plan Development	75%	90%
First CRS Service	75%	90%

The objective of the performance measurement validation is to determine if CRSA is in compliance with the minimum performance standards as required by contract.

B. Description of Data Collection Methodology

The performance measures are defined as follows.

Timeliness of Eligibility Determination #1 -- The percent of AHCCCS members for whom a determination of eligibility was made (i.e., eligible or ineligible) and who were notified in writing of the decision within 14 calendar days of a complete CRS Referral Form received by the CRS subcontractor.

Timeliness of Eligibility Determination #2 -- The percent of AHCCCS members for whom a determination of eligibility could not be made from the CRS Referral Form and who were notified in writing within 14 calendar days of receipt of the Referral Form that additional information or medical evaluation was required in order to make a determination of medical eligibility.

Timeliness of Initial Service Plan Development -- The percent of AHCCCS members for whom an initial service plan (ISP) was completed on or before the date of positive eligibility determination by the CRS subcontractor.

First CRS Service -- The percent of AHCCCS members who receive their first CRS service by the date specified on the ISP or within 90 calendar days of the date of positive eligibility determination.

CRSA collects the numerator and denominator data from the CRS clinic systems for all AHCCCS members who meet the denominator criteria and provides the information to AHCCCS in a predetermined electronic format. From the information submitted by

CRSA, AHCCCS identifies a statistically significant random sample of recipients who meet the numerator criteria and either requests from CRSA the medical charts or other hardcopy documentation for validation purposes, or performs validation at site visits. The findings included in this report are limited to those reported by CRSA.

C. Description of the Data for CYE 2010

CRSA’s reported rates for each performance measure in CY 2010 compared to CY 2009 are presented in **Table 3**.

**Table 3: Children’s Rehabilitative Services
 Performance Measure Rates by Contract Year**

Performance Measure	Percent of Members Meeting Numerator Criteria	
	CYE 2009	CYE 2010
Timeliness of Eligibility Determination #1	92%	99%
Timeliness of Eligibility Determination #2	96%	99%
Timeliness of Initial Service Plan Development	100%	100%
First CRS Service	50%	39%

CRSA exceeds both the MPS and the Goal for three of the four required performance measures; timeliness of eligibility determinations #1, #2, and timeliness of an initial service plan development. The percent of children who receive their first CRS service by the date specified in their service plan or within 90 calendar days of eligibility is the only performance measure below the minimum standard and lower than the rate reported in 2009. CRSA believes that the findings do not accurately reflect their performance because system limitations and data reporting difficulties may have caused an underreporting of this measure.

D. Conclusions: Strengths and Opportunities for Improvement

CRSA exceeded the MPS and the Goal for three of the four required performance measures during CYE 2010. The time it takes to get the first CRS service is the only performance measure below the minimum standard.

CRSA developed a corrective action plan to improve the timeliness of the first CRS service. Interventions are aimed at improving the accuracy of the information used to report the measures; identifying the barriers to timeliness of the first CRS service; and ongoing monitoring for compliance. In addition, CRSA reviews performance measurement data at each meeting of the CRS Utilization Management/Quality Management (UM/QM) committee and presents the data to the Steering Committee.

The greatest opportunity for improvement in the coming year is to improve the

timeliness of the first CRS service. CRSA has begun the process of identifying potential barriers to meeting the minimum standard for this measure. The impact of no-shows to scheduled appointments or members receiving the service through their acute care/ALTCS contractor, and other potential barriers should be further explored.

VII. PERFORMANCE IMPROVEMENT PROJECT PERFORMANCE

A. Introduction and Objectives

PIPs are an important component of the overall AHCCCS QAPI Strategy. The requirement to design and implement PIPs is included in AHCCCS' contract with CRSA and outlined in the AHCCCS Medical Policy Manual (AMPM) in Policy 980, Chapter 900.

AHCCCS' Medical Policy Manual complies with the CMS protocols for conducting PIPs. These protocols state that "The purpose of PIPs is to assess and improve processes, and thereby, outcomes of care. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner."

As required in 42 CFR 438.236, PIPs shall include the following components.

- Identify clinical or non-clinical areas for improvement
- Gather baseline data from administrative data and other sources
- Design and implement interventions
- Measure the effectiveness of the intervention
- Maintain and sustain the improvement

AHCCCS requires that a baseline measurement be collected and analyzed at the beginning of the PIP. During the first year of the PIP, the contractor is expected to implement interventions to improve performance based on an evaluation of barriers to care, use of services, and evidence-based approaches to improving performance, as well as any unique factors such as its membership, provider network, or geographic area(s) served. Contractors are expected to utilize a Plan-Do-Study-Act (PDSA) cycle, to test changes and interventions quickly and refine them as necessary. The PIP is expected to continue until significant improvement is achieved and sustained for one year.

AHCCCS requires all Contractors to submit a quality management plan and evaluation to report their interventions, analysis of interventions and internal measurements, changes or refinements to interventions, and results from repeat measures on an annual basis. Contractors are required to use the PIP Reporting Template developed by AHCCCS for this purpose.

AHCCCS must approve all PIP proposals prior to implementation. The approval process includes the following 10 activities from the CMS protocol for conducting PIP reviews.

1. Review the selected study topic(s)
2. Review the study question(s)
3. Review selected study indicator(s)
4. Review the identified study population

5. Review sampling methods (if sampling was used)
6. Review the MCO/PIHP's data collection procedures
7. Assess the MCO/PIHP's improvement strategies
8. Review data analysis and interpretation of study results
9. Assess the likelihood that reported improvement is "real" improvement
10. Assess whether the MCO/PIHP has sustained its documented improvement

In contract year 2010, CRSA completed its work on the Non-Utilization Among CRS Members PIP and its Eligibility and Enrollment PIP. The Eligibility and Enrollment PIP was reviewed this contract year. CRSA began work on this PIP in CYE 2008 and has completed a baseline and two remeasurements. The objective of the review is to determine to what extent CRSA is in compliance with the following.

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating the effectiveness of the interventions
- Planning and initiating activities to increase or sustain improvement

Eligibility and Enrollment Performance Improvement Project

The purpose of this PIP is to increase the proportion of applications with definitive eligibility determinations of either eligible or ineligible within 14 days of receipt of the original application by reducing the number of applications that are pended for needing more information.

B. Background

The eligibility and enrollment process for participation in the CRS program has been a long standing problem for potential members, providers, AHCCCS health plans, ALTCS contractors, and other stakeholders.

Prior to October 1, 2008, CRS eligibility and enrollment was a two-step process. First, the application was reviewed for preliminary medical eligibility then the potential member was scheduled for a visit with a CRS provider to confirm the diagnosis and enroll the member in the CRS program. Several problems such as incomplete documentation, rescheduled or cancelled visits, and no-shows to the visit could delay enrollment in the program. During this time, CRS was able to definitively determine 21% of applications as eligible or ineligible within 14 days.

In response to these problems, CRSA modified the Administrative Rule and streamlined the process. As of October 1, 2008, there is no longer a requirement to send the potential member to a visit with a CRS provider to confirm the diagnosis before enrollment, unless the medical director cannot make a determination without seeing the child. Eligibility and enrollment is now a one-step process. In the first quarter after the change in the eligibility process, CRSA reported that 49% of initial applications were definitively determined within 14 days. While this represented a significant

improvement, 30% of the applications received in December 2008 were submitted without adequate documentation to determine eligibility and were pended. This is of concern because applications in a pended status do not have appeal rights. Although changes were made to expedite the eligibility and enrollment process, problems remained.

In order to better understand the problem, a pilot study was conducted to address the following two questions:

- Does completeness of application vary by referral source, diagnosis, age, person making the decision about completeness of information?
- What are the reasons that applications are deemed incomplete? Is there no documentation at all? Are certain elements consistently missing? Is the CRS diagnosis unclear? Is there actually enough documentation, but a standard for documentation is set higher than needed to make an appropriate decision?

Findings from the pilot study are presented in **Tables 4** and **5**.

Table 4. Determinations by Referral Source (AHCCCS members)					
	Definitive Determination (Eligible or Ineligible)		Need More Information		Total
	n	Percent	n	Percent	
Provider	90	79%	24	21%	114
Health Plan	59	78%	17	22%	76
Parent	7	54%	6	46%	13
Other	5	31%	11	69%	16
Total	161	74%	58	26%	219

Table 5. Insufficient Needed Information by Not Received or Received but Inadequate (AHCCCS members)			
	Not Received	Received but Inadequate	Total Insufficient
History and Physical	0	11	11
Imaging	19	0	19
Lab Results	11	0	11
Progress/Consultation Notes	29	20	49
Hospital Records	1	1	2
Other	2	0	2

Analysis of the findings revealed that 66% of the applicants were eligible, 8% ineligible, and 26% of the applications needed more information before a determination could be made. Over three-fourths of the applications submitted by providers and health plans contained enough information to make an eligibility determination while less than half

of the applications submitted by other sources had sufficient documentation. Of the applications that were missing sufficient documentation, inadequate or missing progress or consultation notes and missing imaging and lab results were the major problems identified. CRSA used the findings to develop the following intervention strategies for its PIP.

- Provide educational materials to providers and health plans to specify diagnoses that are covered by CRS and what information should be submitted with an application. (Websites, electronic codes, AHCCCS medical director meetings, CRS coordination meetings.)
- Target initial training to high-volume referral sources: AHCCCS Health Plans, cardiologists, neurologists, orthopedists.
- Develop a mailer to stuff into letter for when provider sends inappropriate diagnoses, giving immediate feedback on CRS-covered diagnostic conditions.
- Develop education for discharge planners at hospitals and NICU nurses, and explore opportunities for them to facilitate application process.
- Continue to monitor performance and analyze patterns for strategic opportunities

C. Description of Data Collection Methodology

The study indicator is the percent of original applications with eligibility determination of eligible and ineligible within 14 days. The numerator, denominator, and study population are clearly defined. All members meeting the criteria are included in the study population.

Data collection procedures are clearly identified. Monthly eligibility determination files are the source of the data. The information on the files is routinely validated. Findings are compared to the baseline and two remeasurements. Due to the unique nature of the CRS program, no other valid comparisons are available. Barriers and limitations of the study are identified. An analysis plan was presented but does not allow CRS to determine if one intervention strategy is more effective than another.

D. Description of Data for CYE 2010

In its annual PIP Report submitted to AHCCCS, CRSA reported the findings displayed in **Table 6**.

Table 6: The Proportion of Original Applications Determined Eligible or Ineligible with 14 Days

Measurement	Measurement Period	Numerator	Denominator	Rate (%)
Baseline	10/01/2008 – 12/31/2008	440	896	49%
Remeasurement 1	07/01/2009 – 12/31/2009	2069	2775	75%
Remeasurement 2	01/01/2010 – 06/30/2010	2734	3286	83%

These findings demonstrate that the proportion of applications with definitive eligibility determinations of eligible or ineligible within 14 days of receipt of the original application increased from 49% at baseline, to 75% at the first remeasurement, to 83% at the second remeasurement. No changes in methodology between measurements were reported. The improvement is statistically significant and exceeds the performance goals established by AHCCCS.

The analysis of the findings reported by CRSA is clear and organized. In its annual report, CRSA described its intervention strategies and provided a status update in its work plan. Highlights from the CRSA work plan include the following actions.

- CRSA conducted quarterly data validation on a random sample of eligibility determinations and initiated new strategies to address identified problems such as calling the referral source to identify required documentation.
- A revised CRS application and updated Referral Guidelines were posted to the CRS-APIPA website.
- Improvement opportunities were added to the agenda for quarterly meetings with AHCCCS contractors.
- A training session with top referral sources was scheduled.
- An article on CRS referrals was included in the provider newsletter.
- The pended letter was modified to clearly identify that applicants cannot be enrolled in the CRS program until discharged from the hospital.
- CRS-APIPA implemented an outbound call program for discharge planners and provides telephone training on a case-by-case basis.

The mailer that CRS was to develop to stuff into a letter for when a provider refers a non-covered diagnostic condition was not discussed. QQ was unable to determine if this strategy was implemented. The report included a discussion of the effectiveness of the interventions as a whole but did not identify if one intervention was more effective than another. The annual report did not provide any discussion or feedback from providers or

staff on which strategies were found to be most effective or plans for sustaining improvement.

E. External Data Validation

The purpose of the data validation was to measure data agreement between the CRSA and QQ sampled data on the percent of original applications with eligibility determination of eligible and ineligible within 14 days.

QQ selected a simple random sample of 30 cases with an over-sampling of 6 cases from the eligibility files provided by CRSA. A list of 36 prime identification numbers (and other case identifiers) was sent to CRSA requesting the original CRS application (along with all supporting documents) and a copy of the determination letter for those on the list. The 36 files were reviewed to identify if an eligibility determination was made within 14 days. Two records were excluded from the sample because QQ was unable to identify the date of the referral to CRS. The findings of QQ’s review of the timeliness of CRSA’s eligibility determinations compared to the CRSA reported findings are presented in **Table 7**.

Table 7: Percent of Applications with Definitive Determination (Eligible or Ineligible) within 14 Days

	QQ Sample	Reported
Numerator	31	27344
Denominator	34	3286
Rate %	91%	83%

Based on a random sample of 34 initial CRS applications, QQ identified that CRSA notified 91% of the applicants of their eligibility status within 14 days. The average number of days from the initial application to a definitive eligibility determination was 9 days. QQ’s findings exceed those reported by CRSA in its PIP report but are consistent with the findings reported in its annual Quality Management Plan Evaluation where CRSA reports 90-93% compliance with eligibility determinations within 14 days. The differences in the two sources reported by CRSA may be due to the use of different data sources for the report.

CRSA’s PIP findings are based on Medical Eligibility Determination files while QQ’s findings and those reported by CRSA in its Quality Management Plan Evaluation are based on a hardcopy of the application and determination notice sent to the referral source or the applicant. Data entry errors and other system issues with the eligibility files may have impacted the PIP findings reported by CRSA. Regardless of the data source, all findings greatly exceed the goals established for this PIP.

A secondary measure identified by CRSA in the purpose of the study was to reduce the number of applications that are pended for needing more information. Pended applications are of concern because applicants in this status have no appeal rights.

CRSA did not measure or report on the reduction of applications in this status or include it as a study indicator for the PIP. However, this measure was easily identified by QQ in the data validation process. These findings are displayed in **Table 8**. Applications pending for needing more information were reduced from 26% at baseline to 9% in the QQ sample.

**Table 8: Eligibility Outcome of Initial CRS Application
 At the Baseline and From Data Validation Sample**

Applications Reviewed	Records	Rate %	Baseline/ Pilot Study
Eligible	29	85%	66%
Ineligible	2	6%	8%
Pended for More Information	3	9%	26%
Total Reviewed	34		

F. Conclusions: Strengths and Opportunities for Improvement

CRSA demonstrated a statistically significant improvement in the proportion of CRS initial applications definitively determined as eligible or ineligible within 14 days. CRSA reported that the proportion of applications determined eligible or ineligible within 14 days of the original application increased from 49% at baseline to 83% at the second remeasurement. QQ validated these findings and found the improvement to be greater than that reported by CRSA.

QQ identified that 91% of the applications in its sample were determined eligible or ineligible within 14 days. On average CRSA made a definitive eligibility determination within nine days of receiving the initial application. In addition, CRS reduced the number of applications pended for needing additional information from 26% at baseline to 9% in the sample reviewed by QQ.

Streamlining the eligibility process by eliminating the need for the applicant to see a CRS provider to confirm the qualifying diagnosis before enrollment, working closely with high-volume referral sources, and other educational efforts aimed at reducing the number of pended applications appear to be effective. Soliciting feedback from providers and staff to evaluate which interventions are the most useful; ensuring procedures are in place to sustain improvement; and exploring the development of an online application process with built-in prompts represent opportunities for improvement.

QQ has a high level of confidence in the validity of the results reported with this PIP.

VIII. CONCLUSIONS AND RECOMMENDATIONS FOR CHILDREN'S REHABILITATIVE SERVICES ADMINISTRATION

Overall, CRSA meets the intent of the standards for quality, timeliness, and access to care as required under 42 CFR 438.204. Conclusions and recommendations for each required EQR activity are identified below.

Organizational Assessment and Structure Performance

CRSA has written policies and procedure in place to appropriately manage program operations. With minor exceptions, policies comply with federal and state requirements. However, many policies have not been fully implemented. The percent of standards rated at full compliance has declined from 82.6% in CYE 2009 to 58% in CYE 2010.

Member Information, Reinsurance, and Third Party Liability are in full compliance with the standards reviewed. The Grievance System improved 16 percentage points compared to the previous review and is in compliance with 94% of the standards reviewed this contract year.

Delivery Systems, Medical Management, and Quality Management demonstrated full compliance with less than 40% of the standards reviewed. Performance in these program areas significantly declined compared to the findings reporting in CYE 2009. Failure to implement and monitor critical policies and an inadequate review of delegated functions are the primary reasons for poor performance in these areas.

- An internal monitoring program should be employed to ensure that all policies and corrective actions are implemented and outcomes documented.

Performance Measurement Performance

CRSA exceeded the MPS and the Goal for three of the four required performance measures during CYE 2010. The time it takes to get the first CRS service is the only performance measure below the minimum standard.

CRSA developed a corrective action plan to improve the timeliness of the first CRS service. Interventions are aimed at improving the accuracy of the information used to report the measures; identifying the barriers to timeliness of the first CRS service; and ongoing monitoring for compliance.

- Barriers to timely first CRS service should continue to be identified. Findings should be quantified and guide the development of solutions.
- A PIP to improve the timeliness of the first CRS visit should be considered.

Performance Improvement Project Performance

CRSA demonstrated a statistically significant improvement in the proportion of CRS initial applications definitively determined as eligible or ineligible within 14 days. CRSA reported that the proportion of applications determined eligible or ineligible within 14 days of the original application increased from 49% at baseline to 83% at the second remeasurement. QQ validated these findings and found the improvement to be greater than that reported by CRSA.

QQ identified that 91% of the applications in its sample were determined eligible or ineligible within 14 days. On average CRSA made a definitive eligibility determination within nine days of receiving the initial application. In addition, CRSA reduced the number of applications pended for needing additional information from 26% at baseline to 9% in the sample reviewed by QQ.

Streamlining the eligibility process by eliminating the need for the applicant to see a CRS provider to confirm the qualifying diagnosis before enrollment, working closely with high-volume referral sources, and other educational efforts aimed at reducing the number of pended applications appear to be effective.

- Feedback from providers and staff on which interventions were most useful should be solicited, and a plan to ensure that improvements are sustained should be developed.
- The possibility of an online application process with built-in prompts to ensure applications are complete and appropriate should be explored.

APPENDIX

ADHS/CRSA

List of Documents Provided to HCE QualityQuest by AHCCCS for External Quality Review

1. CYE 2010 EQRO Crosswalk
2. AHCCCS Strategic Plan
3. AHCCCS/CRSA Contract Amendment and Extension
4. Cultural Competency Policy
5. Cultural Competency Plan Annual Evaluation of 2009-2010
6. Member Information Policy
7. Member Handbook Checklist
8. Provider Network Development and Management Plan Policy
9. Network Management and Development Plan Checklist
10. QAPI Strategy
11. QAPI Strategy Report
12. QAPI Program Contract & Medical Policy Requirements
13. QAPI Program for PIPs
14. QAPI Program for Performance Measures
15. CYE 2010 Operational and Financial Review
16. CYE 2010 MM/UM Annual Work Plan Description
17. CYE 2010 MM/UM Children with Special Health Care Needs Work Plan Evaluation
18. Eligibility and Enrollment PIP 2nd Remeasurement Report
19. CYE 2010 Performance Measures
20. CYE 2010 Annual Quality Management Evaluation
21. CYE 2010 Quality Management Children with Special Health Care Needs Work Plan Evaluation