Arizona Health Care Cost Containment System (AHCCCS)

2014–2015 External Quality Review Annual Report *for* Acute Care and DES/CMDP Contractors

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1. Executive Summary

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

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

The Arizona Health Care Cost Containment System (AHCCCS), the first statewide Medicaid managed care system in the nation, continues as a national leader and innovator in designing and administering effective and efficient financing, contracting, and service delivery models for Medicaid managed care programs.

As permitted by the Centers for Medicare & Medicaid Services (CMS), and as allowed under federal regulation, AHCCCS elected to retain responsibility for performing the three mandatory activities described in 42 CFR 438. AHCCCS also conducted overall validation of encounter data according to industry standards, an optional EQR activity.

In addition AHCCCS contracted with HSAG to conduct the optional activity of administering and reporting the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-1] Health Plan Survey for Medicaid members enrolled in the Acute Care and KidsCare programs.

AHCCCS prepared Contractor-specific reports of findings related to each of the activities, and as applicable, required its Contractors to prepare and submit their proposed corrective action plans to AHCCCS for review and approval.

AHCCCS contracted with HSAG, as its EQRO, to prepare this annual 2014–2015 EQR technical report. This report presents AHCCCS' and HSAG's findings from conducting each of the activities, as well as HSAG's analysis and assessment of Contractor performance and, as applicable, recommendations to improve the Contractor's performance.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR 438.354(b) and (c). HSAG has extensive experience and expertise in both conducting the mandatory and optional activities and in using the information that either HSAG derived from directly conducting the activities or that a State Medicaid agency derived from conducting the activities. HSAG uses the

[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

information and data to draw conclusions and make recommendations about the quality and timeliness of, and access to, care and services the State's MCOs provide.

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

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

HSAG has prepared the annual report for AHCCCS for 11 consecutive years. The report complies with requirements set forth at 42 CFR 438.364.

In addition to children and adults enrolled in AHCCCS' Acute Care Medicaid managed care program, children enrolled in KidsCare, Arizona's Children's Health Insurance Program (CHIP), also receive services through the same managed care Contractors. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized CHIP under Title XXI of the Social Security Act and applied specific Medicaid managed care requirements, such as a mandatory annual external review of the quality of care, to state CHIP programs. This is HSAG's fifth annual EQRO report that also addresses the Acute Care Contractor performance related to members eligible for the KidsCare program.

While this report addresses performance among Contractors serving KidsCare members, nationwide economic conditions resulted in AHCCCS' decision to freeze enrollment in the KidsCare program, effective January 1, 2010. As a result of this enrollment freeze, children who aged out of KidsCare were not replaced by newly eligible members. In April 2012, CMS approved AHCCCS' waiver amendment which included funding for the KidsCare II program; however, this program expired in January 2014. Approximately 2,600 members remain enrolled in the KidsCare program.

This Executive Summary includes an overview of HSAG's 2014–2015 EQR and a high-level summary of the results. The results include a description of HSAG's findings with respect to performance by the AHCCCS Contractors in complying with AHCCCS contract requirements and the applicable federal 42 CFR 438 requirements for each activity. Additional sections of this annual 2014–2015 EQR technical report include the following:

- Section 2—An overview of the history of the AHCCCS program and a summary of AHCCCS' quality assessment and performance improvement (QAPI) strategy goals and objectives.
- Section 3—A description of the 2014–2015 EQR activities.
- Section 4—An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care programs and those that are specific to the Acute Care program (i.e., Acute Care Contractors and the Arizona Department of Economic Security/Comprehensive Medical and Dental Plan [DES/CMDP] Contractor).
- Section 5—An overview of the Contractors' best and emerging practices.

- Section 6 (Organizational Assessment and Structure Performance)—A presentation of findings for Contractors in complying with select AHCCCS contract requirements, and as applicable, HSAG's recommendations to improve Contractors' performance and members' timely access to quality care and services.
- Section 7 (Performance Improvement Project Performance)—A presentation of Contractor-specific PIP results and HSAG's associated findings and recommendations.
- Section 8 (CAHPS Results)—A presentation of the CAHPS Health Plan Survey for Medicaid members enrolled in Acute Care and KidsCare programs.

Performance measurement rates for CYE 2013 have been calculated, but the data were under review at the time this report was written. CYE 2013 and 2014 performance measurement rates, as well as the associated findings and recommendations, will be included in the annual 2015–2016 EQR technical report.

Overview of the 2014–2015 External Review

During the time period of the review, AHCCCS contracted with the Contractors listed below to provide services to members enrolled in the AHCCCS Acute Care Medicaid managed care program. The results of a competitive bid process during SFY 2012–2013 resulted in one health plan's contract terminating on 9/30/2013 and a new health plan becoming effective on 10/1/2013.

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

- Bridgeway Health Solutions (BHS) (contract effective through 9/30/2013)
- Care1st Health Plan Arizona, Inc. (Care1st)
- Health Choice Arizona (HCA)
- Health Net Access (Health Net) (contract start date 10/1/2013)
- Maricopa Health Plan (MHP)
- Mercy Care Plan (MCP)
- Phoenix Health Plan, LLC (PHP)
- University Family Care (UFC)
- UnitedHealthcare Community Plan (UHCCP)
- Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP)

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

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

Organizational Assessment and Structure Standards

AHCCCS conducted an organizational assessment and structural review of Contractors' performance for the nine Acute Care Contractors and DES/CMDP. AHCCCS reviewed the Acute Care Contractors' performance on approximately 129 compliance standards and DES/CMDP's performance on 113 standards. Based on AHCCCS' review findings and assessment of the degree to which the Contractor complied with the standards, AHCCCS assigned the applicable compliance designation to the Contractor's performance:

- Standards scored as 90 through 100 percent were designated as Full Compliance.
- Standards scored as 75 through 89 percent were designated as Substantial Compliance.
- Standards scored as 50 through 74 percent were designated as Partial Compliance.
- Standards scored as 0 through 49 percent were designated as Noncompliance.

If a standard was not applicable to a Contractor, AHCCCS noted this using an N/A designation. When AHCCCS evaluated performance for a standard as less than fully compliant or made a recommendation worded as "The Contractor must" or "The Contractor should," the Contractor was required to develop a corrective action plan (CAP), submit it to AHCCCS for review and approval, and implement the corrective actions.

Findings

Figure 1-1 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of the 11 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 1-1—Categorized Levels of Compliance with Technical Standards for Acute Care and DES/CMDP Contractors[1-2]

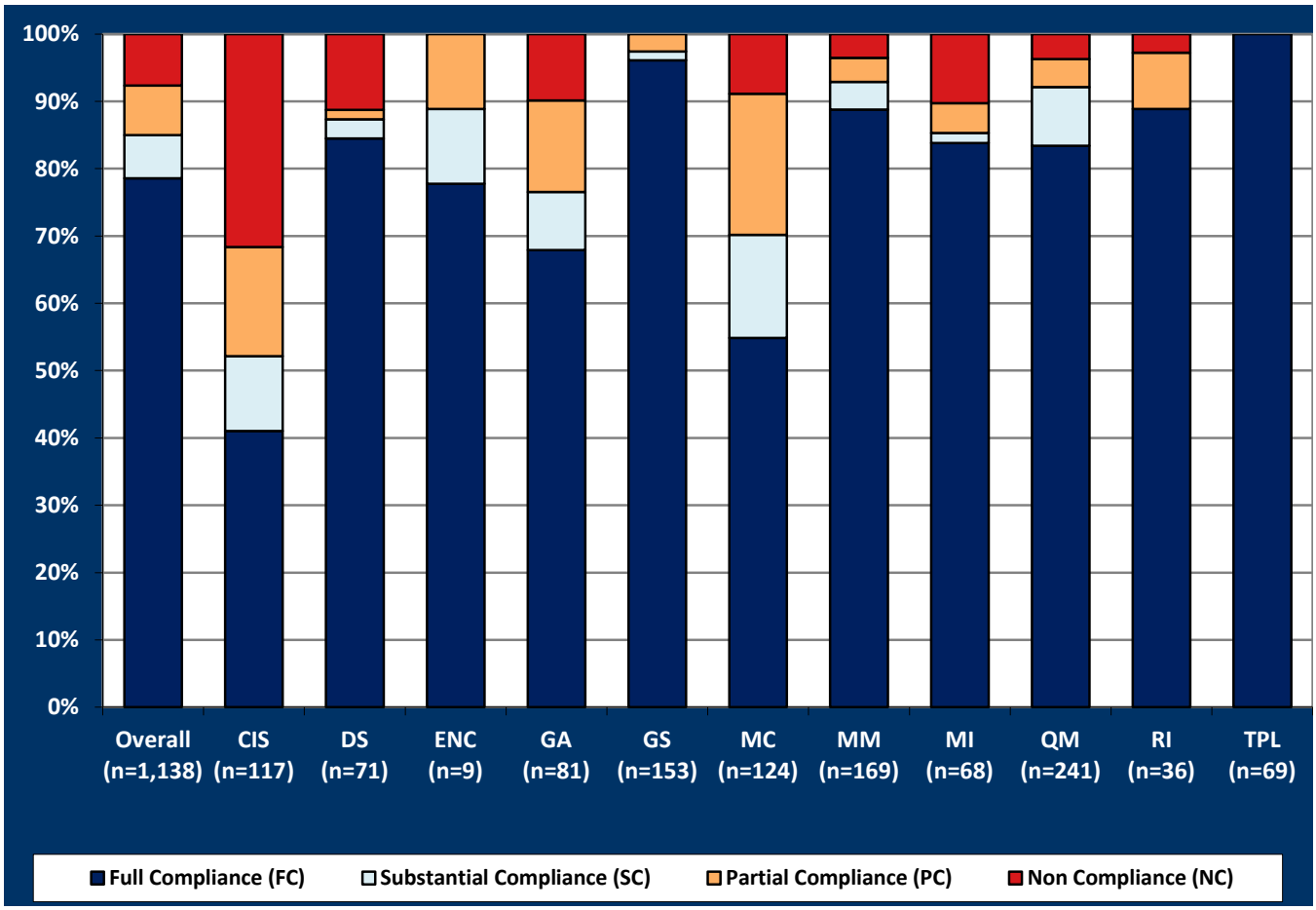


Figure 1-1 shows that the nine Contractors were in full compliance for 78.6 percent of the 1,138 reviewed standards (left-most bar, labeled "Overall"), with moderate variation in performance across nine of the 11 categories of standards and wider variation for the Claims and Information Systems and Maternal and Child Health and EPSDT categories. The Contractors' strongest performance was for the standards associated with the Third-Party Liability category, which showed 100.0 percent of the related standards scored as fully compliant. The Contractors showed strong performance for standards associated with the Grievance Systems, Medical Management, and Reinsurance categories. More than 85.0 percent of the related standards in each of these categories were scored as fully compliant. Of the 11 categories of standards, the Claims and Information Systems category showed the lowest percentage of standards in full compliance (41.0 percent) and the highest percentage of standards in noncompliance (31.6 percent). While seven additional categories included standards scored as noncompliant, no category had more than 12.0 percent of its standards scored as such. Categories with less than 80 percent of the reviewed standards in full compliance included Encounters (77.8 percent), General Administration (67.9 percent), Maternal and Child Health and EPSDT (54.8

[1-2] The compliance categories are abbreviated as follows: CIS=Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS=Grievance Systems, MC= Maternal and Child Health and EPSDT, MI=Member Information, MM=Medical Management, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

percent), and Claims and Information Systems (41.0 percent). These categories' results suggest targeted opportunities for improvement.

A comparison of the CAPs across compliance categories highlights areas for quality improvement activities for the Acute Care and DES/CMDP Contractors as a group. Table 1-1 presents the number and proportion of CAPs required within and across the 11 categories for the compliance standards reviewed for CYE 2014.

Table 1-1—Corrective Action Plans By Category for Acute Care and DES/CMDP Contractors

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	117	69	59.0%	28.0%
Delivery Systems	71	11	15.5%	4.5%
Encounters	9	2	22.2%	0.8%
General Administration	81	26	32.1%	10.6%
Grievance Systems*	153	6	3.9%	2.4%
Maternal and Child Health and EPSDT	124	56	45.2%	22.8%
Medical Management	169	19	11.2%	7.7%
Member Information	68	11	16.2%	4.5%
Quality Management**	241	42	17.4%	17.1%
Reinsurance	36	4	11.1%	1.6%
Third-Party Liability	69	0	0.0%	0.0%
Overall	**1,138**	**246**	**21.6%**	**100%**

* Though one standard in this category was scored as fully compliant, AHCCCS provided a recommendation to the Contractor. That Contractor was not required to develop a CAP for the standard.
**One Contractor was required to develop CAPs for two standards in this category that were scored as N/A.

Table 1-1 shows that the Contractors were required to develop CAPs for 21.6 percent of the standards reviewed during CYE 2014. The largest number of required CAPs (69) was in the Claims and Information Systems category. The Contractors were required to develop at least one CAP for standards in 10 of the 11 categories. However, CAPs were not required for any standards in the Third-Party Liability category. The fewest number of total required CAPs (two) were received for the Encounters category; however, this category only had a total of nine standards. Categories with the largest percentage of CAPs relative to the number of standards in the category were Claims and Information Systems (59.0 percent), Maternal and Child Health and EPSDT (45.2 percent), and General Administration (32.1 percent).

Conclusions

The nine Acute Care and DES/CMDP Contractors were in full compliance for 78.6 percent of the 1,138 reviewed standards. Performance varied widely among the nine Contractors, with AHCCCS requiring the Contractors to submit CAPs for a variety of topics. The number of CAPs ranged from 19 for Care1st to 58 for Health Net. Only one Contractor, Health Net, received full compliance for

less than 75.0 percent of its standards. Overall, AHCCCS required the Acute Care and DES/CMDP Contractors to submit 69 CAPs for the standards associated with the Claims and Information Systems category (59.0 percent of possible category standards).

With 85.0 percent of standards in full or substantial compliance and 7.6 percent in noncompliance, AHCCCS' CYE 2014 Acute Care and DES/CMDP OR identified relatively positive results. Most of the CAPs were related to monitoring, reporting, and communications processes.

Recommendations

The intent of the OR is to evaluate a Contractor's performance on and compliance with AHCCCS' standards related to access, structure and operations, and measurement and improvement. Overall, the Claims and Information Systems, Maternal and Child Health and EPSDT, and Quality Management categories showed the largest opportunities for improvement, as 67.9 percent of the total CAPs required by AHCCCS were related to these categories.

Based on AHCCCS' review of Acute Care and DES/CMDP Contractor performance in CYE 2014 and the associated opportunities for improvement identified as a result of the OR, HSAG recommends the following:

- Acute Care and DES/CMDP Contractors should conduct internal reviews of operational systems to identify barriers that impact their compliance with AHCCCS standards. Specifically, Contractors should cross-reference existing policies and procedures with AHCCCS requirements and ensure, at a minimum, that they are in alignment with both the intent and content of AHCCCS standards.
- Contractors should develop and implement systems for monitoring the timeliness, accuracy, and completeness of all AHCCCS-required reports and deliverables.
- Contractors should evaluate their current monitoring programs and activities. When deficiencies are noted, the Contractors should take steps to either develop new procedures and review mechanisms or augment existing ones. In many cases, Contractors can apply lessons learned from improving performance for one category of standards to other categories.
- All Contractors should review their Claims and Information Systems and bring them into compliance with the relevant standards, as 59.0 percent of all standards in this category required a CAP. As a majority of Contractors were not in full compliance with selected standards, Contractors should work with their information systems personnel to accomplish the following:
  - Ensure that the remittance advice forms sent to providers contain the minimum information required by AHCCCS, including the following:
    - An adequate description of all denials and adjustments
    - The reasons for denials and adjustments
    - The amount billed
    - The amount paid
    - Application of Coordination of Benefits and copays
    - Provider rights for claim disputes
    - Instructions for the submission of claim disputes or corrected claims.

- Ensure that applicable interest is paid on all claims, including overturned claim disputes.
- Ensure that provider registration data provided by AHCCCS are accepted and integrated into the Contractor's Claims and Information Systems, and this information is appropriately applied by the Contractor when processing claims.

Performance Improvement Projects (PIPs)

HSAG received documentation from AHCCCS regarding the Acute Care Contractors' and DES/CMDP's self-reported performance on an AHCCCS-mandated PIP. In CYE 2011, AHCCCS began the baseline measurement of a PIP, *Inpatient Readmissions within 30 Days*, for all lines of business. This PIP focuses on decreasing the number of inpatient readmissions for any cause within 30 days of the initial hospitalization. Because the goal of the PIP is to lower the number of readmissions, a lower rate by a Contractor is indicative of better performance.

Findings

During CYE 2014, the *Inpatient Readmissions within 30 Days* PIP was in the second remeasurement phase, and the PIP was closed mid-cycle by AHCCCS. AHCCCS' decision to close this PIP resulted from national and state-specific factors that have contributed to declining readmission rates and also because several improvement interventions have since been institutionalized by AHCCCS and its Contractors. As a result of this mid-cycle closure, AHCCCS opted not to generate official measurements and instead relied on Contractor-generated rates submitted to AHCCCS in the Contractors' annual PIP reports. Due to disparate measurement periods, source data, and calculation methods among DES/CMDP and the Acute Care Contractors, it is not possible to reliably compare Contractors' self-reported performance on the *Inpatient Readmissions within 30 Days* PIP.

Conclusions

The *Inpatient Readmissions within 30 Days* PIP for the Acute Care Contractors and DES/CMDP was closed mid-cycle by AHCCCS, and performance results for this PIP were limited to the Contractors' final PIP reports submitted to AHCCCS. Comparative results among the Contractors were not available due to the disparate measurement periods, source data, and calculation methods among the Contractors. AHCCCS will continue to measure performance on this topic through future performance measure validation activities.

Recommendations

As AHCCCS will continue to measure performance on this topic through future performance measure validation activities, HSAG recommends that the Contractors continue to monitor the outcomes associated with the reported interventions to reduce inpatient readmissions. Since Contractor-specific strengths and opportunities could not be reliably identified from the data provided, HSAG recommends that AHCCCS fully validate Contractors' PIP submissions for inclusion in future annual EQR reports.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Plan-Specific Adult and Child Survey and Statewide KidsCare Survey

Description

The CAHPS health plan surveys are standardized survey instruments that measure members' satisfaction levels with their healthcare.[1-3] For 2013, HSAG administered the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental set to adult members in the Acute Care program, and the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the Children with Chronic Conditions (CCC) measurement set to child members in the Acute Care program and KidsCare program that met age and enrollment criteria.[1-4] For the Acute Care program, these surveys were administered using a plan-specific sampling methodology. For the KidsCare program, the survey was administered using a statewide sampling methodology. For both the Acute Care and KidsCare programs, the survey administration protocols used were in accordance with the National Committee for Quality Assurance (NCQA) specifications. These standard protocols promote the comparability of resulting health plan- and/or state-level CAHPS data.

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

Acute Care Program Findings

Table 1-2 presents the 2013 adult and general child Medicaid CAHPS survey aggregate results for all Acute Care Contractors and DES/CMDP for members enrolled in the Acute Care program. The table displays the following information for each of the CAHPS survey measures: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response); three-point mean scores; and overall 2013 member satisfaction ratings (i.e., star ratings).

Table 1-2—Adult and Child Medicaid CAHPS Results for Acute Care and DES/CMDP Contractors

CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	55.9%	★★★ 2.402	70.3%	★★★★ 2.627
Rating of All Health Care	51.2%	★★★ 2.347	69.3%	★★★★★ 2.624
Rating of Personal Doctor	60.0%	★★ 2.454	74.6%	★★★★ 2.680

[1-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Table 1-2—Adult and Child Medicaid CAHPS Results for Acute Care and DES/CMDP Contractors				
Rating of Specialist Seen Most Often	63.6%	★★★ 2.504	73.8%	★★★★ 2.642
Composite Measures				
Getting Needed Care	81.0%	★★★ 2.325	84.0%	★★★ 2.444
Getting Care Quickly	80.6%	★★ 2.370	88.4%	★★ 2.599
How Well Doctors Communicate	88.2%	★★★ 2.553	92.3%	★★ 2.671
Customer Service	86.6%	★★★★ 2.510	88.1%	★★★★ 2.546
Shared Decision Making	49.5%	NA	55.3%	NA
Individual Item Measures				
Coordination of Care	75.1%	NA	77.2%	NA
Health Promotion and Education	68.9%	NA	71.1%	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

With the transition to the CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

KidsCare Program Findings

Table 1-3 presents the 2013 general child CAHPS survey results for the statewide KidsCare program. The table displays the following information: 2013 question summary rates and global proportions, three-point mean scores, and overall 2013 member satisfaction ratings for each of the CAHPS survey measures.

Table 1-3—General Child CAHPS Results *for* the KidsCare Program			
Measure	**2013 Rate**	**Three-Point Mean**	**Star Rating**
Global Ratings			
Rating of Health Plan	68.9%	2.603	★★★
Rating of All Health Care	65.9%	2.592	★★★★★
Rating of Personal Doctor	71.9%	2.646	★★★★
Rating of Specialist Seen Most Often	68.5%	2.575	★★

Table 1-3—General Child CAHPS Results *for* the KidsCare Program			
Composite Measures			
Getting Needed Care	85.6%	2.420	★★★
Getting Care Quickly	88.9%	2.592	★★
How Well Doctors Communicate	92.5%	2.639	★★
Customer Service	89.9%	2.508	★★★★
Shared Decision Making	55.0%	NA	NA
Individual Item Measures			
Coordination of Care	76.5%	NA	NA
Health Promotion and Education	70.1%	NA	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

With the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

Conclusions

Based on the evaluation of the Acute Care and KidsCare programs' overall member satisfaction ratings (i.e., star ratings), priority assignments were assigned for each CAHPS measure. The priority assignments are grouped into four main categories for quality improvement (QI): top, high, moderate, and low priority, and are based on the results of the NCQA comparisons. Table 1-4 shows how the priority assignments were determined for the Acute Care and KidsCare programs on each CAHPS measure.

Table 1-4—Derivation of Priority Assignments on Each CAHPS Measure	
NCQA Comparisons (Star Ratings)	**Priority Assignment**
★	**Top**
★★	**High**
★★★	**Moderate**
★★★★	**Low**
★★★★★	**Low**

NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures; therefore, priority assignments could not be derived for these measures.

Overall

Based on the evaluation of the Acute Care program's overall member satisfaction ratings for the adult and child Medicaid populations, the measures identified as areas of top and high priority are the specific areas that should be targeted for quality improvement initiatives. For the adult Medicaid Acute Care program, the priority areas identified for quality improvement were *Rating of Personal Doctor* and *Getting Care Quickly*. For the child Medicaid Acute Care program, the priority areas identified for quality improvement were *Getting Care Quickly* and *How Well Doctors Communicate*.

KidsCare

Based on the evaluation of the KidsCare program's overall member satisfaction ratings, the measures identified as areas of high priority are the specific areas that should be targeted for quality improvement initiatives. For the KidsCare program, the priority areas identified for quality improvement were *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, and *How Well Doctors Communicate.*

Recommendations

Overall

Based on the Acute Care program's overall performance on the CAHPS survey measures, recommendations for improvement were identified. These recommendations include best practices and other proven strategies that may be used or adapted by the program to target improvement in the areas of *Rating of Personal Doctor*, *Getting Care Quickly*, and *How Well Doctors Communicate*. To improve the overall performance of the *Rating of Personal Doctor* global rating, QI activities should target maintaining truth in scheduling and patient-direct feedback. To improve members' satisfaction under the *Getting Care Quickly* measure, QI activities should target decreasing no-show appointments and using electronic communication. To improve members' satisfaction under the *How Well Doctors Communicate* measure, QI activities should focus on communication tools and improving health literacy.

KidsCare

Based on the statewide KidsCare program's performance on the CAHPS survey measures, recommendations for improvement were identified. These recommendations include best practices and other proven strategies that may be used or adapted by the program to target improvement in the areas of *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, and *How Well Doctors Communicate*. To improve the overall performance of the *Rating of Specialist Seen Most Often* global rating, QI activities should target planned visit management and skills training. To improve the satisfaction of parents/caretakers of child members regarding the *Getting Care Quickly* measure, QI activities should target decreasing no-show appointments and using electronic communication. To improve the satisfaction of parents/caretakers of child members regarding the *How Well Doctors Communicate* measure, QI activities should focus on communication tools and improving health literacy.

Overall Findings, Conclusions, and Recommendations

Organizational Assessment and Structure Standards

The nine Acute Care and DES/CMDP Contractors were in full compliance for 78.6 percent of the 1,138 reviewed standards. Performance varied widely among the nine Contractors, with AHCCCS requiring the Contractors to submit CAPs for a variety of topics. The number of CAPs ranged from 19 for Care1st to 58 for Health Net. With 85.0 percent of standards in full or substantial compliance and 7.6 percent in noncompliance, AHCCCS' CYE 2014 Acute Care and DES/CMDP OR identified generally positive results. Most of the CAPs were related to monitoring, reporting, and communications processes; and specific recommendations addressed standards in the Claims and Information Systems, Maternal and Child Health and EPSDT, and Quality Management categories.

Performance Improvement Projects

Since official PIP performance results were not calculated by AHCCCS, strong conclusions have not been identified regarding the best practices and opportunities to improve Contractor performance. However, Contractors should continue to monitor and evaluate the effectiveness of existing interventions on this topic in support of AHCCCS' anticipated performance measure validation activities concerning inpatient readmissions.

Conclusions

In general, and as documented in detail in other sections of this report, the Acute Care and DES/CMDP Contractors made some improvements in the timeliness of, access to, and quality of care they provide to Medicaid members. While several opportunities for improvement are highlighted throughout the report, the opportunities for improvement and the associated recommendations should not detract from the targeted progress that has been made by each of the Acute Care and DES/CMDP Contractors.

2. Background

This section of the report includes a brief history of the AHCCCS Medicaid managed care programs and a description of AHCCCS' Quality Assessment and Performance Improvement (QAPI) strategy. The description of the QAPI strategy summarizes AHCCCS':

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

History of the AHCCCS Medicaid Managed Care Program

AHCCCS has operated throughout its 33-year history as a pioneer and recognized, respected leader in developing and managing innovative, quality, and cost-effective Medicaid managed care programs. AHCCCS' model for delivering services has always been one that emphasizes and promotes the goal of providing timely member access to quality healthcare and preventive services.

AHCCCS operates under a federal 1115 Research and Demonstration Waiver that allows for the operation of a total managed care model that mainstreams members and allows them to select their providers. AHCCCS was the first statewide Medicaid managed care system in the nation and has operated under this waiver since 1982 when its Acute Care program began. In December 1988 AHCCCS added the Arizona Long Term Care System (ALTCS) program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and physically disabled (EPD) populations. In October 1990 AHCCCS began coverage of comprehensive behavioral health services for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals.

AHCCCS contracts with private and public managed care organizations (MCOs) to provide services to its members statewide. Within the AHCCCS program, the MCOs are called "Contractors."

AHCCCS' Strategic Plan

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

- AHCCCS Vision: Shaping tomorrow's managed health care…from today's experience, quality, and innovation.
- AHCCCS Mission: Reaching across Arizona to provide comprehensive quality health care to those in need.

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

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

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

AHCCCS' Strategic Goals and related Strategies are as follows:

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

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

AHCCCS must pursue continuous quality improvement.

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

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

- Align and integrate the model for individuals with SMI and Dual-eligible members.

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

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

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

AHCCCS Quality Strategy

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

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

AHCCCS has had a formal QAPI plan in place since 1994; established and submitted an initial quality strategy to CMS in 2003; and has continued to update and submit revisions of the strategy as needed to CMS. AHCCCS' QAPI strategy was last revised in October 2012. AHCCCS administration oversees the overall effectiveness of its QAPI strategy with several divisions/offices

within the agency sharing management responsibilities. For specific initiatives and issues, AHCCCS frequently involves other internal and/or external collaborations/participants.

Quality Strategy Scope, Goals, and Objectives

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

AHCCCS uses a workgroup model for considering and deciding whether to add new clinical or nonclinical projects for enhancing the well-being of its members. The first step is to review the current components of AHCCCS' quality initiatives and examine the various processes in place to develop, review, and revise quality measures. Following the review, the workgroup reviews AHCCCS' materials that define and illustrate the agency's focus on quality, its approach to quality improvement, and existing quality measurement initiatives and processes. AHCCCS is also diligent in identifying and incorporating opportunities to improve care coordination through designing new or enhancing current projects and programs that include more than one aspect of a member's healthcare needs.

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

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

- Involving the public, such as the State Medicaid Advisory Committee, physicians, and others associated with the medical community at large, and other State agencies.
- Frequently evaluating the quality strategy to ensure that it remains aligned with new federal and State regulations/mandates, programs, funding, technologies, and opportunities for improvement.

Operational Performance Standards

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

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

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

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

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

Performance Improvement Project Requirements and Targets

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

blood lead levels for children, improving timeliness of prenatal care). However, AHCCCS also selects PIPs that the Contractors must conduct.

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

3. Description of EQR Activities

Mandatory Activities

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

- Validate Contractor PIP (as described in further detail in Section 7 of this report, AHCCCS elected to close the Contractor PIP mid-cycle and therefore did not validate the PIP).
- Validate Contractor performance measures—Performance measurement rates for CYE 2013 have been calculated, but the data were under review at the time this report was written. CYE 2013 and 2014 performance measurement rates, as well as the associated findings and recommendations, will be included in the annual 2015–2016 EQR technical report.
- Review Contractor performance in complying with the AHCCCS contract requirements and the federal Medicaid managed care regulations cited at 42 CFR 438.358.

Optional Activities

AHCCCS contracted with HSAG to conduct the following optional activity:

- Administer and report the results of the CAHPS Health Plan Survey for its adult and child Medicaid members and KidsCare members enrolled in the Acute Care program.

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

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

AHCCCS Quality Initiatives

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

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

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

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

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

pursuing opportunities to ensure coordination of care between the Medicaid program and those plans that participate in the exchange in order to manage utilization and transition of care.

- Worked collaboratively with the Arizona Association of Health Plans (AzAHP) representing the organizations that contract with AHCCCS to create a new Credentialing Alliance (CA) aimed at making the credentialing and recredentialing process easier for providers through eliminating duplication of efforts and reducing administrative burdens. Prior to establishing the CA, providers had to apply for credentials with each Contractor, whereas with the CA, providers need only apply for credentialing/recredentialing once and their status is accepted by all AHCCCS Contractors.

Selecting and Initiating New Quality Improvement Initiatives

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

In selecting and initiating new quality improvement initiatives, AHCCCS:

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

Collaboration/Initiatives

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

- Arizona and Maricopa County Asthma Coalitions: AHCCCS is collaborating with ADHS, the Department of Economic Security (DES), community agencies, and organizations to identify and provide quality improvement resources to Contractors that can be used to support optimal health outcomes among members with asthma and other respiratory diseases.

- Arizona Early Intervention Program (AzEIP): AHCCCS collaborates with AzEIP, a program that is administered by DES. The program seeks to facilitate early intervention services for children under 3 years of age to ensure they receive timely access and availability of services.
- The Arizona Partnership for Immunization (TAPI): AHCCCS continues to partner with TAPI. TAPI communicates immunization trends and best practices with AHCCCS and its Contractors. TAPI has a new Teen Vaccination Campaign that includes provider education and parent and teen outreach.
- Center for Medicaid and CHIP Services (CMCS) Maternal and Infant Health Initiative: Postpartum Care Action Learning Series: The AHCCCS Clinical Quality Management (CQM) Unit applied and was selected to participate in this initiative. This initiative involves a rapid-cycle improvement project aimed at increasing the rate of postpartum visits as well as enhancing the family planning content discussed during those visits. As part of this initiative, AHCCCS CQM has formed an Arizona team which includes a pilot site, health plan representatives, and an obstetrician.
- Center for Health Care Strategies—Oral Health Initiative: The focus of this seven-state collaborative is twofold: to increase the rate of preventive dental care for children under the age of 21 and to increase the sealant rate for children ages 6–9. AHCCCS has formed a collaborative work group to drive these improvements across the State; all AHCCCS Contractors have agreed to share data and implement interventions relevant to this initiative.
- Arizona Department of Health Services Immunization Program: AHCCCS continues to collaborate with the Arizona Department of Health Services (ADHS) to ensure efficient and effective administration and oversight of the federal Vaccines for Children (VFC) Program. VFC Program representatives provide education to Contractors, regular notifications to AHCCCS regarding vaccine-related trends and issues, and updates regarding the Arizona State Immunization Information System (ASIIS).
- Genetic Testing Work Group: AHCCCS is collaborating with its Contractors to determine the appropriate genetic testing processes for AHCCCS members when medically necessary.
- Nutrition: AHCCCS facilitated a member nutrition work group that included efforts around coverage for adults and individuals with special healthcare needs, regardless of age. The goal is to expand access to nutrition services for members and is supported by AHCCCS Contractors.
- ADHS Office of Environmental Health: AHCCCS and several Contractors participated in the Arizona Childhood Lead Poisoning Elimination Coalition to develop strategies to increase testing of children who are enrolled in AHCCCS or who live in areas with the highest risk of lead poisoning due to the prevalence of older housing, industries that use/produce lead, and the use of lead-containing pottery or folk medicines. CMS has approved implementing a targeted approach to lead screening based on data obtained and analyzed by the ADHS.
- Arizona Health-e Connection/Arizona Regional Extension Center: Arizona Health-e Connection (AzHeC) is a public-private community agency geared toward promotion of and provider support for electronic health record (EHR) integration into the healthcare system. AzHeC is a key partner with AHCCCS in promoting the use of health information technology (HIT) as well as Arizona's health information exchange (HIE). As a subset of AzHeC, the Arizona Regional Extension Center (REC) provides technical assistance and support to Medicare and Medicaid eligible professionals who are working to adopt, implement, or upgrade (AIU) an EHR in their practice and/or achieve Meaningful Use in order to receive monetary payments through state

(Medicaid) and national (Medicare) EHR incentive programs. The long-term goal is to be able to use this technology for quality improvement purposes and to improve outcomes for AHCCCS members.

- CRS Referral and Care Coordination: AHCCCS has continued to work with UHCCP-CRS and with Acute Care Contractors to ensure timely referral and care coordination for children with special healthcare needs. AHCCCS worked with stakeholders to determine how to better serve this special needs population and continues to work with UHCCP-CRS to ensure timely and appropriate care is delivered to children enrolled in CRS.

5. Contractor Best and Emerging Practices

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

Care1st Arizona

- Care Coordination Team: The Care Coordination Team reaches out to members to assist them with their healthcare needs. Care coordinators are available to speak to members about their specific healthcare needs, respond to questions, and provide tips on how to get the best care from their healthcare providers.
- Wellness Messages: The Quality Management Department uploads monthly "wellness messages" to the health plan information system, Managed Health Care, to indicate if a member is missing a specific service (for example, HbA1c testing if diagnosed with diabetes). Whenever health plan staff personnel have contact with members, they check the wellness messages screen and remind the member of any needed services or visits.
- Provider Education—Increased provider education regarding early preventive dental care beginning with a dental visit with members during pregnancy.
- Back-to-School Provider Incentive: The back-to-school incentive is open to all Care1st EPSDT providers. This provider incentive is designed to increase the rate of Acute Care members who received preventive visits by 9/30/14. The incentive provided an additional $25 to PCPs who complete well visits for children missing a visit since 10/1/13.
- Focused Diabetes Disease Management Program: In addition to external and internal referrals, members are identified for the program through claims, laboratory, medication, and hospitalization admission data. A disease management nurse completes a comprehensive initial assessment. If the member participates in the program, he or she receives education about the disease, its symptoms, medication prescribed, and effective tools for self-management, and may receive assistance in making appointments with a PCP or specialist and obtaining any needed equipment.

Health Choice Arizona (HCA)

- T.H.A.N.X. Program: The Think Healthy About Nutrition and eXercise (THANX) program provides after-school health and wellness education to schools in medically underserved communities. Students enrolled in the program learn about fitness and nutrition, and the program enables children to engage in daily physical activity after school. HCA currently serves four schools in the Phoenix metropolitan area.
- Member Incentives: HCA continues to offer incentives for members meeting recommended well visits and immunizations, as well as at least four prenatal visits.
- Postpartum Care: Members with high birth rates are visited in hospitals to provide support, transition from the hospital to home with a newborn, community resources, and education about

newborn and child-related topics. The intent is to increase the likelihood that the member just giving birth engages in postpartum care and in pediatric care for her newborn.

- Provider Visits: HCA conducts quarterly site visits to provider offices to focus on performance on measures.

Health Net Access (HNA)

- Transition Care Management Program: Members who are discharged from a hospital are assisted with transition of care needs and referrals to case management, disease management, and behavioral health services. The health plan transition team provides medication reconciliation and member education on the importance of follow-up with a PCP and red flags that members need to recognize to identify problems with medical conditions.
- Chronic Care/Disease Management Program: The program includes members who benefit from clearly outlined interventions that produce measurable outcomes. Members assigned to Chronic Care/Disease Management have one or more of the following conditions: asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease, and diabetes.

Maricopa Health Plan (MHP)

- Dental Initiatives: Mailings are sent to all children with no dental claim in two years with a list of dentists in their area. In addition, live outreach calls with a targeted focus on helping members to find a dentist in their area have been successful.
- Well-Child Visits (3–6 years of age): Guardians receive prerecorded reminder calls regarding the importance of well visits. Member reminder postcards are mailed to guardians. Harkins theatre gift cards were used as a member incentive.
- Immunization Monitoring: MHP monitors the Arizona State Immunization Information System (ASIIS) data on all members missing immunizations quarterly.
- Postpartum Education: Members receive a weekly call for 12 weeks after delivery and receive educational information on a variety of topics such as rest, nutrition, and exercise.

Mercy Care Plan (MCP)

- Member Advisory Council (MAC): MCP encourages members to volunteer to serve on the MAC for a period of two years. Committee meetings are held quarterly to discuss issues that are important to members.
- Health Risk Assessment: MCP distributes a health risk assessment tool to all new members who are age 1 or older. Surveys are mailed within two weeks of enrollment to new members (or the parents/guardians of new members under the age of 18). Members are identified through an automated data extraction and validation process. Members older than 18 receive a survey with items appropriate for adults, and members younger than 18 receive a survey with items appropriate for a child. A self-addressed, stamped envelope is enclosed for the member to use

when returning the assessment. A toll-free phone number is available for members to call the Integrated Care Management department if they have questions regarding the survey.

- Integrated Care Management (ICM)/Disease Management: The program is designed to assist members diagnosed with targeted chronic illnesses or conditions to better manage their illness/condition. Services are offered with the intent of reducing the frequency and severity of exacerbations, promoting more efficient use of healthcare resources, and achieving optimal health outcomes. The ICM disease management program assists practitioners and providers in managing members who are diagnosed with these targeted chronic illnesses: asthma, diabetes, COPD, CHF, and depression.
- Perinatal Case Management: All pregnant members 15 years of age and younger are flagged as high-risk and referred to case management for perinatal care coordination. Health plan perinatal case managers work with contracted facilities to offer childbirth classes to all pregnant members.

Phoenix Health Plan (PHP)

- Complex Case Management: This program is a collaborative effort among physicians, members, and PHP staff to assist members with complex case management needs. The program assesses plans, implements, coordinates, monitors, and evaluates options to meet member needs. Members who are medically complex and have multiple conditions that require intensive medical and psychosocial interventions are identified and offered participation in the complex case management program. The program is based on education, guidance, and management from the PCP and case manager, as well as coordination and monitoring of members' progress. To achieve better outcomes, evidence-based techniques that emphasize patient empowerment, collaborative goal setting, and problem-solving skills are used. Case managers are sensitive to family dynamics, as well as community and cultural issues, in order to avoid barriers that lead to poor outcomes.
- Disease Management: The program is a collaborative effort among physicians, members, and PHP staff to assist members with identified diseases. The program assesses plans, implements, coordinates, monitors, and evaluates options to meet member needs. Members who have asthma/COPD which requires medical and psychosocial interventions are identified and offered participation in the Disease Management program. PHP's Disease Management is based on education, guidance, and management from the PCP, specialists, and the case manager, as well as coordination and monitoring of members' progress. To achieve better outcomes, evidence-based techniques that emphasize patient empowerment, collaborative goal setting, and problem-solving skills are used. Case managers are sensitive to family dynamics, as well as community and cultural issues, in order to avoid barriers that lead to poor outcomes.
- New Member Health Risk Assessment: PHP uses the new member health risk assessment (HRA) to obtain baseline assessments and identify new members' healthcare needs. If an HRA is not received by PHP within 60 days, another is sent to the member to complete. Members may send the HRA back or call the Case Management voicemail to complete the HRA by phone. In addition, new members are screened if hospitalized within the first 90 days of enrollment to the health plan.

UnitedHealthcare Community Plan (UHCCP)

- UnitedHealthcare Transitions Platform: This platform (tool) was launched to reduce emergency room visits, inpatient admissions, and readmissions. The tool automatically notifies medical practices twice a day of admissions and discharges related to inpatient and emergency department visits. If a provider's office enters follow-up visit information, the tool will make calls to patients to remind them of upcoming appointments. Utilization of the platform is open to any contracted practice.
- Dental Collaborative: UHCCP created a dental collaborative of several community organizations that provide oral health services in order to better identify and treat health plan members.
- Provider-focused Activities: UHCCP increased provider-focused efforts during CYE 2014 with provider visits by provider advocates, Accountable Care Communities (ACC) team, and Clinical Practice Consultants (CPC) team to identify members who need follow-up care and to mail providers quarterly gap-in-care reports.
- Discharge Planning Assessment: UHCCP conducts a discharge planning assessment and a readmission risk assessment tool for all members who are discharged. During this assessment, referrals and resources can be offered when appropriate. In addition, a referral is made to the transitional care manager upon discharge if the readmission risk assessment tool score is greater than 13. Any member currently working with a high-risk case manager will have his or her care transitions managed by an assigned case manager who receives notification of an admission.

University Family Care (UFC)

- Dental Initiatives: Mailings are sent to all children with no dental claim in two years with a list of dentists in their area. In addition, live outreach calls with a targeted focus on assisting members with finding a dentist in their area have proven to be successful.
- Well-Child Visits (3–6 years of age): Guardians receive prerecorded reminder calls regarding the importance of well visits. Member reminder postcards are mailed to guardians. Harkins theatre gift cards are used as a member incentive.
- Immunization Monitoring: UFC monitors the Arizona State Immunization Information System (ASIIS) data on all members missing immunizations quarterly.
- Postpartum Education: Members receive a weekly call for 12 weeks after delivery and receive educational information on a variety of topics such as rest, nutrition, and exercise.

Arizona Department of Economic Security/Comprehensive Medical and Dental Plan (CMDP)

- EPSDT and Dental Visits: CMDP developed a 120-Day Report which generates monthly emails to Division of Child Safety specialists notifying them of children who have not received an EPSDT or dental visit within 120 days of being removed from their home.
- Preventive Services: CMDP outreach coordinators work closely with Arizona Kinship Support Services (Kinship) placements to provide education regarding preventive services.

- Inpatient Hospital Review: CMDP routinely reviews inpatient hospital worksheets and documentation to ensure reviews are started within one business day of notification. Weekly inpatient rounds are conducted to review all cases for medical necessity, discharge planning, and case management involvement issues.
- Member Participation: Members are invited to participate in the health plan quarterly quality management/performance improvement committee meeting to share their ideas regarding healthcare services.

6. Organizational Assessment and Structure Performance

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

AHCCCS has extensive experience preparing for, conducting, and reporting findings from its reviews of Contractors' performance in complying with federal and AHCCCS requirements. As permitted by 42 CFR 438.258(a), AHCCCS elected to conduct the functions associated with the federal Medicaid managed care requirements mandatory compliance review activity. In accordance with, and satisfying, the requirements of 42 CFR 438.364(a)(1–5), AHCCCS then contracted with HSAG as an EQRO, to use the information AHCCCS obtained from its compliance review activities to prepare this section of the annual EQR report.

Conducting the Review

CYE 2013 commenced a new, three-year cycle of ORs, and AHCCCS conducted ORs for all Acute Care Contractors and the DES/CMDP Contractor during CYE 2014. ORs were most recently conducted for these contractors during CYE 2010 and CYE 2011. (Note: Health Net Access was not an AHCCCS Contractor until CYE 2013.) Two contractors offering more than one line of business, Mercy Care Plan and UnitedHealthcare Community Plan, received an OR during CYE 2014 for each line of business; however, only the results pertaining to the Acute Care standards are presented here.

AHCCCS conducted an extensive review of the Acute Care and DES/CMDP Contractors' performance to assess their compliance with federal and State laws, rules and regulations, and the AHCCCS contract in 11 performance categories. AHCCCS conducted these ORs using a review tool first used during CYE 2011.

The review assessed Contractors' performance in the following categories:

- Claims and Information Systems—(13 standards)
- Delivery Systems—(eight standards)
- Encounters—(three standards)
- General Administration—(nine standards)
- Grievance Systems—(17 standards)
- Maternal and Child Health and EPSDT—(14 standards)
- Medical Management—(19 scored standards and one standard for information only)

- Member Information—(eight standards)
- Quality Management—(28 standards)
- Reinsurance—(four standards)
- Third-Party Liability—(eight standards)

Objectives for Conducting the Review

AHCCCS' objectives for conducting the OR were to:

- Determine if the Contractors satisfactorily met AHCCCS' requirements as specified in its contract, AHCCCS policies, Arizona Revised Statute, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR Part 438).
- Increase AHCCCS' knowledge of the Contractors' operational encounter processing procedures.
- Provide technical assistance and identify areas where Contractors can improve, as well as areas of noteworthy performance and accomplishments.
- Review the Contractors' progress in implementing recommendations AHCCCS made during prior ORs.
- Determine if the Contractors complied with their own policies and evaluate the effectiveness of those policies and procedures.
- Perform Contractor oversight as required by CMS in accordance with AHCCCS' 1115 waiver.
- Provide information to HSAG as AHCCCS' EQRO to use in preparing this report as described in 42 CFR 438.364.

HSAG designed a summary tool to organize the information AHCCCS presents in the individual Contractor reports documenting each Contractor's performance in complying with the operational standards. Additionally, this summary tool facilitated a comparison of the Contractors' performance.

The summary tool focused on the objectives of HSAG's analysis, which were to:

- Determine each Contractor's compliance with standards established by the State to comply with the requirements of the AHCCCS contract and 42 CFR 438.204(g).
- Analyze data from the review of each Contractor's compliance with the standards, allowing HSAG to draw conclusions as to the quality and timeliness of, and access to, care and services furnished to members by individual Contractors and statewide, across Contractors.
- Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and across Contractors.

Methodology for Conducting the Review

While AHCCCS reviews the operational and financial performance of the Contractors throughout the year, it also conducts formal reviews on a schedule that ensures it reviews all applicable CMS

and AHCCCS contract requirements at least once every three years. AHCCCS conducts the ORs consistent with CMS' protocol for EQROs that conduct the reviews.[6-1]

AHCCCS conducted an extensive review of Contractor performance in meeting standards. AHCCCS provided the Contractors with: (1) a detailed description of the contract requirements and expectations for each of the standards that AHCCCS would review, and (2) a list of documents and information that was to be available to AHCCCS for its review during the OR process.

AHCCCS' methodology was consistent across all Contractors and included the following:

- Review activities that AHCCCS conducted to assess Contractors' performance, including:
  - Reviewing documents and deliverables Contractors were required to submit to AHCCCS.
  - Conducting interviews with key Contractor administrative and program staff. Reviews generally required three to four days, depending on the extent of the review.
- Activities AHCCCS conducted following the review, including:
  - Documenting and compiling the results of its reviews, preparing the draft reports of findings, and issuing the draft reports to the Contractors for their review and comment. In the report, each standard and substandard was individually listed with the applicable performance designation based on AHCCCS' review findings and assessment of the degree to which the Contractor was in compliance with the standards. Performance designations were as follows:
    - Full compliance (FC): 90 percent to 100 percent compliant
    - Substantial compliance (SC): 75 percent to 89 percent compliant
    - Partial compliance (PC): 50 percent to 74 percent compliant
    - Noncompliance (NC): 0 percent to 49 percent compliant
    - Not Applicable (N/A): Standard was not applicable to UHCCP-CRS
    - Information Only (IO): Standard was assessed for information only
  - The reports sent to the Contractors also included, when applicable, any AHCCCS recommendations, which began with one of the following three phases:
    - *The Contractor must* …. This statement indicates a critical noncompliant area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
    - *The Contractor should* …. This statement indicates a noncompliant area that must be corrected to be in compliance with the AHCCCS contract but is not critical to the day-to-day operation of the Contractor.
    - *The Contractor should consider* …. This statement is a suggestion by the review team to improve the operations of the Contractor but is not directly related to contract compliance.
- Reviewing and responding to any Contractor challenges to AHCCCS' draft report findings and, as applicable based on AHCCCS' review of the challenges, revising the draft reports.

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 26, 2015.

- Issuing the final Contractor reports describing the findings, scores, and, as applicable, required Contractor CAPs for each standard AHCCCS reviewed.

AHCCCS' review team members included employees of the Division of Health Care Management (DHCM) in Acute and ALTCS Operations, Reinsurance, Data Analysis and Research, Medical Management, Clinical Quality Management; and the Office of Administrative Legal Services (OALS).

AHCCCS' review activities complied with the CMS requirement to assess each Contractor on the extent to which it addressed the recommendations for quality improvement AHCCCS made as a result of its findings from the previous year's review. Fundamental to this process, AHCCCS requires its Contractors to propose formal CAPs, and have the CAPs accepted by AHCCCS, for deficiencies in the Contractor's performance that AHCCCS identified as part of its ongoing monitoring and/or formal annual OR processes.

From its review of the Contractors' CAPs and associated documentation, AHCCCS determines if:

- The activities and interventions specified in the CAPs could reasonably be anticipated to correct the deficiencies AHCCCS identified during the OR (or other monitoring activity) and bring the Contractor back into compliance with the applicable AHCCCS standards.
- The documentation demonstrates that the Contractor had implemented the required action(s) and is now in compliance with one or more of the standards requiring a CAP.
- Additional or revised CAPs or documentation are still required from the Contractor for one or more standards and if the CAP process remains open and continuing.

AHCCCS follows up on each Contractor's implementation of the CAPs and related outcomes during its ongoing monitoring and oversight activities as well as during future ORs. These activities determine whether the corrective actions were effective in bringing the Contractor back into compliance with AHCCCS requirements.

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

Using the verified results AHCCCS obtained from conducting the ORs, HSAG organized and aggregated the performance data and the required CAPs for each Contractor and across Contractors. HSAG then analyzed the data by performance category (e.g., Quality Management and Delivery Systems) and by each standard within a category.

Based on its analysis, HSAG drew conclusions about the quality and timeliness of, and access to, care and services provided by each Contractor and statewide across Acute Care Contractors. HSAG identified data-driven Contractor performance strengths and, where applicable, opportunities for improvement. When HSAG identified opportunities for improvement, it also provided recommendations to improve the quality and timeliness of, and access to, the care and services Contractors provided to AHCCCS members.

Contractor-Specific Results

AHCCCS reviewed Contractors' performance on approximately 129 compliance standards, with the number of standards reviewed ranging from 113 to 129 by Contractor. The percentage of standards in full compliance with requirements ranged from 53.6 percent to 84.5 percent across Contractors. Contractor-specific results are presented below.

Care1st Health Plan (Care1st)

Care1st of Arizona (Care1st) has contracted with AHCCCS since 2003 for the Acute Care population.

Findings

Figure 6-1 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of 11 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-1—Categorized Levels of Compliance With Technical Standards for Care1st[6-2]

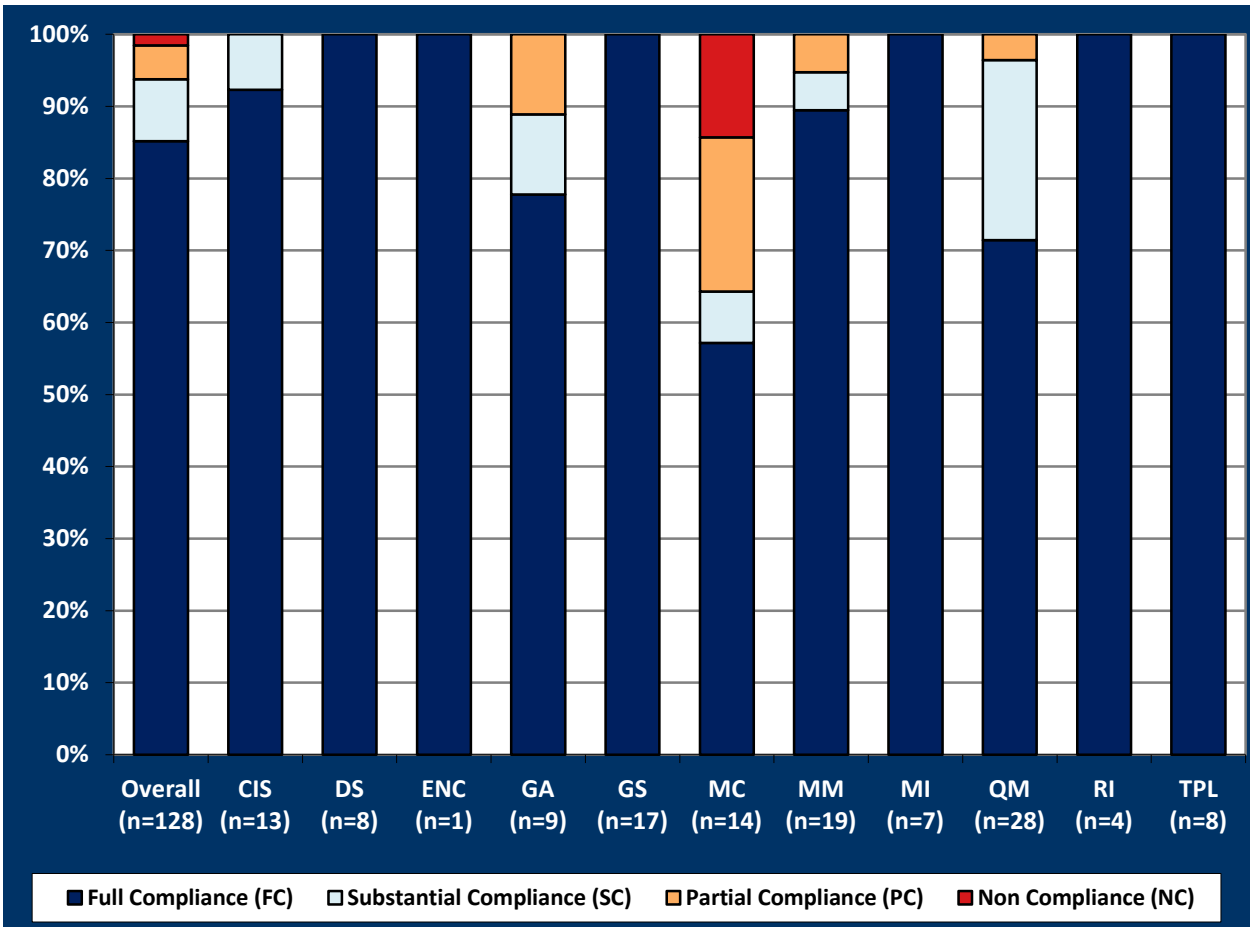


Figure 6-1 shows that Care1st was in full compliance for 85.2 percent of the 128 reviewed standards, with some variation in performance across the categories of standards. The Contractor's

[6-2] The compliance categories are abbreviated as follows: CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

strongest performance was for the standards associated with the Delivery Systems, Encounters, Grievance Systems, Member Information, Reinsurance, and Third-Party Liability categories. AHCCCS scored all standards associated with these categories as fully compliant.

Of the 11 categories of standards, the Maternal and Child Health and EPSDT category showed the lowest percentage of standards in full compliance (57.1 percent) and showed the greatest opportunity for improvement, with 14.3 percent of the standards scored in noncompliance. Maternal and Child Health and EPSDT was the only category with standards scored as noncompliant. Categories with less than 80 percent of the reviewed standards in full compliance included General Administration (77.8 percent), Quality Management (71.4 percent), and Maternal and Child Health and EPSDT (57.1 percent). These results suggest targeted opportunities for improvement.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor "should" or "must" implement a required action to address a deficit within the standard. Table 6-1 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed during CYE 2014.

Table 6-1—Corrective Action Plans by Category for Care1st

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	13	1	7.7%	5.3%
Delivery Systems	8	0	0.0%	0.0%
Encounters	1	0	0.0%	0.0%
General Administration	9	2	22.2%	10.5%
Grievance Systems	17	0	0.0%	0.0%
Maternal and Child Health and EPSDT	14	6	42.9%	31.6%
Medical Management	19	2	10.5%	10.5%
Member Information	7	0	0.0%	0.0%
Quality Management	28	8	28.6%	42.1%
Reinsurance	4	0	0.0%	0.0%
Third-Party Liability	8	0	0.0%	0.0%
Overall	**128**	**19**	**14.8%**	**100%**

Table 6-1 shows that the Contractor was required to develop CAPs for 14.8 percent of the standards reviewed during CYE 2014. The largest number of required CAPs (eight) was in the Quality Management category. Care1st was required to develop CAPs for five of the 11 categories. However, CAPs were not required for the Delivery Systems, Encounters, Grievance Systems, Member Information, Reinsurance, and Third-Party Liability categories. The largest percentages of CAPs relative to the number of standards in a category were in the Maternal and Child Health and

EPSDT (42.9 percent), Quality Management (28.6 percent), and General Administration (22.2 percent) categories.

Strengths

While not all standards were scored as fully compliant, Care1st demonstrated strong performance for the OR review as one of two Contractors with noncompliant standards in only one category. Care1st was one of three Contractors with less than 16.0 percent of overall category standards requiring CAPs. Care1st was in full compliance for all standards within six categories (Delivery Systems, Encounters, Grievance Systems, Member Information, Reinsurance, and Third-Party Liability), and the Contractor was not required to develop CAPs for standards in these categories. Additionally, Care1st had the lowest percentage of CAPs required when compared with the other Acute Care Contractors.

Opportunities for Improvement and Recommendations

OR findings for Care1st demonstrated focused opportunities for improvement, as 19 of the standards reviewed (14.8 percent) remained less than fully compliant with AHCCCS' required policies and procedures or required corrective action. Among the five categories in which Care1st was required to develop a CAP, 73.7 percent of the CAPs were clustered among two categories: Quality Management (eight CAPs) and Maternal and Child Health and EPSDT (six CAPs). The Contractor was required to submit CAPs for 42.9 percent of the standards in the Maternal and Child Health and EPSDT category, and 28.6 percent of the standards in the Quality Management category. As of March 2015, AHCCCS determined that corrective actions were completed and the CAPs were closed for 16 of the standards (84.2 percent).

In the final report generated from the Contractor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

- **Claims and Information Systems:**

  Open Corrective Actions as of March 2015

  - The Contractor's remit must accurately address all reasons for denying or adjusting claims.

- **General Administration:**

  Completed Corrective Actions as of March 2015

  - The Contractor must update its policies/procedures to reflect that records are maintained until three years after members have exceeded 18 years of age or for at least six years after the last date the child received medical or healthcare services from the provider, whichever comes first.
  - The Contractor must ensure that all policies and procedures are reviewed annually. The Contractor should also revise its tracking mechanism to include all review/revision dates of policies and procedures to align with the dates documented within the policies/procedures themselves.

- **Maternal and Child Health and EPSDT:**

  Completed Corrective Actions as of March 2015

  - The Contractor should provide evidence of monitoring the maternity care program's outreach activities for effectiveness.
  - The Contractor must implement specific objectives to increase postpartum visit utilization provided within 60 days of delivery.
  - The Contractor must monitor EPSDT providers for participation in the Arizona State Immunization Information System (ASIIS) and the Vaccines for Children (VFC) program. The Contractor must provide education and promote provider participation in ASIIS and the VFC program.
  - The Contractor must demonstrate coordination with the Children's Rehabilitative Services (CRS). The Contractor must demonstrate coordination with the ASIIS program.
  - The Contractor must demonstrate implementation of a process to educate providers about the Arizona Early Intervention Program (AzEIP) including the need for providers to request authorization for medically necessary services from the Contractor. The Contractor must demonstrate its monitoring, evaluation, and implementation of interventions aimed at reducing members on a wait list for medically necessary early intervention services.
  - The Contractor must provide evidence of the implementation of a process for transitioning a child (who is receiving nutritional therapy) to or from another Contractor, or another service program. The Contractor must develop and implement a process for monitoring and implementing referrals for underweight/overweight members. The Contractor must develop and implement a process for monitoring provider compliance in implementing interventions for members identified as underweight/overweight, including education and/or nutrition referrals.

- **Medical Management:**

  Completed Corrective Actions as of March 2015

  - The Contractor should consider documenting through the CASQIC/MM Committee meeting minutes the analyses of interventions and changes made to interventions based on the committee's recommendations.
  - The Contractor must document discussion of disease management outcomes, evaluations, and interventions in the CASQIC/MM Committee meeting minutes.

- **Quality Management:**

  Completed Corrective Actions as of March 2015

  - The Contractor must track and report to AHCCCS and regulatory agencies, as appropriate, all cases of abuse, neglect, exploitation, and unexpected death as specified in the AHCCCS Medical Policy Manual (AMPM) Chapter 900, Section 960.

- The Contractor must track, monitor, and trend all Quality of Care (QOC) concerns as specified in AMPM Chapter 900, Section 960.
- The Contractor must be able to demonstrate implementation of community initiatives and involvement with community organizations.
- The Contractor must follow its own policies and procedures, and include all aspects for evaluation of organizational providers in the recredentialing process. The Contractor must ensure that all organizational, provider-specific information required in the AMPM is reviewed during recredentialing and that recredentialing is completed a minimum of every three years.
- The Contractor must document all data review and evaluation processes.
- The Contractor must include in its policies the process to verify that electronic signatures are used when electronic documents are utilized by the provider.
- The Contractor should consider using the tool developed by the Association which includes information regarding prenatal care and birth history for members under 21 years of age.
- The Contractor must have a process to ensure IRR.

Summary

Care1st had positive CYE 2014 OR results, as 120 of the 128 standards reviewed were scored as fully or substantially compliant (93.8 percent). Care1st had only one category in which standards were scored as noncompliant. Six of the 11 categories (Delivery Systems, Encounters, Grievance Systems, Member Information, Reinsurance, and Third-Party Liability) had the respective standards scored as fully compliant, and Care1st was not required to develop CAPs for any of the standards associated with these categories. Among the five remaining categories, the General Administration, Maternal and Child Health and EPSDT, and Quality Management categories presented the greatest opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

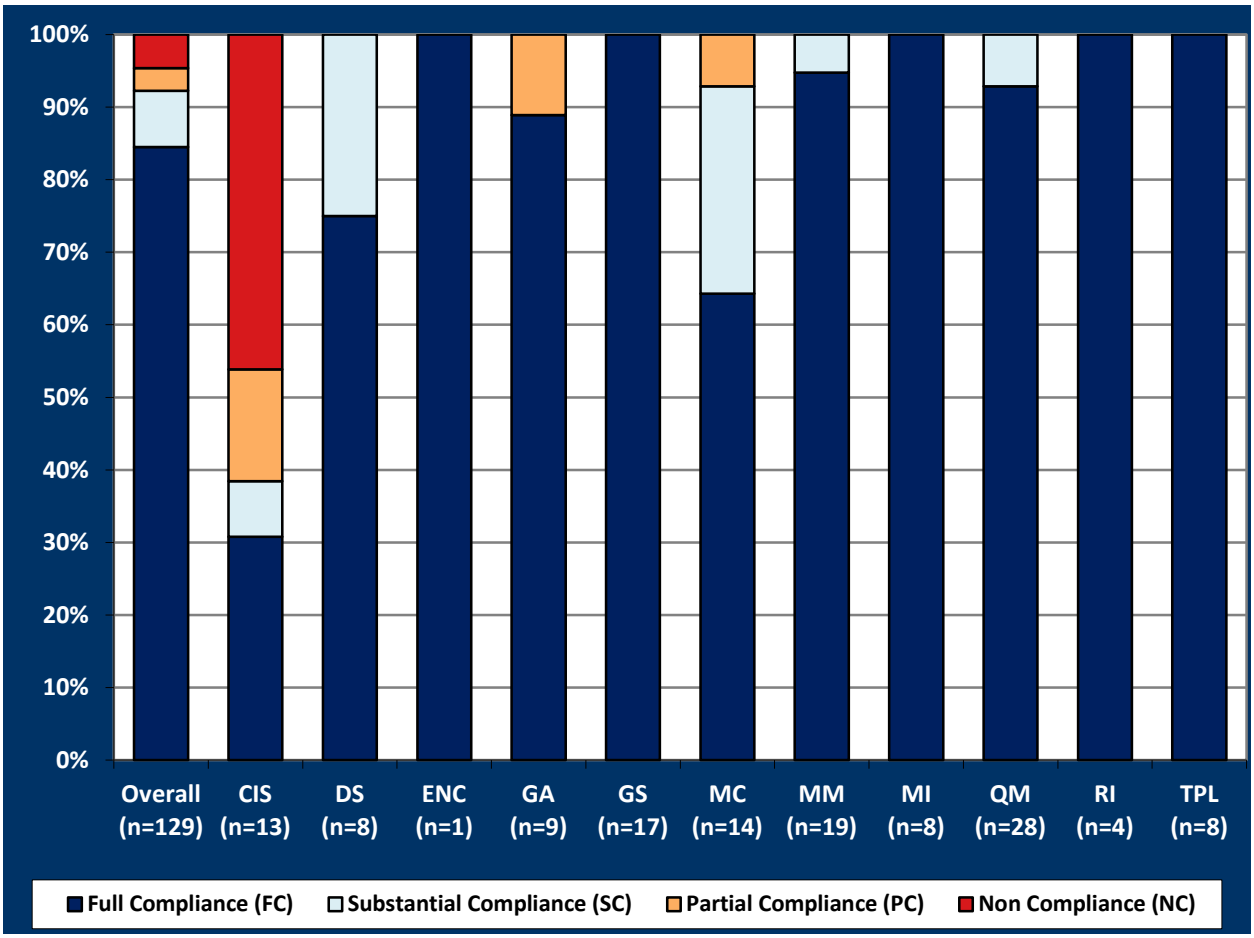
Health Choice Arizona (HCA)

Health Choice Arizona (HCA) has contracted with AHCCCS since 1990 for the Acute Care population.

Findings

Figure 6-2 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of 11 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-2—Categorized Levels of Compliance With Technical Standards for HCA[6-3]



[6-3] The compliance categories are abbreviated as follows: CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

Figure 6-2 shows that HCA was in full compliance for 84.5 percent of the 129 reviewed standards, with encouraging performance across the categories of standards. The Contractor's strongest performance was for the standards associated with the Encounters, Grievance Systems, Member Information, Reinsurance, and Third-Party Liability categories. AHCCCS scored these categories fully compliant for all related standards.

Of the 11 categories of standards, the Claims and Information Systems category was the only category in which the Contractor had noncompliant standards. Categories with less than 80 percent of the reviewed standards in full compliance included Delivery Systems (75.0 percent), Maternal and Child Health and EPSDT (64.3 percent), and Claims and Information Systems (30.8 percent). These categories' results suggested focused opportunities for improvement.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor "should" or "must" implement a required action to address a deficit within the standard. Table 6-2 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed during CYE 2014.

Table 6-2—Corrective Action Plans by Category for HCA

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	13	9	69.2%	45.0%
Delivery Systems	8	2	25.0%	10.0%
Encounters	1	0	0.0%	0.0%
General Administration	9	1	11.1%	5.0%
Grievance Systems	17	0	0.0%	0.0%
Maternal and Child Health and EPSDT	14	5	35.7%	25.0%
Medical Management	19	1	5.3%	5.0%
Member Information	8	0	0.0%	0.0%
Quality Management	28	2	7.1%	10.0%
Reinsurance	4	0	0.0%	0.0%
Third-Party Liability	8	0	0.0%	0.0%
Overall	**129**	**20**	**15.5%**	**100%**

Table 6-2 shows that the Contractor was required to develop CAPs for 15.5 percent of the standards reviewed during CYE 2014. The largest number of required CAPs (nine) was in the Claims and Information Systems category. HCA was required to develop at least one CAP for standards in six of the 11 categories. However, CAPs were not required for any standards in the Encounters, Grievance Systems, Member Information, Reinsurance, and Third-Party Liability categories. The largest percentages of CAPs relative to the number of standards in a category were in the Claims

and Information Systems (69.2 percent), Maternal and Child Health and EPSDT (35.7 percent), and Delivery Systems (25.0 percent) categories.

Strengths

While not all standards were scored as fully compliant, HCA demonstrated strong performance for the OR review as one of two Contractors with noncompliant standards in only one category. HCA was in full compliance for all standards within five categories (Encounters, Grievance Systems, Member Information, Reinsurance, and Third-Party Liability), and the Contractor was not required to develop CAPs for standards in these categories.

Opportunities for Improvement and Recommendations

OR findings for HCA demonstrated focused opportunities for improvement, as 20 of the standards reviewed (15.5 percent) remained less than fully compliant with AHCCCS' required policies and procedures or required corrective action. Among the six categories in which HCA was required to develop a CAP, 70.0 percent of the CAPs were clustered among two categories: Claims and Information Systems (nine CAPs) and Maternal and Child Health and EPSDT (five CAPs). The Contractor was required to submit CAPs for 69.2 percent of the standards in the Claims and Information Systems category, and 35.7 percent of standards in the Maternal and Child Health and EPSDT category. As of January 2015, AHCCCS determined that corrective actions were completed and the CAPs were closed for 19 of the standards (95.0 percent).

In the final report generated from the Contractor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

- **Claims and Information Systems:**

  Completed Corrective Actions as of January 2015

  - The Contractor must have a mechanism to inform providers of the appropriate address for the submission of medical records associated with EDI and paper claims. The Contractor must have a mechanism in place to ensure Contractor staff, such as the provider claims educator, provider services manager, provider services staff, etc., are able to direct providers/billers to information regarding claim submission.
  - The Contractor must ensure its claims payment system correctly edits primary insurance coverage based on AHCCCS-supplied third-party liability (TPL) information.
  - The Contractor must ensure it has AHCCCS-compliant policies and procedures for the recoupment of overpayments and adjustments for underpayments.
  - The Contractor must ensure it pays applicable interest on all claims, including overturned claim disputes.
  - Unless otherwise indicated in a contract, the Contractor must apply quick pay discounts.
  - The Contractor should develop and maintain policies and procedures that ensure it accepts and accurately integrates provider registration data provided by AHCCCS into its claims system.

- The Contractor must correctly link the original and adjusted claim, including the claim amounts. Further, the Contractor should correct the adjusted payment for claims #315763640.
  - The Contractor should ensure it audits contract loading of both large groups and individual practitioners for accuracy of payment against hard copy contracts at least once every five-year period. The Contractor should ensure it correctly pays the correct contracted rates and, in the absence of a written negotiated rate, the Contractor pays according to Arizona Revised Statute requirements.

Open Corrective Actions as of January 2015

- The Contractor must ensure that its remittance advices include the reason for and an adequate description of all denials and adjustments, the amount billed, application of coordination of benefits and copays, provider rights for claim disputes, and instructions for submission of claim disputes and corrected claims.

- **Delivery Systems:**

Completed Actions as of January 2015

- The Contractor should have a process to determine provider representative staffing adequacy and, at a minimum, perform an annual review of provider relations/provider network staffing adequacy for each geographic service area (GSA).
- The Contractor should ensure it clearly communicates the provider's rights to advocate on behalf of the member regarding:
  - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or nontreatment.
  - The enrollee's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.

- **General Administration:**

Completed Actions as of January 2015

- The Contractor must ensure that all policies and procedures are reviewed at least annually.

- **Maternal and Child Health and EPSDT:**

Completed Actions as of January 2015

- The Contractor must demonstrate implementation of a process to identify postpartum depression and refer members to the appropriate healthcare providers.
- The Contractor should ensure that providers document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of

family planning services. The Contractor must have a process to monitor the medical necessity of sterilizations of members younger than 21 years of age.

- The Contractor should include in the medical record review tool the ability to document use of the EPSDT tracking form for each appropriate age, all required vaccines, and all EPSDT elements.
- The Contractor should develop and implement a process for monitoring, evaluating, and implementing interventions aimed at reducing members on a wait list for early intervention services.
- The Contractor should monitor provider compliance in implementing interventions with members identified as overweight, including education provided by the primary care provider and/or nutrition referrals.

- **Medical Management:**

  Completed Actions as of January 2015

  - The Contractor should document the education provided to prescribers on utilization pattern problems, including a summary of interventions used and the interventions' effect on quality of care.

- **Quality Management:**

  Completed Actions as of January 2015

  - The Contractor must ensure primary care provider records contain an appropriate past medical record including smoking/substance use history for all members.
  - The Contractor must have a process to ensure IRR.

Summary

HCA had positive CYE 2014 OR results. Of the 129 standards reviewed, 119 were scored as fully or substantially compliant (92.3 percent). HCA had only one category where standards were scored as noncompliant. Five of the 11 categories (Encounters, Grievance Systems, Member Information, Reinsurance, and Third-Party Liability) had the respective standards scored as fully compliant, and HCA was not required to develop CAPs for any of the standards associated with these categories. Among the six remaining categories, the Claims and Information Systems and Maternal and Child Health and EPSDT categories presented the greatest opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

Health Net Access (HNA)

HNA has contracted with AHCCCS since 2014 for the Acute Care population.

Findings

Figure 6-3 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of 11 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-3—Categorized Levels of Compliance With Technical Standards for HNA[6-4]

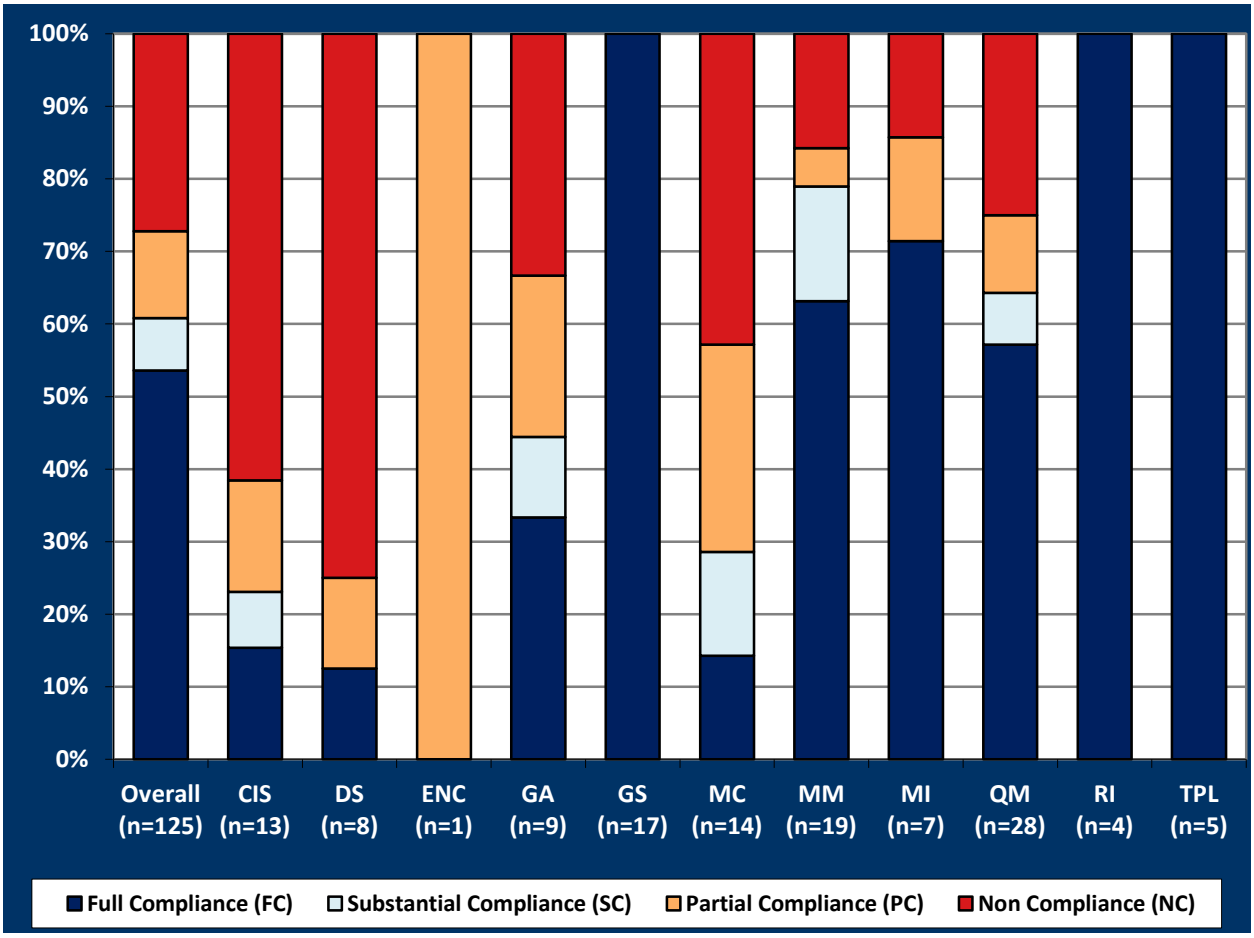


Figure 6-3 shows that HNA was in full compliance for 53.6 percent of the 125 reviewed standards, with a large variation in performance across the categories of standards. The Contractor's strongest

[6-4] The compliance categories are abbreviated as follows: CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

performance was for the standards associated with the Grievance Systems, Reinsurance, and Third-Party Liability categories. AHCCCS scored these categories fully compliant for all related standards.

Of the 11 categories of standards, the Encounters category showed the lowest percentage of standards in full compliance (0.0 percent). However, the small number of standards within this category (i.e., one) may have influenced this result. HNA had seven categories with standards scored as noncompliant (Claims and Information Systems, Delivery Systems, General Administration, Maternal and Child Health and EPSDT, Medical Management, Member Information, and Quality Management). Categories with less than 60 percent of the reviewed standards in full compliance included Quality Management (57.1 percent), General Administration (33.3 percent), Claims and Information Systems (15.4 percent), Maternal and Child Health and EPSDT (14.3 percent), Delivery Systems (12.5 percent), and Encounters (0.0 percent). These categories' results suggested significant opportunities for improvement.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor "should" or "must" implement a required action to address a deficit within the standard. Table 6-3 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed during CYE 2014.

Table 6-3—Corrective Action Plans by Category for HNA

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	13	11	84.6%	18.9%
Delivery Systems	8	7	87.5%	12.1%
Encounters	1	1	100.0%	1.7%
General Administration	9	6	66.7%	10.3%
Grievance Systems	17	0	0.0%	0.0%
Maternal and Child Health and EPSDT	14	12	85.7%	20.7%
Medical Management	19	7	36.8%	12.1%
Member Information	7	2	28.6%	3.5%
Quality Management	28	12	42.9%	20.7%
Reinsurance	4	0	0.0%	0.0%
Third-Party Liability	5	0	0.0%	0.0%
Overall	**125**	**58**	**46.4%**	**100%**

Table 6-3 shows that the Contractor was required to develop CAPs for 46.4 percent of the standards reviewed during CYE 2014. HNA was required to develop at least one CAP for standards in eight of the 11 categories. However, CAPs were not required for any standards in the Grievance Systems, Reinsurance, and Third-Party Liability categories. The largest percentage of required CAPs was in

the Encounters category; however, the small number of standards within this category (i.e., one) influenced this result. Other than the Encounters category, the largest percentages of CAPs relative to the number of standards in a category were in the Delivery Systems (87.5 percent), Maternal and Child Health and EPSDT (85.7 percent), and Claims and Information Systems (84.6 percent) categories.

Strengths

HNA was in full compliance for all standards within three categories (Grievance Systems, Reinsurance, and Third-Party Liability), and the Contractor was not required to develop CAPs for standards in these categories.

Opportunities for Improvement and Recommendations

The OR findings for HNA demonstrated widespread opportunities to bring standards into full compliance, as 58 of the standards reviewed (46.4 percent) were less than fully compliant with AHCCCS' required policies and procedures or required corrective action. Among the categories in which HNA was required to develop CAPs, 84.5 percent of the total CAPs were clustered among five categories (Maternal and Child Health and EPSDT, Quality Management, Claims and Information Systems, Delivery Systems, and Medical Management) and demonstrated focused areas for improvement. As of February 2015, AHCCCS determined that corrective actions were completed and the CAPs were closed for 42 of the standards (72.4 percent).

In the final report generated from the Contractor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

- **Claims and Information Systems: Completed Corrective Actions as of February 2015**
  - The Contractor must inform providers of the appropriate address for submitting resubmissions of paper and electronic claims, or medical records associated with paper claims. The Contractor must ensure that its staff members are able to direct providers/billers to information regarding claim submission.
  - The Contractor must pay applicable interest on all claims, including overturned claim disputes.
  - The Contractor must ensure it accurately applies and has accurate policies for quick pay discounts.
  - The Contractor must ensure overturned claim disputes are processed in a manner consistent with the claim dispute decision within 15 business days of the decision. The Contractor must also ensure there is documentation to support decisions and that staff is aware of the process.
  - The Contractor must adopt nationally recognized methodologies to correctly pay claims including but not limited to the National Correct Coding Initiative (NCCI), Multiple Procedure/Surgical Reductions, and Global Day Evaluation and Management (E&M) Bundling standards.

- The Contractor must adopt a formal process for integrating provider registration data from AHCCCS that includes:
  - Matching Contractor files against the newly received AHCCCS files for accuracy and omission.
  - Reconciling newly added data and identifying newly added or removed records for action.
- The Contractor's claim system must not require the recoupment of previous paid amounts when the provider's claim is adjusted for data correction (excluding payment to wrong provider) or additional payment is made.

Open Corrective Actions as of February 2015

- The Contractor must ensure its remittance advice reflects the accurate amount billed, an accurate amount paid for all claim lines, information on provider rights for claim disputes, and instructions for submitting claim disputes and corrected claims. These requirements must be included on all remittance advices the Contractor and its subcontractors make available to providers, whether electronic or paper.
- The Contractor must have claim payment system edits that look for primary insurance coverage based on AHCCCS-supplied TPL information, and must edit for primary insurance coverage when the claim contains a primary payment amount and is accompanied by an explanation of benefits (EOB) but no segment of TPL is in the member file.
- The Contractor must ensure it has AHCCCS-compliant policies and procedures for the recoupment of overpayments and adjustments for underpayments.
- The Contractor should ensure it loads contracted and noncontracted rates into its system. The Contractor should ensure it audits contract loading for accuracy of payment against hard copy contracts at least once every five-year period. The Contractor should ensure it correctly pays the correct contracted rates and, in the absence of a written negotiated rate, the Contractor pays according to Arizona Revised Statute requirements.

- **Delivery Systems:**

Completed Corrective Actions as of February 2015

- The Contractor must have policies and procedures for assigning PCP thresholds to monitor when PCP capacities are reached or exceeded, for monitoring appointment standards more frequently for those providers who appear on the 1800 report or who have exceeded their contracted capacity, to adjust (reduce or close) a PCP's panel when a PCP is noncompliant with AHCCCS appointment availability and wait-time standards and the noncompliance is not resolved through other actions such as a corrective action plan.
- The Contractor must have a policy and procedure that prohibits discrimination against providers who serve high-risk populations or that specialize in conditions that result in costly treatment.
- The Contractor must clearly communicate the provider's rights to advocate on behalf of the member regarding:

  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or nontreatment.
  - The enrollee's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.
- The Contractor must have policies and procedures for acknowledging and responding to provider inquiries such as a three-business day acknowledgement of the inquiry, 30-business day resolution of the inquiry, and taking systemic action and implementing corrective actions when appropriate.
- The Contractor must ensure that its prior authorization policy states that out-of-network referrals are made in accordance with appointment standards and that the Contractor adheres to its policy.

Open Actions as of February 2015

- The Contractor must document the process for evaluating its provider services staffing needs in a policy or procedure that includes annual review of staffing adequacy and how the Contractor uses its provider call tracking/resolution time frames when assessing staffing needs.
- The Contractor must conduct ongoing training for provider service representative staff that includes new hire training and ongoing representative training, and document this process in policies and procedures.

- **Encounters:**

Completed Corrective Actions as of February 2015

- The Contractor must ensure encounters are complete, accurate, and timely, and ensure omitted and inaccurate encounters are submitted and corrected.

- **General Administration:**

Open Corrective Actions as of February 2015

- The Contractor must maintain all operational records/files for a period of five years; HIPAA-related documents/files for a period of six years; and records for three years after a member has exceeded the age of 18 years or for at least six years after the last date the child received services from the provider, whichever date occurs later.
- The Contractor must develop and implement a formalized training process for new employees that includes training on AHCCCS guidelines. The Contractor must also develop training requirements for ongoing training based on changes in the AHCCCS program. Additionally, the Contractor must ensure that training documents provided for its staff are accurate.

- The Contractor must develop and implement the annual monitoring and oversight work plan as addressed in its own policy. The Contractor must perform regular audits of its organization to mitigate fraud and abuse.
- The Contractor must ensure that providers or subcontractors train their staff on the Federal False Claims Act provisions.
- The Contractor must document audit findings, note deficiencies, and implement corrective action as appropriate.
- The Contractor must ensure that it collects the required information regarding ownership and control of its fiscal agents and administrative services subcontractors. Additionally, the Contractor must ensure that the appropriate criminal background checks are conducted on all persons with an ownership or control interest in the Contractor and its fiscal agents. Moreover, the Contractor must ensure that the information contained in its policy, Exclusion Monitoring, is updated and is being followed. The Exclusion Monitoring policy was created, last reviewed, and approved on July 13, 2013, but the vendor listed in the policy is not currently providing screening.

- **Maternal and Child Health and EPSDT:**

Completed Corrective Actions as of February 2015

- The Contractor must monitor the maternity care program outreach activities for effectiveness. The Contractor must have an implemented process to monitor and evaluate low birth weight/very low birth weight deliveries and to implement interventions to decrease low birth weight/very low birth weight in births. The Contractor must have an implemented process to monitor and reduce Cesarean section rates and elective inductions prior to 39 weeks gestation.
- The Contractor must have an implemented process to monitor and evaluate postpartum activities and interventions to increase postpartum utilization. The Contractor must have an implemented process to identify postpartum depression and to refer members to the appropriate healthcare providers.
- The Contractor must have implemented policies and procedures to monitor, evaluate, and improve EPSDT participation. The Contractor should measure the effectiveness of outreach activities and implement quality improvement activities, if not effective. When the Contractor is made aware of missed or no-show appointments, the Contractor must provide targeted outreach to members who miss/no-show for their EPSDT appointments.
- The Contractor must monitor providers to determine if oral health/dental services are provided according to the AHCCCS Dental Periodicity Schedule. The contractor should include in its EPSDT and Adult Monitoring Quarterly Report the interventions implemented to improve provider compliance with providing oral health screening services. The Contractor must monitor and evaluate the effectiveness of oral health/dental outreach activities.
- The Contractor must provide evidence of monitoring EPSDT providers for participation in entering vaccinations into the Arizona State Immunization Information System (ASIIS).

- The Contractor must provide evidence of implementation of the Contractor's coordination with community organizations or agencies and programs to ensure receipt of services as a result of a referral from an EPSDT visit.
- The Contractor must have a process to coordinate care with AzEIP using the AHCCCS/ AzEIP procedure.
- The Contractor must submit evidence of implementation of a process for transitioning a child (who is receiving nutritional therapy) to or from another Contractor or service program (i.e., Women, Infants and Children [WIC]). The Contractor must provide evidence of implementation of monitoring and implementing referrals for underweight/overweight members. The Contractor must provide evidence of implementation of monitoring provider compliance in implementing interventions with members identified as overweight, including education and/or nutrition referral.

Open Corrective Actions as of February 2015

- The Contractor must implement a process to monitor whether pregnant members obtain initial prenatal care appointments within the prescribed time frames according to trimester or risk. The Contractor must implement a process to monitor whether pregnant members obtain return visits in accordance with American Congress of Obstetricians and Gynecologists (ACOG) standards.
- The Contractor must have a documented and implemented process to ensure that both male and female members who wish to use family planning services understand what coverage is available and how to access services. The Contractor should ensure that physicians and other practitioners document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services. The Contractor must have a process to monitor the medical necessity for sterilizations of members under 21 years of age.
- The Contractor must monitor whether EPSDT/well-child visits are provided to all eligible members according to the AHCCCS Periodicity Schedule. The Contractor should distribute outreach material to educate members on the importance of EPSDT services, including childhood obesity and the dangers of lead exposure. The Contractor must measure, monitor, and implement activities to improve member participation rates for age-appropriate screenings, according to the most current EPSDT Periodicity Schedule, including, but not limited to, blood lead screening, blood lead testing, tuberculosis screening/skin testing, developmental assessments, body mass index (BMI)/growth percentile, and appropriate behavioral health referrals.
- The Contractor must monitor, track, and evaluate provider compliance with providing EPSDT/well-child services to all eligible members according to the most current EPSDT Periodicity Schedule. The Contractor must review provider compliance with completing all elements of the EPSDT Tracking Form during each well-child visit. The Contractor must monitor providers' use of the AHCCCS-approved EPSDT Tracking Forms. The Contractor must implement interventions when necessary to improve the rate of use of the AHCCCS-approved EPSDT Tracking Forms.

- **Medical Management:**

  Completed Corrective Actions as of February 2015

  - The Contractor should document through the Medical Management (MM) Committee Meeting minutes the analyses of interventions and make changes to interventions based on the committee's recommendations.
  - The Contractor must have a post-discharge assessment process which includes arrangement of a PCP follow-up appointment; coordination of prescription medications, therapies, and durable medical equipment (DME) as medically necessary; a telephone call to all members to ensure the member's needs have been met; and referrals to appropriate health plan and community resources.
  - The Contractor should demonstrate coordination of services with community resources.
  - The Contractor must have measurable outcomes for its disease management plan.
  - The Contractor must have resources available to assist homeless clinics with obtaining prior authorization and referrals to specialists.
  - The Contractor must provide medical home services and monitor the effectiveness of this service.
  - The Contractor must include provisions for payment of emergency services when:
    - The Contractor approves payment for the treatment of an emergency medical condition in which a representative of the Contractor instructs the enrollee to seek emergency services.
    - The Contractor does not deny emergency services when the emergency room provider, hospital, or fiscal agent has notified the member's Contractor within 10 calendar days of presentation for emergency services.

- **Member Information:**

  Note: HNA developed a CAP (as a product of its internal quality review processes) for one of the standards in this category that was not required by AHCCCS. While HNA completed its corrective action pertaining to this standard, it is not included in the count of CAPs required by AHCCCS.

  Completed Corrective Actions as of February 2015

  - The Contractor must develop and implement a policy and procedure that demonstrates how the Contractor takes into consideration quality of care concerns, wait times, appointment accessibility, and the size of the PCP's panels prior to assigning new members.
  - The Contractor must, at least annually, ensure that its newsletters contain the required information.

- **Quality Management:**

  Completed Corrective Actions as of February 2015

- The Contractor must develop and document a process to provide training for all staff who have contact with members or providers on how to identify and refer suspected quality of care issues to the Quality Management Department at the time of hire and annually thereafter.
- The Contractor must update its policy to include requirements that it will make quality of care and peer review documentation available to the AHCCCS Clinical Quality Management Unit when requested for purposes of quality management, monitoring, and oversight.
- The Contractor must begin conducting on-site visit reviews for purposes of credentialing and recredentialing of providers. The Contractor must ensure that organizational providers have established policies and procedures that meet AHCCCS requirements.
- The Contractor must monitor delegated entities in accordance with AHCCCS requirements. The Contractor must review a minimum of 30 files for each function that is delegated as required by AMPM Chapter 910.
- The Contractor must have a process to ensure that data collected from providers are accurate, timely, and complete. The Contractor must develop a method of review to identify that accurate, complete, logical, and consistent data are collected and reported. The Contractor must develop and implement a detailed written process describing its review and evaluation processes.
- The Contractor must implement the medical record review process according to the requirements in the AMPM. *Note: This recommendation applies to five standards in this category.*
- The Contractor must ensure that all member medical record information is protected by federal and State law and is kept confidential. The Contractor must also ensure that there is adequate supervision of professionals, whose licensure or certification requires supervision, by a licensed professional and that it is documented in the member's medical record.
- The Contractor must develop and implement a procedure to ensure IRR regarding performance measure processes.

Summary

HNA had significant variation in its CYE 2014 OR results, with widespread opportunities for improvement. Of the 125 standards reviewed, 76 were scored as fully or substantially compliant (60.8 percent), and seven categories had standards scored as noncompliant. Three of the 11 categories (Grievance Systems, Reinsurance, and Third-Party Liability) had the respective standards scored as fully compliant, and HNA was not required to develop CAPs for any of the standards associated with these categories. Among the eight remaining categories, the Delivery Systems, Encounters, and Maternal and Child Health and EPSDT categories presented the greatest opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

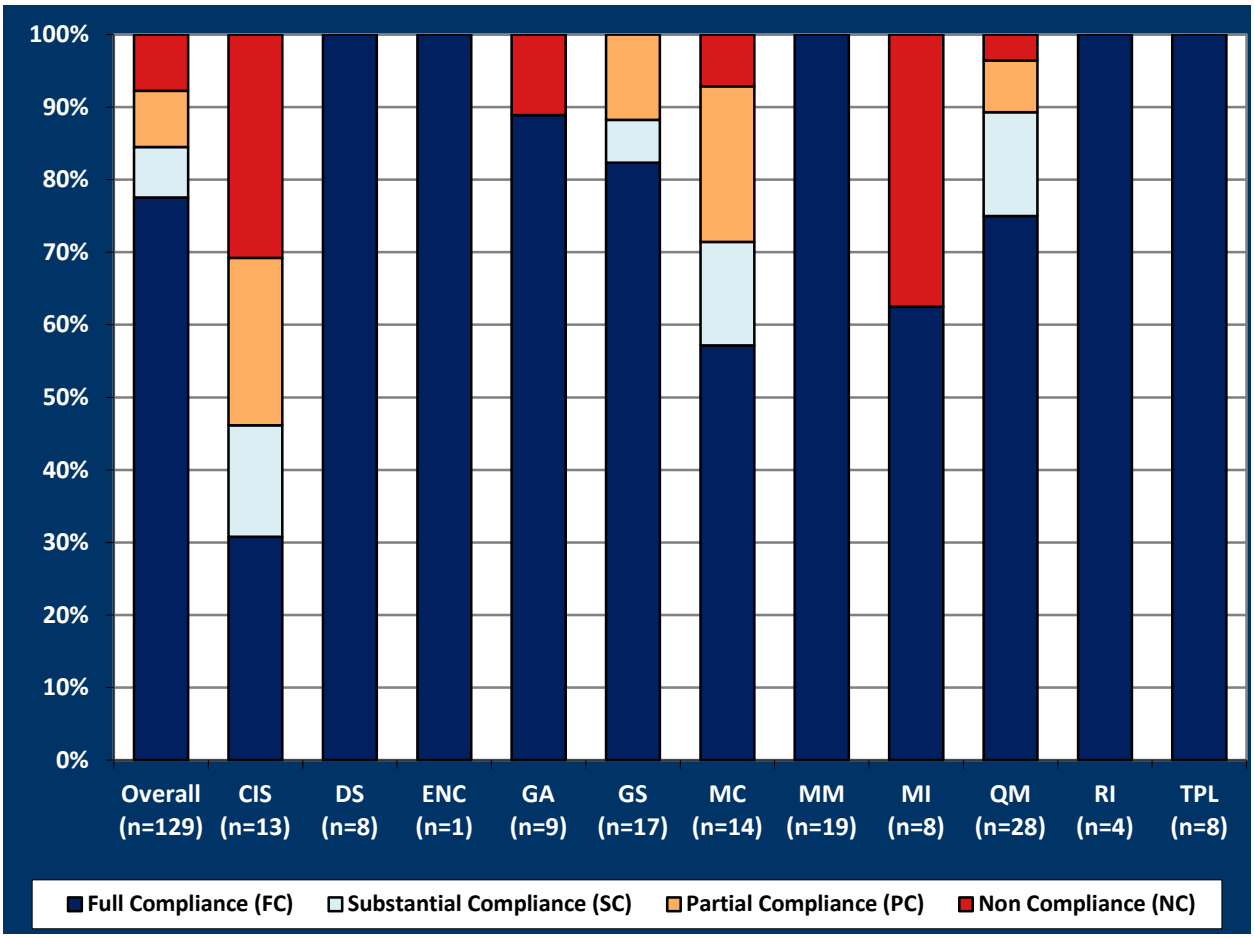
Maricopa Health Plan (MHP)

Maricopa Health Plan (MHP) has contracted with AHCCCS since 1982 for the Acute Care population.

Findings

Figure 6-4 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of 11 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-4—Categorized Levels of Compliance With Technical Standards for MHP[6-5]



[6-5] The compliance categories are abbreviated as follows: CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

Figure 6-4 shows that MHP was in full compliance for 100 of the 129 reviewed standards (77.5 percent), with a large variation in performance across the 11 categories of standards. The Contractor's strongest performance was for the standards associated with the Delivery Systems, Encounters, Medical Management, Third-Party Liability, and Reinsurance categories. AHCCCS scored these categories fully compliant for all related standards.

Of the 11 categories of standards, the Claims and Information Systems category showed the lowest percentage of standards in full compliance (30.8 percent). MHP had five categories with standards scored as noncompliant (Claims and Information Systems, General Administration, Maternal and Child Health and EPSDT, Member Information, and Quality Management). Categories with less than 80 percent of the reviewed standards in full compliance included Quality Management (75.0 percent), Member Information (62.5 percent), Maternal and Child Health and EPSDT (57.1 percent), and Claims and Information Systems (30.8 percent). These categories' results suggest targeted opportunities for improvement.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor "should" or "must" implement a required action to address a deficit within the standard. Table 6-4 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed during CYE 2014.

Table 6-4—Corrective Action Plans by Category for MHP

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	13	9	69.2%	31.0%
Delivery Systems	8	0	0.0%	0.0%
Encounters	1	0	0.0%	0.0%
General Administration	9	1	11.1%	3.5%
Grievance Systems	17	3	17.7%	10.3%
Maternal and Child Health and EPSDT	14	6	42.9%	20.7%
Medical Management	19	0	0.0%	0.0%
Member Information	8	3	37.5%	10.3%
Quality Management	28	7	25.0%	24.1%
Reinsurance	4	0	0.0%	0.0%
Third-Party Liability	8	0	0.0%	0.0%
Overall	**129**	**29**	**22.5%**	**100%**

Table 6-4 shows that the Contractor was required to develop CAPs for 22.5 percent of the standards reviewed during CYE 2014. Three categories shared the largest number of required CAPs (22): Claims and Information Systems, Quality Management, and Maternal and Child Health and EPSDT. AHCCCS required MHP to develop CAPs for standards in six of the 11 categories.

However, CAPs were not required for the Delivery Systems, Encounters, Medical Management, Third-Party Liability, and Reinsurance categories. The largest percentages of CAPs relative to the number of standards in a category were in the Claims and Information Systems (69.2 percent), Maternal and Child Health and EPSDT (42.9 percent), and Member Information (37.5 percent) categories.

Strengths

MHP was in full compliance for all standards within five categories (Delivery Systems, Encounters, Medical Management, Third-Party Liability, and Reinsurance), and the Contractor was not required to develop CAPs for standards in these categories. MHP was only required to develop one CAP for a standard in the General Administration category. MHP was not required to develop any CAPs for the 19 standards in the Medical Management category, and was only required to develop three CAPs for the 17 standards in the Grievance Systems category. Therefore, the Medical Management and Grievance Systems categories were recognized as strengths for the Contractor's program.

Opportunities for Improvement and Recommendations

The OR findings for MHP demonstrated significant opportunities for improvement, as 29 of the standards reviewed (22.5 percent) remained less than fully compliant with AHCCCS' required policies and procedures or required corrective action. AHCCCS required the Contractor to develop at least one CAP for standards in six of the 11 categories, and three or more CAPs in five categories. Among the six categories in which MHP was required to develop a CAP, 75.9 percent of the CAPs were clustered among three categories: Claims and Information Systems (nine CAPs), Quality Management (seven CAPs) and Maternal and Child Health and EPSDT (six CAPs). The Contractor was required to submit CAPs for 69.2 percent of standards in the Claims and Information Systems category. As of January 2015, AHCCCS determined that corrective actions were completed and the CAPs were closed for 21 of the standards (72.4 percent).

In the final report generated from the Contractor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

- **Claims and Information Systems:**

  Completed Corrective Actions as of January 2015

  - The Contractor should take steps to ensure it accurately calculates the quick pay discount rate.
  - The Contractor must have a process in place to train or provide guidance to its subcontractors on the processing of claims specific to the AHCCCS lines of business.
  - The Contractor must ensure that it correctly incorporates provider registration data, including the category of service, into its Claims and Information Systems.
  - The Contractor must ensure it has a process to identify resubmitted claims and a process to adjust claims for data corrections or revised payment.

Open Corrective Actions as of January 2015

- The Contractor must ensure that its remittance advices include all require elements, including the reason and an adequate description of all adjustments, application of coordination of benefits and copays, and instructions for submitting claims disputes and corrected claims.
- The Contractor should review its policies and procedures for the recoupment of overpayments and the adjustment of underpayments to ensure they comply with AHCCCS Contractor Operations Manual Policy 412.
- The Contractor must pay applicable interest on all claims, including overturned claim disputes.
- The Contractor must process overturned claim disputes in a manner consistent with the claim dispute decision within 15 business days of the decision.
- The Contractor should ensure its contracted rates are accurately loaded into its information system.

- **General Administration:**

Completed Corrective Actions as of January 2015

- The Contractor must collect required information for all persons with an ownership or control interest in the Contractor and its fiscal agents, and determine each month whether such individuals have been convicted of a criminal offense related to any program under Medicare, Medicaid, or the Title XX services program.

- **Grievance Systems:**

Completed Corrective Actions as of January 2015

- The Contractor must issue a Notice of Decision as required by AAC R9-34.405(5)(B). The Contractor should issue untimely claim Notices of Decisions citing AAC R9-22-705(B).
- The Contractor must use the appropriate factual and legal basis for the decision as defined in Contract/RFP No. YH14-0001 Section F: Attachment F2.
- The Contractor must include the required information as defined in Contract/RFP No. YH14-0001 Section F: Attachments F2.

- **Maternal and Child Health and EPSDT:**

Completed Corrective Actions as of January 2015

- The Contractor must implement a process to monitor whether pregnant members obtain return visits in accordance with ACOG standards.
- The Contractor must ensure providers document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services.

- The Contractor must implement a process to ensure coordination with State agencies and community programs. The Contractor must implement a process to ensure that members referred to WIC or Head Start are connected with and receive services from these programs.
- The Contractor must develop and implement a process to identify, monitor, evaluate, and implement interventions aimed at reducing the number of members on a wait list for services.
- The Contractor must identify the needs of EPSDT-age members, coordinate their care, conduct adequate follow-up, and ensure that members receive timely and appropriate treatment.

Open Corrective Actions as of January 2015

- The Contractor should implement a referral process or other interventions for members who have been identified with a high BMI. The Contractor should monitor provider compliance in implementing interventions with members identified as overweight, including education and/or nutrition referral.

- **Member Information:**

Completed Corrective Actions as of January 2015

- The Contractor must submit evidence of compliance with this standard.
- The Contractor must respond to this standard with an explanation if the Contractor has not had a material change to operations within the last 12 months from date of the OR.

Open Corrective Actions as of January 2015

- The Contractor must develop policies and procedures to demonstrate it takes into consideration appointment accessibility, quality of care concerns, and wait times when assigning new members.

- **Quality Management:**

Completed Corrective Actions as of January 2015

- The Contractor must develop a process to ensure that all staff who may have contact with members or providers are trained on how to refer suspected quality of care issues to the Quality Management Unit. This training must be provided not only to new employees as demonstrated but annually thereafter to all employees.
- The Contractor must change Policy C1112 A to state that the Contractor ensures that Arizona Medicaid network providers participate in credentialing decisions. The Contractor has implemented a corrective action plan to collect the performance data; however, this was completed after the time frame for the review period. The Contractor must place the correct data collection form in Policy C1112 A. The Contractor must ensure that providers who are

not licensed or certified are included in the credentialing process and must include this information in their credentialing policies.

- The Contractor has implemented a self-determined corrective action plan to begin collecting provider performance monitoring data. Implementation of the data collection process and use of the data will meet the requirements of this standard. The Contractor must conduct medical record reviews every three years, at a minimum. The Contractor should document the credentialing or recredentialing date on the Credentialing/Recredentialing form and should either have the medical director sign the form or remove the signature line from the form.
- The Contractor must meet all requirements for organizational credentialing and recredentialing as specified in AMPM Chapter 950 and the additional requirements specified in the Contractor's policy. The Contractor must also implement and follow up on interventions specified in the AHCCCS-approved OR corrective action plans.
- The Contractor must monitor the receipt of behavioral health information according to AMPM Chapter 940 and the Contractor's own policy. The Contractor should consider adding the above requirement to the medical record audit tool indicator guidelines.
- The Contractor must ensure physician assistants are being appropriately supervised. The Contractor should ensure during on-site visits that providers keep medical records confidential as required under federal and State law.

Open Corrective Actions as of January 2015

- The Contractor must document a process for monitoring IRR related to the collection and entering of data.

Summary

MHP had widespread variation in its CYE 2014 OR results. Of the 129 standards reviewed, 100 were scored as fully compliant (77.5 percent). Five of the 11 categories (Delivery Systems, Encounters, Medical Management, Third-Party Liability, and Reinsurance) had their respective standards scored as fully compliant, and MHP was not required to develop CAPs for any of the standards associated with these categories. Among the six remaining categories, the Claims and Information Systems, Maternal and Child Health and EPSDT, and Member Information categories presented the greatest opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

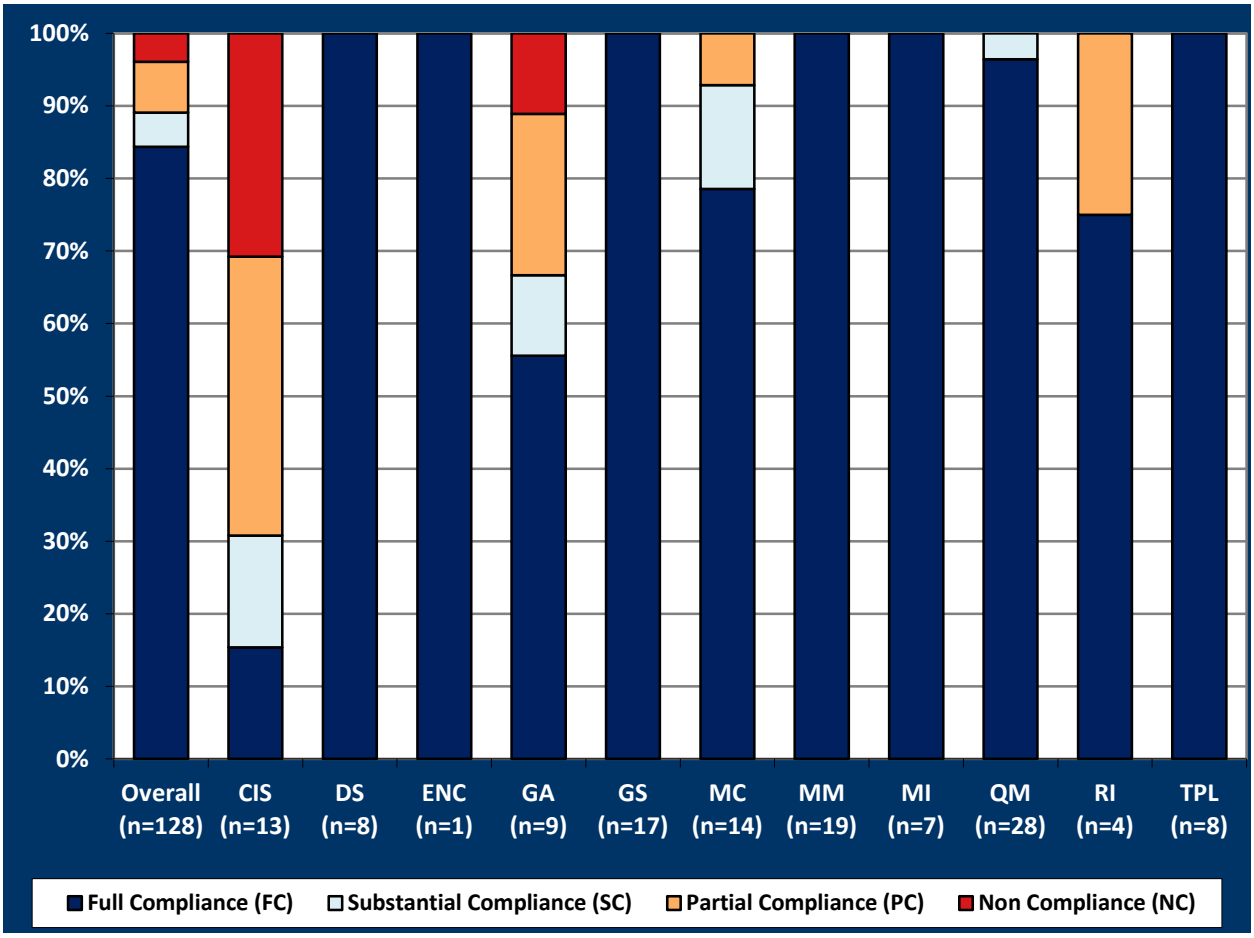
Mercy Care Plan (MCP)

Mercy Care Plan (MCP) has contracted with AHCCCS for the Acute Care program since 1983. AHCCCS conducted the CYE 2014 OR for the Acute Care program concurrent with the OR for MCP's ALTCS EPD line of business.

Findings

Figure 6-5 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of 11 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-5—Categorized Levels of Compliance With Technical Standards for MCP[6-6]



[6-6] The compliance categories are abbreviated as follows: CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

Figure 6-5 shows that MCP was in full compliance for 84.4 percent of the 128 reviewed standards, with some variation in performance across the categories of standards. The Contractor's strongest performance was for the standards associated with the Delivery Systems, Encounters, Grievance Systems, Medical Management, Member Information, and Third-Party Liability categories. AHCCCS scored these categories fully compliant for all related standards.

Of the 11 categories of standards, the Claims and Information Systems category showed the lowest percentage of standards in full compliance (15.4 percent). However, Claims and Information Systems and General Administration were the only categories with noncompliant standards (30.8 percent, and 11.1 percent of category standards were noncompliant, respectively). Categories with less than 80 percent of the reviewed standards in full compliance included Maternal and Child Health and EPSDT (78.6 percent), Reinsurance (75.0 percent), General Administration (55.6 percent) and Claims and Information Systems (15.4 percent). These categories' results suggested important opportunities for improvement.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor "should" or "must" implement a required action to address a deficit within the standard. Table 6-5 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed during CYE 2014.

Table 6-5—Corrective Action Plans by Category for MCP

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	13	11	84.6%	55.0%
Delivery Systems	8	0	0.0%	0.0%
Encounters	1	0	0.0%	0.0%
General Administration	9	4	44.4%	20.0%
Grievance Systems*	17	0	0.0%	0.0%
Maternal and Child Health and EPSDT	14	3	21.4%	15.0%
Medical Management	19	0	0.0%	0.0%
Member Information	7	0	0.0%	0.0%
Quality Management	28	1	3.6%	5.0%
Reinsurance	4	1	25.0%	5.0%
Third-Party Liability	8	0	0.0%	0.0%
Overall	**128**	**20**	**15.6%**	**100%**

* For one standard in this category that was scored as fully compliant, AHCCCS provided a recommendation to the Contractor. The Contractor was not required to develop a CAP for the standard.

Table 6-5 shows that the Contractor was required to develop CAPs for 15.6 percent of the standards reviewed during CYE 2014. The largest number of required CAPs (11) was in the Claims and

Information Systems category. MCP was required to develop at least one CAP for standards in five of the 11 categories. However, CAPs were not required for any standards in the Delivery Systems, Encounters, Grievance Systems, Medical Management, Member Information, and Third-Party Liability categories. The largest percentages of CAPs relative to the number of standards in a category were in the Claims and Information Systems (84.6 percent), General Administration (44.4 percent), and Reinsurance (25.0 percent) categories.

Strengths

MCP was in full compliance for all standards within six categories (Delivery Systems, Encounters, Grievance Systems, Medical Management, Member Information, and Third-Party Liability), and the Contractor was not required to develop CAPs for standards in these categories. Medical Management and Quality Management were recognized as strengths for the Contractor's program. MCP was not required to develop CAPs for any of the 19 standards in the Medical Management category, and was only required to develop one CAP for the 28 standards in the Quality Management category.

Opportunities for Improvement and Recommendations

The OR findings for MCP demonstrated important opportunities for improvement, as 20 of the standards reviewed (15.6 percent) remained less than fully compliant with AHCCCS' required policies and procedures or required corrective action. The Contractor was required to develop at least one CAP in five of the 11 categories. Among the five categories in which MCP was required to develop a CAP, 75.0 percent of the CAPs were clustered among two categories: Claims and Information Systems (11 CAPs) and General Administration (four CAPs). The Contractor was required to submit CAPs for 84.6 percent of the standards in the Claims and Information Systems category, and 44.4 percent of the standards in the General Administration category. As of January 2015, AHCCCS determined that corrective actions were completed and the CAPs were closed for seven of the standards (35.0 percent).

In the final report generated from the Contractor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

- **Claims and Information Systems:**

  Completed Corrective Actions as of January 2015

  - The Contractor must have AHCCCS-compliant policies and procedures for the recoupment of overpayments and the adjustment of underpayments.
  - The Contractor must have a claims processing manual that clearly includes the AHCCCS requirements for claims processing for all AHCCCS lines of business appropriate to the Contractor. The Contractor must have a process in place to train internal and/or subcontractor claims processing staff on the processing of claims specific to the AHCCCS lines of business. The Contractor's claims processing system must include nationally recognized methodologies to correctly pay claims including but not limited to Multiple Procedure/Surgical Reductions and Global Day E & M Bundling standards.

Open Corrective Actions as of January 2015

- The Contractor must ensure its remittance advice includes an adequate description of all denials and adjustments, sufficient reasons for these denials and adjustments, and reflects the correct application of coordination of benefits and copays. Furthermore, the Contractor must ensure its system appropriately applies denial reasons to claims being denied for maximum benefits exceeded.
- The Contractor's claims payment system must edit for primary insurance coverage based on AHCCCS-supplied TPL information.
- The Contractor must pay interest on all nonhospital claims paid more than 45 days after the date of receipt of the clean submission at the rate of 10 percent per annum (calculated daily). The interest is prorated daily and must be paid by the Contractor at the time the clean claim is paid. For all hospital claims the Contractor must pay interest at the rate of 1 percent per month for each month or portion of a month following the 60th day of receipt of the clean claim until the date of payment. The Contractor must also ensure that all claims, including Medicaid claims submitted for dual SNP members, contain an accurate received date. The Contractor must pay interest on all claim disputes as appropriate based on the date of the receipt of the original clean submission (not the claim dispute).
- The Contractor must ensure it accurately applies quick pay discounts on all hospital claims paid within 30 days of receipt of the clean claim. The Contractor must also ensure that all claims contain an accurate received date.
- The Contractor must process overturned claim disputes in a manner consistent with the claim dispute decision within 15 business days of the decision.
- The Contractor must ensure it has procedures in place to accept and integrate the eligibility and enrollment information provided by AHCCCS.
- The Contractor must ensure it accepts and integrates evidence of provider registration data provided by AHCCCS into its Claims and Information Systems, and ensure denials clearly and correctly reflect the appropriate reasons for the denials.
- The Contractor must ensure its claims system has an automated process to identify resubmitted claims, and links all adjustments of a claim with the original claim.
- The Contractor must ensure its policies contain provisions for auditing at least once every five years in addition to any time a contract change is initiated and that it accurately pays providers according to contracted rates.

- **General Administration:**

Completed Corrective Actions as of January 2015

- The Contractor must ensure the operational records/files are maintained for a period of five years.

Open Corrective Actions as of January 2015

- The Contractor must ensure that its prepayment editing process includes member eligibility, covered services, excessive or unusual services for sex or age, duplication of services, prior

authorization, invalid procedure codes, and duplicate claims. The Contractor must ensure that discussion of audit findings, including deficiencies and any implementation of corrective action where appropriate, is documented.

- The Contractor must collect required information for all persons with an ownership or control interest in the Contractor and its fiscal agents and determine monthly whether such individuals have been convicted of a criminal offense related to any program under Medicare, Medicaid, or the Title XX services program.
- The Contractor must ensure that it reviews all policies and procedures annually.

- **Grievance System:**

Note*:* Although MCP was not required to submit a CAP for any of the standards in this category, AHCCCS provided one recommendation to the Contractor, as indicated below. (This standard is not included in the count of CAPs required by AHCCCS.)

- The Contractor must update its Policy 3000.67 to include the missing definition and correct the Request for Expedited Hearing information to read: "The request for hearing must be received within thirty (30) days from the receipt of the appeal resolution."

- **Maternal and Child Health and EPSDT:**

Completed Corrective Actions as of January 2015

- The Contractor must ensure that physicians and other practitioners are documenting in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services. The Contractor must implement a process to monitor medical necessity of sterilizations of members younger than 21 years of age.
- The Contractor should provide documentation of how it ensures that providers report vaccines administered into the ASIIS immunization registry and verify immunization history of children receiving EPSDT services.

Open Corrective Actions as of January 2015

- The Contractor should monitor provider compliance in implementing interventions with members identified as overweight, such as education and/or nutrition referrals.

- **Quality Management:**

Completed Corrective Actions as of January 2015

- The Contractor must participate in appropriate community initiatives and maintain documentation of its participation.

- **Reinsurance:**

  Completed Corrective Actions as of January 2015

  - The Contractor must include procedures to ensure services were encountered correctly.

Summary

MCP had generally positive CYE 2014 OR results, as 108 of the 128 standards reviewed were fully compliant (84.4 percent). Six of the 11 categories (Delivery Systems, Encounters, Grievance Systems, Medical Management, Member Information, and Third-Party Liability) had their respective standards scored as fully compliant, and MCP was not required to develop CAPs for any of the standards associated with these categories. Among the five remaining categories, the Claims and Information Systems and General Administration categories presented the greatest opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

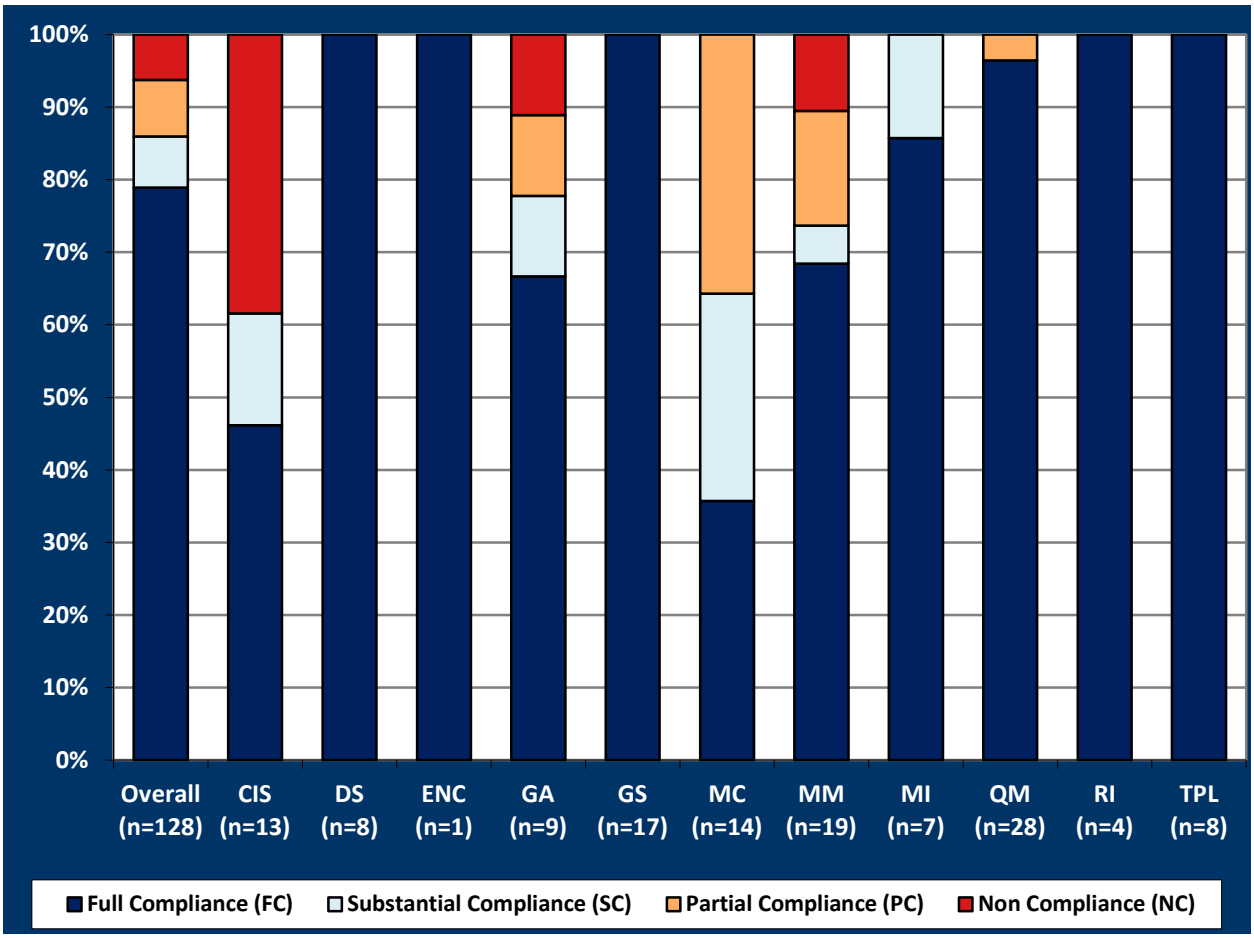
Phoenix Health Plan (PHP)

Phoenix Health Plan (PHP) has contracted with AHCCCS since 1983 for the Acute Care population.

Findings

Figure 6-6 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of 11 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-6—Categorized Levels of Compliance With Technical Standards for PHP[6-7]



[6-7] The compliance categories are abbreviated as follows: CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

Figure 6-6 shows that PHP was in full compliance for 78.9 percent of the 128 reviewed standards, with encouraging performance across the categories of standards. The Contractor's strongest performance was for the standards associated with the Delivery Systems, Encounters, Grievance Systems, Reinsurance, and Third-Party Liability categories. AHCCCS scored these categories as fully compliant for all related standards.

Of the 11 categories of standards, the Maternal and Child Health and EPSDT category showed the lowest percentage of standards in full compliance (35.7 percent). PHP had three categories with standards scored as noncompliant (Claims and Information Systems, General Administration, and Medical Management). Categories with less than 80 percent of the reviewed standards in full compliance included Medical Management (68.4 percent), General Administration (66.7 percent), Claims and Information Systems (46.2 percent), and Maternal and Child Health and EPSDT (35.7 percent). These categories' results suggested targeted opportunities for improvement.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor "should" or "must" implement a required action to address a deficit within the standard. Table 6-6 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed during CYE 2014.

Table 6-6—Corrective Action Plans by Category for PHP

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	13	7	53.9%	25.9%
Delivery Systems	8	0	0.0%	0.0%
Encounters	1	0	0.0%	0.0%
General Administration	9	3	33.3%	11.1%
Grievance Systems	17	0	0.0%	0.0%
Maternal and Child Health and EPSDT	14	9	64.3%	33.3%
Medical Management	19	6	31.6%	22.2%
Member Information	7	1	14.3%	3.7%
Quality Management	28	1	3.6%	3.7%
Reinsurance	4	0	0.0%	0.0%
Third-Party Liability	8	0	0.0%	0.0%
Overall	**128**	**27**	**21.1%**	**100%**

Table 6-6 shows that the Contractor was required to develop CAPs for 21.1 percent of the standards reviewed during CYE 2014. The largest number of required CAPs (nine) was in the Maternal and Child Health and EPSDT category. PHP was required to develop at least one CAP for standards in six of the 11 categories. However, CAPs were not required for any standards in the Delivery Systems, Encounters, Grievance Systems, Reinsurance, and Third-Party Liability categories. The

largest percentages of CAPs relative to the number of standards in a category were in the Maternal and Child Health and EPSDT (64.3 percent), and Claims and Information Systems (53.9 percent) categories.

Strengths

PHP was in full compliance for all standards within five categories (Delivery Systems, Encounters, Grievance Systems, Reinsurance, and Third-Party Liability), and the Contractor was not required to develop CAPs for standards in these categories. PHP was only required to develop one CAP each for the Member Information and Quality Management categories. Grievance Systems and Quality Management were recognized as strengths for the Contactor's program. PHP was not required to develop CAPs for any of the 17 standards in the Grievance Systems category, and was only required to develop one CAP for the 28 standards in the Quality Management category.

Opportunities for Improvement and Recommendations

The OR findings for PHP demonstrated focused opportunities for improvement, as 27 of the standards reviewed (21.1 percent) remained less than fully compliant with AHCCCS' required policies and procedures or required corrective action. PHP was required to develop at least one CAP for standards in six of the 11 categories. Among the six categories in which PHP was required to develop a CAP, 81.5 percent of the CAPs were clustered among three categories: Maternal and Child Health and EPSDT (nine CAPs), Claims and Information Systems (seven CAPs) and Medical Management (six CAPs). AHCCCS required the Contractor to submit CAPs for 64.3 percent of the standards in the Maternal and Child Health and EPSDT category, 53.9 percent of the standards in the Claims and Information Systems category, and 31.6 percent of the standards in the Medical Management category. As of January 2015, AHCCCS determined that corrective actions were completed and the CAPs were closed for 23 of the standards (85.2 percent).

In the final report generated from the Contractor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

- **Claims and Information Systems:**

  Completed Corrective Actions as of January 2015

  - The Contractor must update its policies and procedures to be compliant with current AHCCCS policies and procedures for the recoupment of overpayments.
  - The Contractor must ensure it accurately applies quick-pay discounts.
  - The Contractor must ensure it has a process to identify resubmitted claims and a process to adjust claims for data corrections or revised payment.

  Open Corrective Actions as of January 2015

  - The Contractor must ensure the remittance advice contains an adequate description of all denials and adjustments, the amount billed, an appropriate description of provider rights for claim disputes, and instructions for the submission of corrected claims.

- The Contractor must ensure it pays applicable interest on all claims, including overturned claim disputes.
- The Contractor must ensure it accurately identifies the application of provider demographic information provided by AHCCCS.
- The Contractor should ensure it accurately pays contracted and noncontracted providers.

- **General Administration:**

Completed Corrective Actions as of January 2015

- The Contractor must revise its policy to include that it maintains records until three years after the member has exceeded the age of 18 years or for at least six years after the last date the child received medical or healthcare services from the provider, whichever date occurs later. In addition, the Contractor must revise its policy to reflect the actual length of time that records are retained and that it retains all records.
- The Contractor must ensure that it collects the required information for all persons with an ownership or controlling interest in the Contractor and its fiscal agents in order to determine whether such individuals have been convicted of a criminal offense related to any program under Medicare, Medicaid, or the Title XX services program.
- The Contractor must ensure that all policies and procedures have been reviewed annually.

- **Maternal and Child Health and EPSDT:**

Completed Corrective Actions as of January 2015

- The Contractor must implement a process to monitor whether pregnant members obtain return visits in accordance with ACOG standards.
- The Contractor must implement a process to screen for postpartum depression and to refer identified members to the appropriate behavioral healthcare providers.
- The Contractor should ensure that providers document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services. The Contractor must have a process to monitor the medical necessity for sterilizations of members younger than 21 years of age.
- The Contractor should inform all primary care providers (PCPs) about EPSDT service requirements, including federal, State, and AHCCCS policy requirements.
- The Contractor should provide outreach material and resources to educate members about the risks associated with childhood obesity and available services.
- The Contractor must ensure that an oral health screening is provided by the PCP during the EPSDT visit. The Contractor must monitor and evaluate the effectiveness of oral health/dental outreach activities.
- The Contractor should demonstrate the process of monitoring EPSDT providers for participation in the Vaccines for Children ASIIS program.
- The Contractor should implement a process for utilization of the ASIIS system to verify if immunizations were given.

- The Contractor should implement a process for monitoring and implementing referrals or providing resources for underweight/overweight members. The Contractor should monitor provider compliance in implementing interventions with members identified as overweight, including education and/or nutrition referral.

- **Medical Management:**

  Completed Corrective Actions as of January 2015

  - The Contractor must review, analyze, and trend utilization data; implement interventions for improvement and evaluate the effectiveness of the interventions; and document this information in sufficient detail to the MM Committee. The Contractor must demonstrate a method to assess the quality of services provided when utilization data variances are present.
  - The Contractor should report to the MM Committee the results of monitoring prior authorization decision timeliness and actions taken to improve when deficiencies are identified.
  - The Contractor must implement a process to ensure IRR testing is completed annually.
  - The Contractor must document and present to the MM Committee the outcomes of retrospective reviews and the rationale for the decisions made by the appropriate clinical staff.
  - The Contractor must develop and document a process for monitoring the effectiveness of care coordination/case management.
  - The Contractor must develop a process to document discussion of the outcomes for the chronic care/disease management program in the MM Committee meeting minutes. The Contractor must develop a process to revise the program based on recommendations of the MM Committee.

- **Member Information:**

  Completed Corrective Actions as of January 2015

  - The Contractor must publish AHCCCS-required information in its newsletters twice yearly.

- **Quality Management:**

  Completed Corrective Actions as of January 2015

  - The Contractor must include all required information in the recredentialing process and complete recredentialing at least every three years.

Summary

PHP had generally positive CYE 2014 OR results, as 110 of the 128 standards reviewed were scored as fully or substantially compliant (85.9 percent). Five of the 11 categories (Delivery Systems, Encounters, Grievance Systems, Reinsurance, and Third-Party Liability) had the respective standards scored as fully compliant, and PHP was not required to develop CAPs for any

of the standards associated with these categories. Among the six remaining categories, two categories (Maternal and Child Health and EPSDT, and Claims and Information Systems) presented the greatest opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

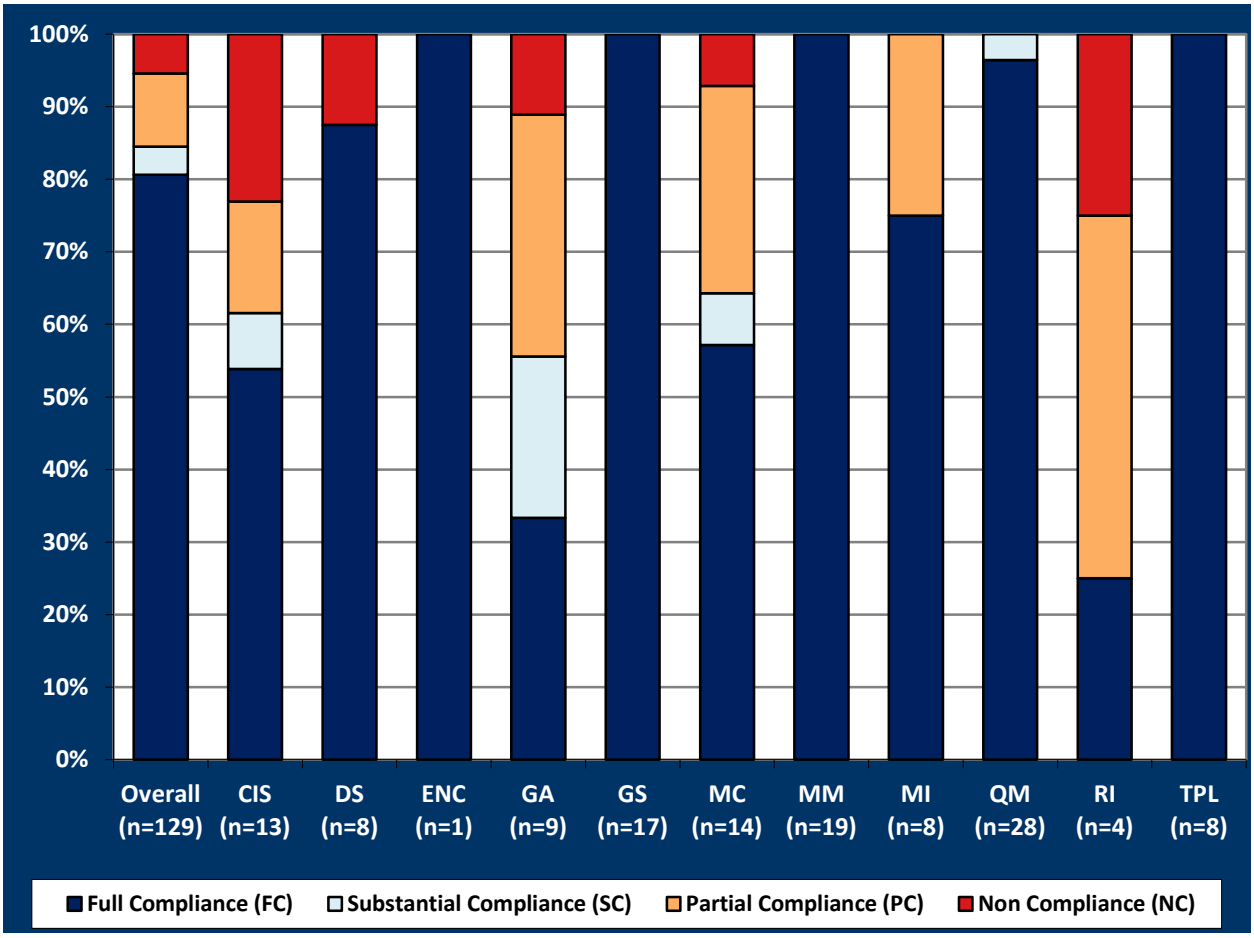
UnitedHealthcare Community Plan (UHCCP)

UnitedHealthcare Community Plan (UHCCP) has contracted with AHCCCS since 1982 for the Acute Care program, though the plan was previously referred to as Arizona Physicians IPA (APIPA). AHCCCS conducted the CYE 2014 OR for the Acute Care program concurrent with the OR for UHCCP's ALTCS EPD and Children's Rehabilitative Services lines of business.

Findings

Figure 6-7 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of 11 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-7—Categorized Levels of Compliance With Technical Standards for UHCCP[6-8]



[6-8] The compliance categories are abbreviated as follows: CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

Figure 6-7 shows that UHCCP was in full compliance for 80.6 percent of the 129 reviewed standards, with a large variation in performance across the categories of standards. The Contractor's strongest performance was for the standards associated with the Encounters, Grievance Systems, Medical Management, and Third-Party Liability categories. AHCCCS scored these categories fully compliant for all related standards.

Of the 11 categories of standards, the Reinsurance category showed the lowest percentage of standards in full compliance (25.0 percent). UHCCP had five categories scored as noncompliant (Claims and Information Systems, Delivery Systems, General Administration, Maternal and Child Health and EPSDT, and Reinsurance). Categories with less than 60 percent of the reviewed standards in full compliance included Maternal and Child Health and EPSDT (57.1 percent), Claims and Information Systems (53.9 percent), General Administration (33.3 percent), and Reinsurance (25.0 percent). These categories' results suggest targeted opportunities for improvement.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor "should" or "must" implement a required action to address a deficit within the standard. Table 6-7 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed during CYE 2014.

Table 6-7—Corrective Action Plans by Category for UHCCP

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	13	6	46.2%	24.0%
Delivery Systems	8	1	12.5%	4.0%
Encounters	1	0	0.0%	0.0%
General Administration	9	6	66.7%	24.0%
Grievance Systems	17	0	0.0%	0.0%
Maternal and Child Health and EPSDT	14	6	42.9%	24.0%
Medical Management	19	0	0.0%	0.0%
Member Information	8	2	25.0%	8.0%
Quality Management	28	1	3.6%	4.0%
Reinsurance	4	3	75.0%	12.0%
Third-Party Liability	8	0	0.0%	0.0%
Overall	**129**	**25**	**19.4%**	**100%**

Table 6-7 shows that the Contractor was required to develop CAPs for 19.4 percent of the standards reviewed during CYE 2014. UHCCP was required to develop at least one CAP for standards in seven of the 11 categories, and was required to develop six CAPs for standards in three of the 11 categories (Claims and Information Systems, General Administration, and Maternal and Child Health and EPSDT). However, CAPs were not required for any standards in the Encounters,

Grievance Systems, Medical Management, and Third-Party Liability categories. The largest percentages of CAPs relative to the number of standards in a category were in the General Administration (66.7 percent), Claims and Information Systems (46.2 percent), and Maternal and Child Health and EPSDT (42.9 percent) categories.

Strengths

UHCCP was in full compliance for all standards within four categories (Encounters, Grievance Systems, Medical Management, and Third-Party Liability), and the Contractor was not required to develop CAPs for standards in these categories. UHCCP was only required to develop one CAP each for the Quality Management and Delivery Systems categories. UHCCP was not required to develop any CAPs from the 19 standards within the Medical Management category, and was required to develop only one CAP from all 28 standards within the Quality Management category. Therefore, Medical Management and Quality Management were recognized as strengths for the Contractor's program.

Opportunities for Improvement and Recommendations

The OR findings for UHCCP demonstrated targeted opportunities for improvement, as 25 of the standards reviewed (19.4 percent) remained less than fully compliant with AHCCCS' required policies and procedures or required corrective action. Among the seven categories in which UHCCP was required to develop a CAP, 72.0 percent were clustered among three categories: General Administration (six CAPs), Claims and Information Systems (six CAPs), and Maternal and Child Health and EPSDT (six CAPs) The Contractor was required to submit CAPs for 66.7 percent of the standards in the General Administration category, 46.2 percent of the standards in the Claims and Information Systems category, and 42.9 percent of the standards in the Maternal and Child Health and EPSDT category. As of January 2015, AHCCCS determined that corrective actions were completed and the CAPs were closed for 15 of the standards (60.0 percent).

In the final report generated from the Contractor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

- **Claims and Information Systems:**

  Completed Corrective Actions as of January 2015

  - The Contractor must have a mechanism to inform providers of the appropriate address for the submission of medical records associated with paper claims. The Contractor must have a mechanism in place to ensure Contractor staff, such as the provider claims educator, Provider Services manager, Provider Services staff, etc., are able to direct providers/billers to information regarding claim submission.
  - The Contractor must ensure its policies and procedures include the request for approval to AHCCCS of cumulative recoupment in excess of $50,000, for the contract year, from one provider or tax identification number (TIN) and the request for approval to AHCCCS of any cumulative recoupment greater than 12 months after the date of the original payment, from one provider or TIN.

- The Contractor must ensure that its information system contains the correct contracted rates.

Open Corrective Actions as of January 2015

- The Contractor must ensure its remittance advices include an adequate description of all denials and adjustments, sufficient reasons for these denials and adjustments, and the amount billed.
- The Contractor must pay 10 percent per annum (calculated daily) on all professional claims paid more than 45 days after the date of receipt of the clean submission. The Contractor must pay interest at the rate of 1 percent per month for each month or portion of a month following the 60th day of receipt of the clean claim until the date of payment. The Contractor must pay applicable interest on all claims, including overturned claim disputes.
- The Contractor must ensure it accepts and integrates evidence of provider registration data provided by AHCCCS into its Claims and Information Systems and appropriately applies this information when processing claims.

- **Delivery Systems:**

Completed Corrective Actions as of January 2015

- The Contractor should ensure it clearly communicates the provider's rights to advocate on behalf of the member regarding:
  - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or nontreatment.
  - The enrollee's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.

- **General Administration:**

Completed Corrective Actions as of January 2015

- The Contractor must revise its policies and procedures to include that it maintains records until three years after the member has exceeded the age of 18 years or for at least six years after the last date the child received medical or healthcare services from the provider, whichever date occurs later.
- The Contractor must ensure that it collects required information for all persons with an ownership or control interest in the Contractor and its fiscal agents and determines monthly whether such individuals have been convicted of a criminal offense related to any program under Medicare, Medicaid, or the Title XX services program. The Contractor must update its policies and/or procedures to reflect all requirements as outlined in the AHCCCS contract with the Contractor.

- The Contractor must revise its policies to reflect that procedures are reviewed annually. Additionally, the Contractor must demonstrate that all policies and procedures have been reviewed annually.

Open Corrective Actions as of January 2015

- The Contractor must ensure that it performs regular audits of the organization to mitigate fraud and abuse.
- The Contractor must ensure that its providers or subcontractors train their staff on the specific components of the federal False Claims Act as identified in this standard.
- The Contractor must ensure that it documents audit findings, notes any deficiencies, and implements corrective action where appropriate.

- **Maternal and Child Health and EPSDT:**

Completed Corrective Actions as of January 2015

- The Contractor should ensure physicians and other practitioners document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services. The Contractor must have a process to monitor medical necessity for sterilizations of members younger than 21 years of age.
- The Contractor must provide evidence of the care coordination process for transitioning members with special healthcare needs who have either been receiving services from CRS and lose eligibility for the CRS Program or at age 21 choose to transition to an Acute Contractor, to adult network providers (including specialty services).

Open Corrective Actions as of January 2015

- The Contractor should implement a process to coordinate services with the WIC, behavioral health, and Head Start programs.
- The Contractor must have a process to educate providers about AzEIP including the need for providers to request authorization for medically necessary services from the Contractor that include a revision to inaccurate language identified in provider education material. The Contractor should develop and implement a proactive process to monitor, evaluate, and implement interventions aimed at reducing members on a wait list for services.
- The Contractor must provide evidence of conducting follow-up to ensure timely and appropriate treatment is received.
- The Contractor should develop a process for monitoring and implementing referrals for underweight/overweight members. The Contractor should develop a process to monitor provider compliance in implementing interventions with members identified as overweight, including education and/or nutrition referral.

- **Member Information:**

Completed Corrective Actions as of January 2015

- The Contractor must provide timely notification to affected members when a PCP or frequently used provider leaves the network. The Contractor must change the date within the letter notices to allow members a choice prior to the Contractor assigning the member a provider.
- The Contractor should create a policy and procedure outlining notification of members when a material network change occurs. The Contractor must demonstrate that it issues member notification to affected members 30 days prior to implementing any material changes.

- **Quality Management:**

  Completed Corrective Actions as of January 2015

  - The Board of Directors must review and approve the Quality Management Plan and Evaluation in a timely manner. The Contractor must have a unique quality management plan, work plan and evaluation for each of line of business.

- **Reinsurance:**

  Completed Corrective Actions as of January 2015

  - The Contractor should develop procedures to ensure services were encountered correctly.
  - The Contractor must ensure it balances to paid claims data for all actions resulting in a payment or overpayment for all contract years. The policies and procedures must be followed for each remittance.
  - The Contractor should follow the process for monitoring the appropriateness of the reinsurance revenue received against paid claims data.

Summary

UHCCP had widespread variation in its CYE 2014 OR results, and 104 of the 129 standards reviewed were fully compliant (80.6 percent). Four of the 11 categories (Encounters, Grievance Systems, Medical Management, and Third-Party Liability) had the respective standards scored as fully compliant, and UHCCP was not required to develop CAPs for any of the standards associated with these categories. Among the seven remaining categories, the General Administration, Claims and Information Systems, and Maternal and Child Health and EPSDT categories presented the greatest opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

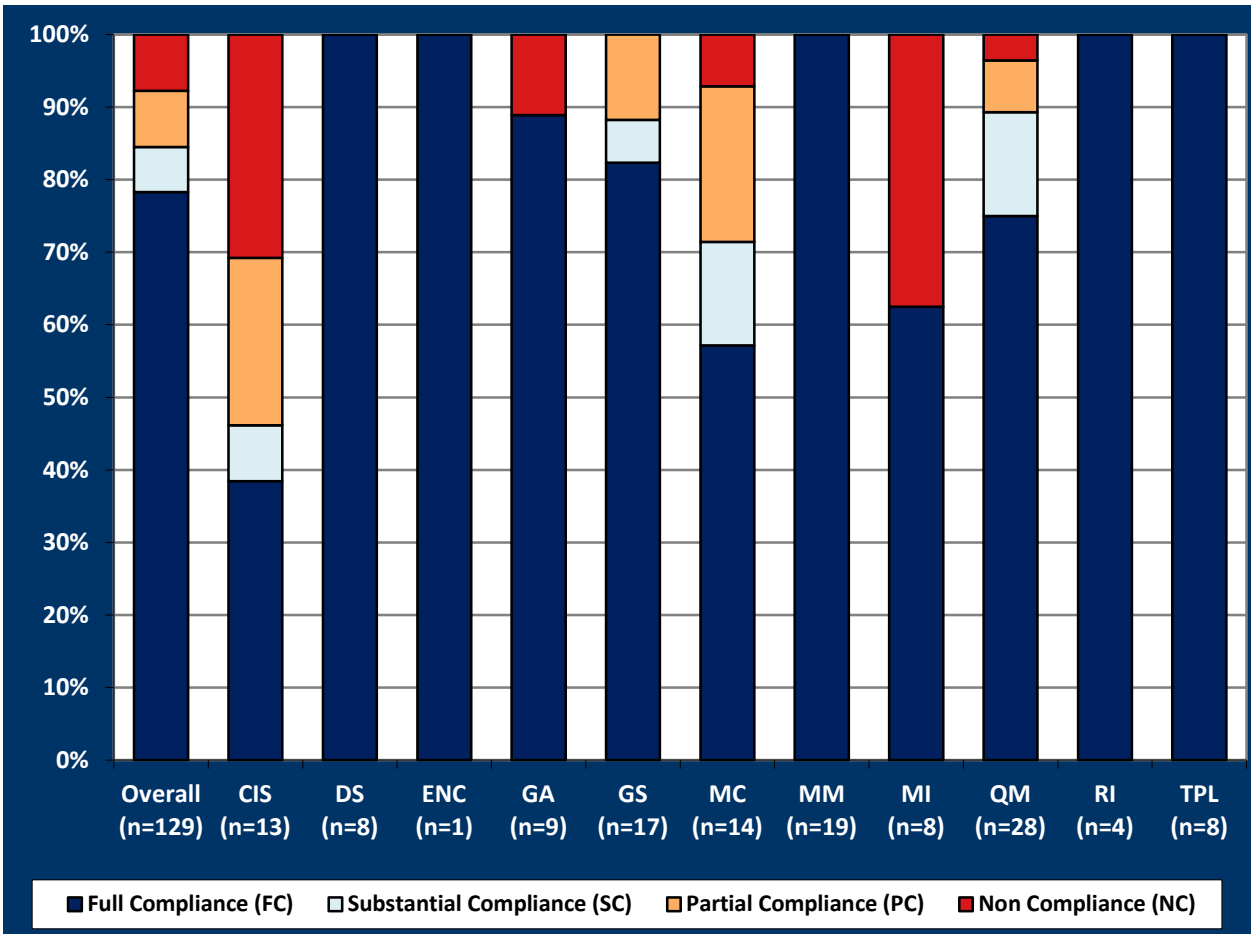
University Family Care (UFC)

University Family Care (UFC) has contracted with AHCCCS since 1997 for the Acute Care population.

Findings

Figure 6-8 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of 11 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-8—Categorized Levels of Compliance With Technical Standards for UFC[6-9]



[6-9] The compliance categories are abbreviated as follows: CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

Figure 6-8 shows that UFC was in full compliance for 78.3 percent of the 129 reviewed standards, with a large variation in performance across the categories of standards. The Contractor's strongest performance was for the standards associated with the Delivery Systems, Encounters, Medical Management, Reinsurance, and Third-Party Liability categories. AHCCCS scored these categories fully compliant for all related standards.

Of the 11 categories of standards, the Claims and Information Systems category showed the lowest percentage of standards in full compliance (38.5 percent). UFC had five categories with standards scored as noncompliant (Claims and Information Systems, General Administration, Maternal and Child Health and EPSDT, Member Information, and Quality Management). Categories with less than 80 percent of the reviewed standards in full compliance included Quality Management (75.0 percent), Member Information (62.5 percent), Maternal and Child Health and EPSDT (57.1 percent), and Claims and Information Systems (38.5 percent). These categories' results suggested targeted opportunities for improvement.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor "should" or "must" implement a required action to address a deficit within the standard. Table 6-8 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed during CYE 2014.

Table 6-8—Corrective Action Plans by Category for UFC

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	13	8	61.5%	28.6%
Delivery Systems	8	0	0.0%	0.0%
Encounters	1	0	0.0%	0.0%
General Administration	9	1	11.1%	3.6%
Grievance Systems	17	3	17.7%	10.7%
Maternal and Child Health and EPSDT	14	6	42.9%	21.4%
Medical Management	19	0	0.0%	0.0%
Member Information	8	3	37.5%	10.7%
Quality Management	28	7	25.0%	25.0%
Reinsurance	4	0	0.0%	0.0%
Third-Party Liability	8	0	0.0%	0.0%
Overall	**129**	**28**	**21.7%**	**100%**

Table 6-8 shows that the Contractor was required to develop CAPs for 21.7 percent of the standards reviewed during CYE 2014. The largest number of required CAPs (eight) was in the Claims and Information Systems category. UFC was required to develop at least one CAP in six of the 11 categories. However, CAPs were not required for any of the standards in the Delivery Systems,

Encounters, Medical Management, Third-Party Liability, or Reinsurance categories. The largest percentages of CAPs relative to the number of standards in a category were in the Claims and Information Systems (61.5 percent), Maternal and Child Health and EPSDT (42.9 percent), and Member Information (37.5 percent) categories.

Strengths

UFC was in full compliance for all standards within five categories (Delivery Systems, Encounters, Medical Management, Third-Party Liability, and Reinsurance), and the Contractor was not required to develop CAPs for standards in these categories. UFC was not required to develop a CAP for the Encounters category, but the category had only one standard; therefore, the result was not considered a strength. UFC was not required to develop any CAPs from the 19 standards within the Medical Management category, and was only required to develop three CAPs from the 17 standards within the Grievance Systems category. Therefore, Medical Management and Grievance Systems were recognized as strengths for the Contractor's program.

Opportunities for Improvement and Recommendations

The OR findings demonstrated many available opportunities for improvement, as 28 of the standards reviewed (21.7 percent) remained less than fully compliant with AHCCCS' required policies and procedures or required corrective action. Among the six categories in which UFC was required to develop a CAP, 75.0 percent of the CAPs were clustered among three categories: Claims and Information Systems (eight CAPs), Quality Management (seven CAPs), and Maternal and Child Health and EPSDT (six CAPs). The Contractor was required to submit CAPs for 61.5 percent of the standards in the Claims and Information Systems category, 42.9 percent of the standards in the Maternal and Child Health and EPSDT category, and 37.5 percent of the standards in the Member Information category. As of September 2014, AHCCCS determined that corrective actions were completed and the CAPs were closed for 11 of the standards (39.3 percent)

In the final report generated from the Contractor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

- **Claims and Information Systems:**

  Completed Corrective Actions as of September 2014

  - The Contractor must have a process in place to train or provide guidance to its subcontractors on the processing of claims specific to the AHCCCS lines of business.
  - The Contractor must ensure it has a process to identify resubmitted claims and a process to adjust claims for data corrections or revised payment.

  Open Corrective Actions as of September 2014

  - The Contractor must ensure that its remittance advices include all required elements, including the reason and an adequate description of all adjustments, application of

coordination of benefits and copays, and instructions for submitting claims disputes and corrected claims.

- The Contractor should review its policies and procedures for the recoupment of overpayments and the adjustment of underpayments to ensure they comply with AHCCCS Contractor Operations Manual Policy 412.
- The Contractor must pay applicable interest on all claims, including overturned claim disputes.
- The Contractor should take steps to ensure it accurately calculates the quick pay discount rate.
- The Contractor must ensure that it correctly incorporates provider registration data, including the category of service, into its Claims and Information Systems.
- The Contractor must ensure contracted rates are accurately loaded into its information system and noncontracted claims are correctly paid.

- **General Administration:**

  Open Corrective Actions as of September 2014

  - The Contractor must collect required information for all persons with an ownership or control interest in the Contractor and its fiscal agents, and determine monthly whether such individuals have been convicted of a criminal offense related to any program under Medicare, Medicaid, or the Title XX services program, as required by this standard.

- **Grievance Systems:**

  Completed Corrective Actions as of September 2014

  - The Contractor must issue Notice of Decision as required by AAC R9-34.405(5)(B). The Contractor should issue untimely claim Notices of Decision citing AAC R9-22-705(B).
  - The Contractor must use the appropriate factual and legal basis for the decision as defined in Contract/RFP No. YH14-0001 Section F: Attachments F2.
  - The Contractor must include the required information as defined in Contract/RFP No. YH14-0001 Section F: Attachments F2.

- **Maternal and Child Health and EPSDT:**

  Completed Corrective Actions as of September 2014

  - The Contractor must develop and implement a process to identify, monitor, evaluate, and implement interventions aimed at reducing the number of members on a wait list for services.

Open Corrective Actions as of September 2014

- The Contractor must implement a process to monitor whether pregnant members obtain return visits in accordance with ACOG standards.
- The Contractor must ensure that providers document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services.
- The Contractor must implement a process to ensure coordination with state agencies and community programs. The Contractor must implement a process to ensure that members referred to WIC or Head Start are connected with and receive services from these programs.
- The Contractor must identify the needs of EPSDT-age members, coordinate their care, conduct adequate follow-up, and ensure that members receive timely and appropriate treatment.
- The Contractor should implement interventions such as referrals and educational materials for members who have been identified with a high body mass index. The Contractor should monitor provider compliance in implementing interventions with members identified as being overweight, including education and/or nutrition referrals.

- **Member Information:**

Completed Corrective Actions as of September 2014

- The Contractor must submit evidence of compliance with the standard regarding training of Member Services representatives and appropriate handling and tracking of member inquiries and complaints.
- The Contractor must respond to this standard with an explanation if the Contractor has not had a material change to operations within the last 12 months from the date of the OR.

Open Corrective Actions as of September 2014

- The Contractor must develop policies and procedures to demonstrate that it takes into consideration appointment accessibility, quality of care concerns, and wait times when assigning new members.

- **Quality Management:**

Completed Corrective Actions as of September 2014

- The Contractor must develop a process to ensure that all staff who may have contact with members or providers are trained on how to refer suspected quality of care issues to the Quality Management Unit. This training must be provided not only to new employees as demonstrated but annually thereafter to all employees.
- The Contractor must monitor the receipt of behavioral health information according to AMPM Chapter 940 and the Contractor's own policy. The Contractor should consider adding the above requirement to the medical record audit tool indicator guidelines.

- The Contractor must ensure physician assistants are being appropriately supervised. The Contractor should ensure during on-site visits that providers keep medical records confidential as required under federal and State law.

Open Corrective Actions as of September 2014

- The Contractor must change Policy C1112 A to state that the Contractor ensures that Arizona Medicaid network providers participate in credentialing decisions. The Contractor has implemented a corrective action plan to collect the performance data; however, this was completed after the time frame for the review period. The Contractor must place the correct data collection form in Policy C1112 A. The Contractor must ensure that providers who are not licensed or certified are included in the credentialing process and must include this information in its credentialing policies.
- The Contractor has implemented a self-determined corrective action plan to begin collecting provider performance monitoring data. Implementation of the data collection process and use of the data will meet the requirements of this standard. The Contractor must conduct medical record reviews every three years, at a minimum. The Contractor should document the credentialing or recredentialing data on the Credentialing/Recredentialing form and should either have the medical director sign the form or remove the signature line from the form.
- The Contractor must meet all requirements for organizational credentialing and recredentialing as specified in AMPM Chapter 950 and the additional requirements specified in the Contractor's policy. The Contractor must also implement and follow up on interventions specified in the AHCCCS-approved OR corrective action plans.
- The Contractor must document a process for monitoring IRR related to the collection and entering of data.

Summary

UFC had widespread variation in its CYE 2014 OR results, as 101 of the 129 standards reviewed were scored as fully compliant (78.3 percent). All standards associated with five of the 11 categories (Delivery Systems, Encounters, Medical Management, Third-Party Liability, and Reinsurance) were scored as fully compliant, and UFC was not required to develop CAPs for any of the standards associated with these categories. Among the six remaining categories, the Claims and Information Systems, Maternal and Child Health and EPSDT, and Member Information categories presented the greatest opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

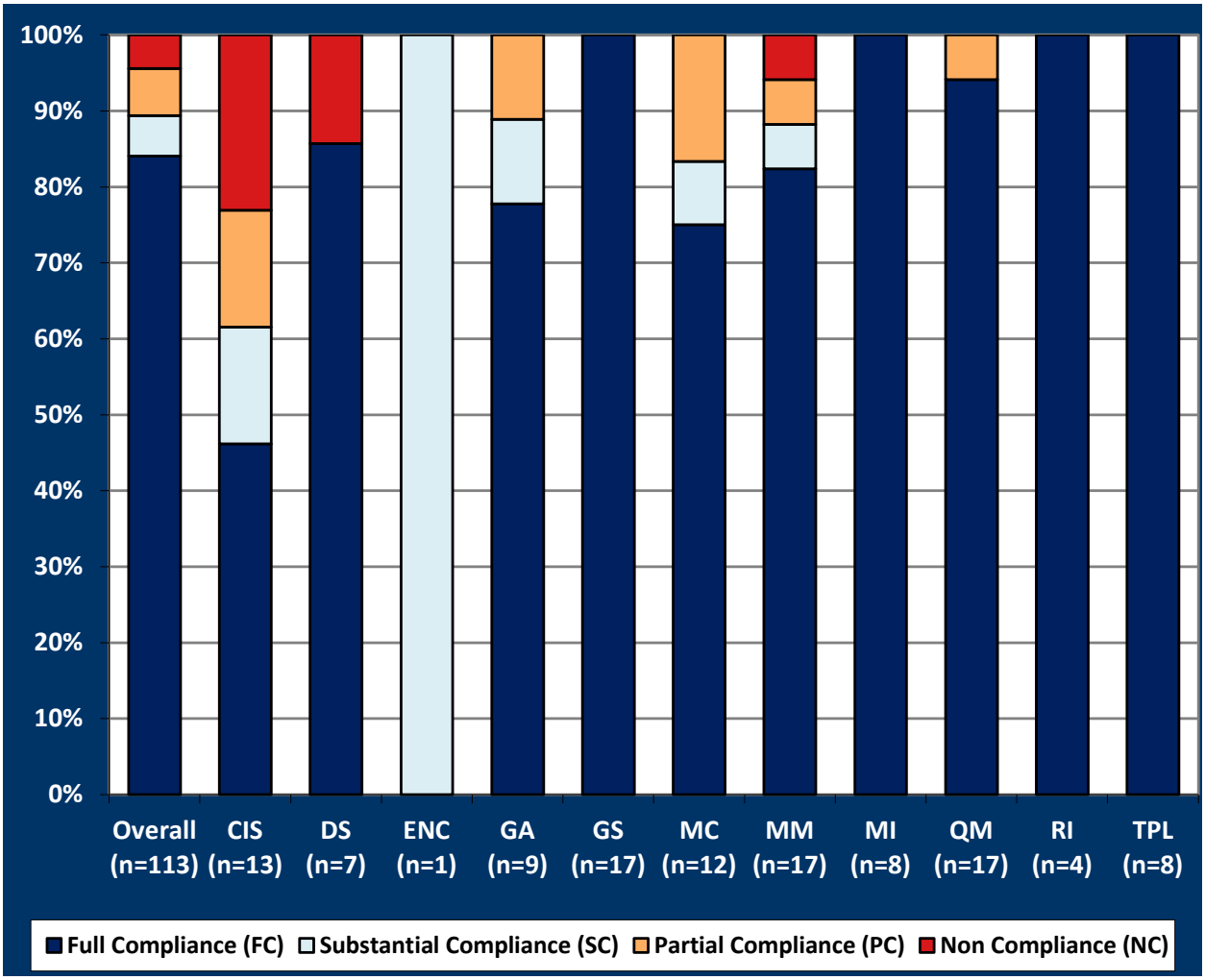
DES/Comprehensive Medical and Dental Programs (CMDP)

DES/CMDP has contracted with AHCCCS since 2003.

Findings

Figure 6-9 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of 11 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-9—Categorized Levels of Compliance With Technical Standards for DES/CMDP[6-10]



[6-10] The compliance categories are abbreviated as follows: CIS= Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS= Grievance Systems, MC= Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

Figure 6-9 shows that DES/CMDP was in full compliance for 84.1 percent of the 113 reviewed standards, with a large variation in performance across the categories of standards. The Contractor's strongest performance was for the standards associated with the Grievance Systems, Member Information, Reinsurance, and Third-Party Liability categories. AHCCCS scored these categories fully compliant for all related standards.

Of the 11 categories of standards, the Encounters category showed the lowest percentage of standards in full compliance (0.0 percent). However, the small number of standards within this category (i.e., one) could have influenced this result. DES/CMDP had three categories with standards scored as noncompliant (Claims and Information Systems, Delivery Systems, and Medical Management). Categories with less than 80 percent of the reviewed standards in full compliance included General Administration (77.8 percent), Maternal and Child Health and EPSDT (75.0 percent), Claims and Information Systems (46.2 percent), and Encounters (0.0 percent). These categories' results suggest targeted opportunities for improvement.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor "should" or "must" implement a required action to address a deficit within the standard. Table 6-9 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed during CYE 2014.

Table 6-9—Corrective Action Plans by Category for DES/CMDP

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	13	7	53.9%	35.0%
Delivery Systems	7	1	14.3%	5.0%
Encounters	1	1	100.0%	5.0%
General Administration	9	2	22.2%	10.0%
Grievance Systems	17	0	0.0%	0.0%
Maternal and Child Health and EPSDT	12	3	25.0%	15.0%
Medical Management	17	3	17.7%	15.0%
Member Information	8	0	0.0%	0.0%
Quality Management*	17	3	17.7%	15.0%
Reinsurance	4	0	0.0%	0.0%
Third-Party Liability	8	0	0.0%	0.0%
Overall	**113**	**20**	**17.7%**	**100%**

*The Contractor was required to develop CAPs for two standards in this category that were scored as N/A.

Table 6-9 shows that the Contractor was required to develop CAPs for 17.7 percent of the standards reviewed during CYE 2014. DES/CMDP was required to develop at least one CAP for standards in seven of the 11 categories. The largest number of required CAPs (seven) was in the Claims and

Information Systems category. The largest percentages of CAPs relative to the number of standards in a category were in the Encounters (100.0 percent), Claims and Information Systems (53.9 percent), and Maternal and Child Health and EPSDT (25.0 percent) categories.

Strengths

CMDP was in full compliance for all standards within four categories (Grievance Systems, Member Information, Reinsurance, and Third-Party Liability), and the Contractor was not required to develop CAPs for standards in these categories. Grievance Systems (17 fully compliant standards and no CAPs) was recognized as a strength for the Contractor's program, as DES/CMDP was not required to develop any CAPs for the 17 standards in this category.

Opportunities for Improvement and Recommendations

The OR findings for DES/CMDP demonstrated targeted opportunities for improvement, as 20 of the standards reviewed (17.7 percent) remained less than fully compliant with AHCCCS' required policies and procedures or required corrective action. The Contractor was required to develop CAPs for at least one standard within seven of the 11 categories. AHCCCS required DES/CMDP to develop CAPs for 100.0 percent of the standards in the Encounters category; however, there was only one standard in this category. The Contractor was required to submit CAPs for 53.9 percent of the standards in the Claims and Information Systems category, and 25.0 percent of the standards in the Maternal and Child Health and EPSDT category. Additionally, AHCCCS provided recommendations on two Quality Management standards that were scored as N/A, and the Contractor was required to develop CAPs for these standards. As of January 2015, AHCCCS determined that corrective actions were completed and the CAPs were closed for 12 of the standards (60.0 percent).

In the final report generated from the Contractor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following items, with notations regarding completed corrective actions:

- **Claims and Information Systems:**

  Completed Corrective Actions as of January 2015

  - The Contractor must have policies and procedures that include the requirement that it submits voided or replaced encounters within 120 days from AHCCCS' approval of the recoupment or the date of refund from the provider. Moreover, the policies must also clearly include all requirements the Contractor must follow when requesting the recoupment, including using the provider's TIN as a basis for determining whether AHCCCS approval is needed, and submission of the provider notification letter.
  - The Contractor must have a documented process in place to train internal and/or subcontractor claims processing staff on processing claims specific to the AHCCCS line of business, and provides periodic refresher/update material as appropriate.
  - The Contractor must have an automated process to identify when a claim is resubmitted.

Open Corrective Actions as of January 2015

- The Contractor must ensure that its remittance advices include all required elements, including the reason and an adequate description of all denials and adjustments, provider rights for claims disputes, and instructions for submitting claims disputes and corrected claims.
- The Contractor must pay interest at a rate of 10 percent per annum (calculated daily) on all professional claims paid more than 45 days after the date of receipt of the clean submission, and as appropriate for interest paid as a result of a resolved claim dispute.
- The Contractor must ensure that it correctly accepts and integrates evidence of provider registration data provided by AHCCCS into its Claims and Information Systems, and ensures denials clearly reflect the appropriate denial reasons.
- The Contractor should ensure its information system contains corrected contracted rates.

- **Delivery Systems:**

Completed Corrective Actions as of January 2015

- The Contractor should ensure that providers have mechanisms to advise or advocate on behalf of the member regarding the following:
  - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits, and consequences of treatment or nontreatment.
  - The enrollee's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions.

- **Encounters:**

Completed Corrective Actions as of January 2015

- The Contractor must ensure encounters are complete, accurate, and timely, and ensure omitted and inaccurate encounters are submitted and corrected.

- **General Administration:**

Completed Corrective Actions as of January 2015

- The Contractor must ensure that its policies and procedures are reviewed annually.

Open Corrective Actions as of January 2015

- The Contractor must ensure that employees have ongoing training based on changes in the AHCCCS program.

- **Maternal and Child Health and EPSDT:**

  Completed Corrective Actions as of January 2015

  - The Contractor must include a process to monitor whether pregnant mothers receive return visits in accordance with ACOG standards.
  - The Contractor should develop and implement a process of care coordination with the Head Start program.
  - The Contractor must have a process that includes documentation of education to providers on the AzEIP, including the need for providers to request authorization for medically necessary services through the Contractor. The Contractor must monitor and implement interventions as needed, aimed at reducing members on a wait list for services.

- **Medical Management:**

  Completed Corrective Actions as of January 2015

  - The Contractor must revise its policies and procedures related to IRR testing for staff involved in making clinical decisions as outlined in the AMPM including an accurate description of the IRR process and time frames. The Contractor must document the actions taken when staff does not meet the Contractor's minimum IRR test score.
  - To comply with transition policies and procedures, the Contractor must implement strategies to ensure all electronic transition information (ETI) forms are fully completed.
  - Although the Contractor is appropriately issuing notices of actions (NOAs) and notices of extension (NOEs), the Contractor did not provide a policy and procedure devoted to NOAs and NOEs including all the requirements outlined in AHCCCS policy. The policy must include the following:
    - The letters must be written in easily understood language.
    - The letters must address the member's right to file an appeal.
    - The letters must address the member's right to have services continue during the appeal process and the circumstances under which the member may be required to pay for these services.

- **Quality Management:**

  Open Corrective Actions as of January 2015

  - The Contractor must have a process, and follow this process, to ensure Peer Review Committee confidentiality is documented and maintained. The Contractor must also reflect in policy that documentation specific to peer review will be made available to AHCCCS for purposes of quality management, monitoring, and oversight.
  - While the Contractor is scored "Not Applicable" for this standard due to its continuing time frame to implement its use of the AzAHP contracting process, delays in implementation by the Contractor led AHCCCS to require the Contractor to develop a CAP for the

implementation of its agreement. The CAP must include the implementation of all credentialing activities required in federal rule, contract, and AMPM Chapter 900 by August 8, 2014, regardless of whether requirements are carried out through AzAHP or by the Contractor internally. AHCCCS will monitor this implementation as part of the CAP follow-up process. In addition, the process should ensure participation of Arizona Medical Network providers in making credentialing decisions. The Contractor should review the "Reviewer Comments" sections under QM 9, QM 10, QM 11, and QM 12 for any applicable feedback specific to the credentialing requirements covered by these standards.

- While the Contractor is scored "Not Applicable" for this standard due to its continuing time frame to implement the CYE 2011 CAP, delays in implementation by the Contractor and the need for the Contractor to implement an internal medical record review (MRR) process rather than subcontracting to AzAHP led AHCCCS to require the Contractor to develop a CAP for the implementation of its MRR process. The CAP must include the implementation of an MRR process covering all MRR requirements in federal rule, contract, and AMPM Chapter 900 by August 8, 2014, as indicated in the CYE 2011 OR. Further, the process and policy must also demonstrate that a corrective action plan will be required from providers who are not compliant with maintaining comprehensive medical records and the Contractor will monitor the status of the corrective action plan. AHCCCS will monitor this implementation as part of the CAP follow-up process. Implementation of an MRR process must not be dependent on its contract with the Association, particularly if the Association is not moving forward with implementing a collaborative MRR process. The Contractor should review the "Reviewer Comments" sections under MCH 4, QM 18, QM 19, QM 20, QM 21, and QM 24 for feedback specific to the MRR requirements covered by these standards.

Summary

DES/CMDP had generally positive CYE 2014 OR results. While 84.1 percent of the 113 standards reviewed were scored as fully compliant, the Contractor was required by AHCCCS to develop CAPs for at least one standard within seven of the 11 categories. The Encounters, Claims and Information Systems, and Maternal and Child Health and EPSDT categories presented important opportunities for improvement, as they had the largest proportion of CAPs relative to the number of standards in each category.

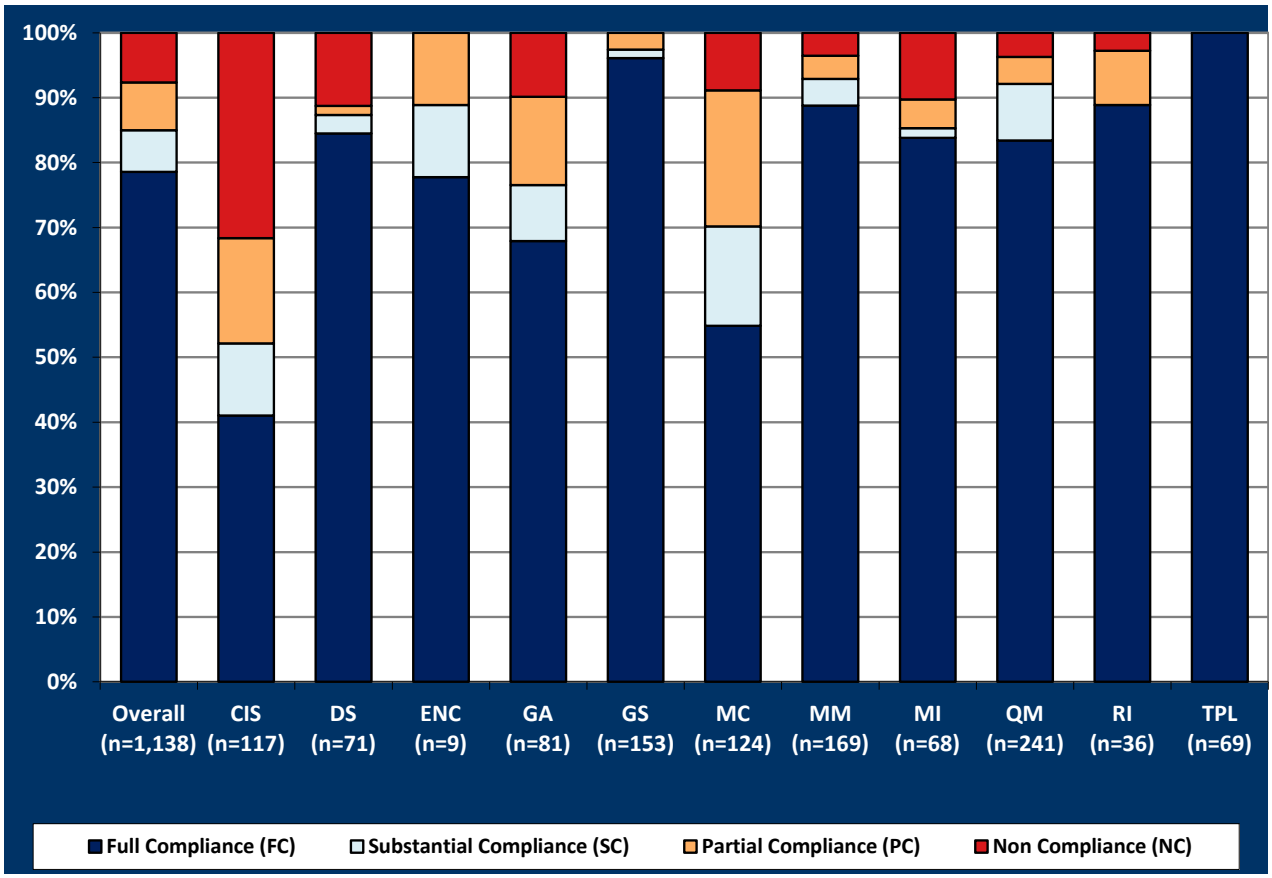
Comparative Results for Acute Care and DES/CMDP Contractors

The following section presents a comparative analysis of the performance results from AHCCCS' OR for the nine Acute Care and DES/CMDP Contractors. Findings are provided on the proportion of each Contractor's compliance standards assessed in full compliance, substantial compliance, partial compliance, and noncompliance. A comparison of the percentage of reviewed compliance standards requiring a CAP is also presented for all Contractors combined.

Findings

Figure 6-10 presents the overall compliance results (i.e., the far-left bar, labeled "Overall") and the results for each of 11 categories of OR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-10—Categorized Levels of Compliance With Technical Standards for Acute Care and DES/CMDP Contractors[6-11]



[6-11] The compliance categories are abbreviated as follows: CIS=Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS=Grievance Systems, MC= Maternal and Child Health and EPSDT, MI=Member Information, MM=Medical Management, QM=Quality Management, RI=Reinsurance, and TPL=Third-Party Liability.

Figure 6-10 shows that the nine Contractors were in full compliance for 78.6 percent of the 1,138 reviewed standards (left-most bar, labeled "Overall"), with moderate variation in performance across nine of the 11 categories of standards and wider variation for the Claims and Information Systems and Maternal and Child Health and EPSDT categories. The Contractors' strongest performance was for the standards associated with the Third-Party Liability category, which showed 100.0 percent of the related standards fully compliant. The Contractors showed strong performance for the standards associated with the Grievance Systems, Medical Management, and Reinsurance categories. More than 85.0 percent of the related standards in each of these categories were scored as fully compliant.

Of the 11 categories of standards, the Claims and Information Systems category showed the lowest percentage of standards in full compliance (41.0 percent) and the highest percentage of standards in noncompliance (31.6 percent). While seven additional categories included standards scored as noncompliant, no category had more than 12.0 percent of its standards scored as such. Categories with less than 80 percent of the reviewed standards in full compliance included Encounters (77.8 percent), General Administration (67.9 percent), Maternal and Child Health and EPSDT (54.8 percent), and Claims and Information Systems (41.0 percent). These categories' results suggest targeted opportunities for improvement.

All Contractors had at least one category, Third-Party Liability, in which all related standards were scored as fully compliant. Two Contractors, Care1st and MCP, had all standards associated with six of the 11 categories scored as fully compliant. Four Contractors (Care1st, HCA, MCP, and DES/CMDP) each had at least 84.0 percent of all standards scored as fully compliant.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor "should" or "must" implement a required action to address a deficit within the standard. Table 6-10 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed during CYE 2014.

Table 6-10—Corrective Action Plans by Category for Acute Care and DES/CMDP Contractors

Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	117	69	59.0%	28.0%
Delivery Systems	71	11	15.5%	4.5%
Encounters	9	2	22.2%	0.8%
General Administration	81	26	32.1%	10.6%
Grievance Systems*	153	6	3.9%	2.4%
Maternal and Child Health and EPSDT	124	56	45.2%	22.8%
Medical Management	169	19	11.2%	7.7%
Member Information	68	11	16.2%	4.5%

Table 6-10—Corrective Action Plans by Category for Acute Care and DES/CMDP Contractors				
Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Quality Management**	241	42	17.4%	17.1%
Reinsurance	36	4	11.1%	1.6%
Third-Party Liability	69	0	0.0%	0.0%
Overall	**1,138**	**246**	**21.6%**	**100%**

* For one standard in this category that was scored as fully compliant, AHCCCS provided a recommendation to the Contractor. That Contractor was not required to develop a CAP for the standard.
** One Contractor was required to develop CAPs for two standards in this category that were scored as N/A.

Table 6-10 shows that the Contractors were required to develop CAPs for 21.6 percent of the standards reviewed during CYE 2014. The largest number of required CAPs (69) was in the Claims and Information Systems category. The Contractors were required to develop at least one CAP for standards in 10 of the 11 categories. However, CAPs were not required for any standards in the Third-Party Liability category. The fewest number of total required CAPs (two) were received for the Encounters category; however, this category only had a total of nine standards. The largest percentages of CAPs relative to the number of standards in a category were in the Claims and Information Systems (59.0 percent), Maternal and Child Health and EPSDT (45.2 percent), and General Administration (32.1 percent) categories.

Strengths

Each of the nine Contractors had at least one category in which all related standards were scored as fully compliant. Two Contractors, Care1st and MCP, had six of the 11 categories scored with 100.0 percent of the standards in full compliance. Four Contractors (Care1st, HCA, MCP, and DES/CMDP) each had at least 84.0 percent of all standards scored as fully compliant. When examining specific categories, complying with Grievance Systems standards was an apparent strength across Acute Care and DES/CMDP Contractors. The category showed 147 of the reviewed standards (96.1 percent) to be in full compliance (n=153), and AHCCCS only required six CAPs among the nine Contractors. The Medical Management and Reinsurance categories were also identified as strengths for the nine Acute Care and DES/CMDP Contractors. AHCCCS required the Contractors to submit CAPs for less than 12 percent of the respective standards (23 total CAPs) between the two categories. Together, these two categories accounted for 18.0 percent of all reviewed standards (n=205), but only 9.4 percent of the total number of CAPs.

When analyzing the standards within each category, there were 69 standards across the 11 categories that were scored as fully compliant without any CAPs required for each of the nine Contractors. Among all Contractors, the Third-Party Liability category is the only category in which AHCCCS scored all associated standards as fully compliant with no required CAPs.

Opportunities for Improvement and Recommendations

Performance varied widely among the nine Contractors, with AHCCCS requiring the Contractors to submit CAPs on a variety of topics. The number of CAPs ranged from a low of 19 for Care1st to a high of 58 for HNA. No Contractors were scored fully compliant for more than 84.5 percent of their

standards, and four Contractors had fewer than 80 percent of their standards in full compliance and had more than 25 CAPs each. HNA and MHP were required to submit the greatest number of CAPs (58 and 29, respectively). AHCCCS required the Acute Care and DES/CMDP Contractors to submit 69 CAPs for the standards in the Claims and Information Systems category (59.0 percent of standards assessed for the category). Overall, the Claims and Information Systems, Maternal and Child Health and EPSDT, and Quality Management categories presented the largest proportional opportunities for improvement, as 67.9 percent of the total CAPs required by AHCCCS were related to these categories.

HNA's CYE 2014 OR results showed the most frequent opportunities for improvement, with AHCCCS requiring the Contractor to submit 58 CAPs for the 125 reviewed standards (46.4 percent). With only 53.6 percent of the reviewed standards in full compliance, opportunities for improvement are widespread for this Contractor. MHP had 77.5 percent of its standards in full compliance, also indicating substantial opportunities for improvement. Care1st, HCA, and MCP demonstrated the strongest performance, with at least 84.0 percent of the reviewed standards in full compliance. AHCCCS required these Contractors to each submit 20 or fewer CAPs.

When comparing performance among the Contractors for individual standards, there were nine standards for which at least seven of the eligible Contractors were required to submit a CAP. Claims and Information Systems, Standard 2, had the highest proportion of Contractors required to submit CAPs, with each of the nine Contractors evaluated for this standard receiving a less than fully compliant score; further, at the time of this report, none of the Contractors' CAPs for this standard had been closed by AHCCCS. Claims and Information Systems, Standard 5 and Standard 10, had the highest proportion of Contractors scored as noncompliant (88.9 percent each). Table 6-11 below details the overall performance of the nine standards for which at least seven of the eligible Contractors were required to submit a CAP.

Table 6-11—Selected Levels of Compliance by Standard for Acute Care and DES/CMDP Contractors

Category and Standard	Eligible Contractors	Fully Compliant Contractors		Substantially Compliant Contractors		Partially Compliant Contractors		Noncompliant Contractors	
		#	%	#	%	#	%	#	%
Claims and Information Systems 2	9	0	0.0%	1	11.1%	2	22.2%	6	66.7%
Claims and Information Systems 4	9	1	11.1%	6	66.7%	1	11.1%	1	11.1%
Claims and Information Systems 5	9	1	11.1%	0	0.0%	0	0.0%	8	88.9%
Claims and Information Systems 10	9	1	11.1%	0	0.0%	0	0.0%	8	88.9%
Claims and Information Systems 12	9	2	22.2%	2	22.2%	4	44.4%	1	11.1%
Claims and Information Systems 13	9	1	11.1%	3	33.3%	3	33.3%	2	22.2%
Maternal and Child Health and EPSDT 10	9	1	11.1%	3	33.3%	3	33.3%	2	22.2%

Table 6-11—Selected Levels of Compliance by Standard for Acute Care and DES/CMDP Contractors									
Category and Standard	Eligible Contractors	Fully Compliant Contractors		Substantially Compliant Contractors		Partially Compliant Contractors		Noncompliant Contractors	
		#	%	#	%	#	%	#	%
Maternal and Child Health and EPSDT 11	9	2	22.2%	4	44.4%	3	33.3%	0	0.0%
Maternal and Child Health and EPSDT 13	9	1	11.1%	3	33.3%	3	33.3%	2	22.2%

Though the categories of standards provide a valuable framework for assessing overall performance, comparing Contractor performance among selected individual standards allows for a focused examination of the Contractors' opportunities for improvement. Additionally, the standards identified in Table 6-11 illuminate opportunities for AHCCCS to provide additional oversight and potential technical assistance to Contractors.

Opportunities for improvement generated by the OR, as well as required CAPs, identify areas within the structural operations of each Contractor that require significant attention and improvement. All Contractors were required to develop CAPs that could be resolved by ensuring that policies and protocols contain all AHCCCS-required elements and associated time frames (e.g., Notice of Action letters to members and service determination notices) and that Contractor staff monitor compliance with these requirements. Deficiencies in coordination of care also directly impact access to care and the timeliness and quality of care provided to members by the Contractors.

Based on AHCCCS' review of Acute Care and DES/CMDP Contractor performance in CYE 2014 and the associated opportunities for improvement identified as a result of the OR, HSAG recommends the following:

- Acute Care and DES/CMDP Contractors should conduct internal reviews of operational systems to identify barriers that impact their compliance with AHCCCS standards. Specifically, Contractors should cross-reference existing policies and procedures with AHCCCS requirements and ensure, at a minimum, that they are in alignment with both the intent and content of AHCCCS standards.
- Contractors should develop and implement systems for monitoring the timeliness, accuracy, and completeness of all AHCCCS-required reports and deliverables.
- Contractors should evaluate their current monitoring programs and activities. When deficiencies are noted, the Contractors should take steps to either develop new procedures and review mechanisms or augment existing ones. In many cases, Contractors can apply lessons learned from improving performance for one category of standards to other categories.
- All Contractors should review their Claims and Information Systems and bring them into compliance with the relevant standards, as 59.0 percent of all standards in this category required a CAP. As a majority of Contractors were not in full compliance with selected standards, Contractors should work with their information systems personnel to accomplish the following:

- Ensure that the remittance advice forms sent to providers contain the minimum information required by AHCCCS, including:
  - An adequate description of all denials and adjustments.
  - The reasons for denials and adjustments.
  - The amount billed.
  - The amount paid.
  - Application of coordination of benefits and copays.
  - Provider rights for claim disputes.
  - Instructions for the submission of claim disputes or corrected claims.
- Ensure that applicable interest is paid on all claims, including overturned claim disputes.
- Ensure that provider registration data provided by AHCCCS are accepted and integrated into the Contractor's Claims and Information Systems, and this information is appropriately applied by the Contractor when processing claims.

Summary

With 85.0 percent of standards in full or substantial compliance and 7.6 percent in noncompliance, AHCCCS' CYE 2014 Acute Care and DES/CMDP OR had positive overall results. Most CAPs were related to monitoring, reporting, and communications processes.

7. Performance Improvement Project Performance

In accordance with 42 CFR 438.240(d), AHCCCS requires Contractors to have a QAPI program that (1) includes ongoing programs of performance improvement projects (PIPs) designed to achieve favorable effects on health outcomes and member satisfaction; and (2) focuses on clinical and/or nonclinical areas that involve the following:

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

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

One of the three EQR-related activities mandated by the federal Medicaid managed care requirements and described at 42 CFR 438.358(b)(1) is the annual validation of MCO and PIHP PIPs required by a state and underway during the preceding 12 months. The requirement at 42 CFR 438.358(a) allows a state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory and optional EQR-related activities.

AHCCCS typically conducts the functions associated with the mandatory Medicaid managed care act activity of validating its Contractors' PIPs. However, AHCCCS opted to close the PIP, *Inpatient Readmissions within 30 Days*, and instead rely on the Contractors' reported performance measurements going forward to monitor performance. This decision was made as a result of national and state-specific factors that have contributed to declining readmission rates (a positive outcome), and also because several improvement interventions have since been institutionalized by AHCCCS and its Contractors, namely:

- Adoption of the HEDIS measure *Readmission within 30 Days* as a contract-required performance measure, allowing for continued focus on the topic by Contractors.
- Inclusion of this measure in the payment withhold formula. This readmission measure is one of six measures that Acute-care contractors are held accountable for annually as part of payment reform.
- Alignment with shared savings arrangements. Shared savings arrangements are now contractually mandated with increasing requirements annually. AHCCCS expects that Contractors' care efforts will focus on providing care in the most appropriate yet least expensive setting and that use of higher levels of care/more expensive settings and resulting outcomes will be better managed.
- In addition, CMS has made readmission a central focus by limiting instances where readmissions would be a reimbursable expense.

Because the Contractor-reported results on *Inpatient Readmissions within 30 Days* were not validated due to AHCCCS' closure of this PIP, HSAG is presenting the results and improvement

activities as reported by the Contractors, but is unable to assess strengths and weaknesses or provide an evaluation of findings because the results have not been validated.

To replace this PIP topic, AHCCCS has required all lines of business, including Acute Care Contractors and the DES/CMDP Contractor, to initiate a new PIP focused on increasing the number of prescribers electronically prescribing medications and increasing the number of prescriptions submitted electronically. CYE 2014 was the baseline year for this PIP, and further details regarding the PIP methodology were not available at the time of this annual report but will be reported in subsequent years.

Contractor-Specific Results

AHCCCS provided to HSAG its CYE 2014 Contractor PIP performance results for seven Acute Care Contractors and for DES/CMDP. The Acute Care Contractors for which data were provided were Care1st, HCA, MHP, MCP, PHP, UFC, and UHCCP. The PIP conducted during CYE 2014 for the Acute Care Contractors and for DES/CMDP was *Inpatient Readmissions within 30 Days*, which focused on decreasing the number of inpatient readmissions among members 21 through 64 years of age for any cause within 30 days of the initial hospitalization. Because the goal of the PIP was to lower the number of readmissions, a lower rate by a Contractor indicates better performance.

During CYE 2014, the *Inpatient Readmissions within 30 Days* PIP was in the second remeasurement period, and the PIP was closed by AHCCCS. Contractors used baseline data collected during the CYE 2011 measurement period to implement strategies to decrease the number of inpatient hospitalization readmissions among Medicaid members beginning in CYE 2012. It is expected that Contractor education efforts during and beyond the CYE 2012 intervention period will result in a smaller percentage of Acute Care members requiring readmission within 30 days of a discharge from an inpatient hospitalization.

This section includes Contractors' PIP remeasurement results as submitted to AHCCCS by the Contractors, along with specific activities and interventions during the measurement period from October 1, 2013, through September 30, 2014. Because data presented below were supplied by the Contractors, results may differ from the PIP baseline rates reported in the 2012–2013 previous annual EQR report. Also, because the results were not validated by AHCCCS, an assessment of Contractors' strengths and weaknesses could not be performed.

Care1st Health Plan (Care1st)

Table 7-1 presents the *Inpatient Readmissions within 30 Days* PIP results reported to AHCCCS by Care1st. Care1st noted in its PIP report that these remeasurement results were generated from the Contractor's internal data using the HEDIS technical specifications for the *Plan All-Cause Readmission* measure. Care1st did not specify which year(s) of HEDIS technical specifications were used when calculating the rates for the remeasurement periods.

Table 7-1—*Inpatient Readmissions within 30 Days* PIP Results *for* Care1st				
PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2012, to Sept. 30, 2013	Remeasurement Period 2 Oct. 1, 2013, to Sept. 30, 2014	Relative Percent Change From Baseline[A]
Percentage of members with an inpatient readmission within 30 days	15.9%	11.6%	12.4%	NA

[A] HSAG opted to present this result as NA because the Contractor noted that the baseline rates cannot be reliably compared to remeasurement rates due to differences in the calculation methodologies.

Table 7-1 shows Care1st's self-reported *Inpatient Readmissions within 30 Days* PIP results for the baseline period and two remeasurement periods. Care1st noted in its PIP Report that rates cannot be reliably compared over time due to differences in calculation methodologies. During CYE 2014, the Contractor broadened previously reported in-home case management interventions such that more members could benefit from community-based services. Care1st acknowledged that its work on this PIP reinforced the value of partnering with organizations that provide home and community-based social support services.

Health Choice Arizona (HCA)

Table 7-2 presents the *Inpatient Readmissions within 30 Days* PIP results reported to AHCCCS by HCA. HCA noted in its PIP Report that these remeasurement results were generated from the Contractor's internal data without changes from the original PIP methodology.

Table 7-2—*Inpatient Readmissions within 30 Days* PIP Results *for* HCA				
PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2012, to Sept. 30, 2013	Remeasurement Period 2 Oct. 1, 2013, to Sept. 30, 2014	Relative Percent Change From Baseline[A]
Percentage of members with an inpatient readmission within 30 days	14.8%	11.1%	9.5%	-35.8%

[A] The *Relative Percent Change from Baseline* was calculated by HSAG using Contractor-supplied PIP results and was not validated by AHCCCS.

Table 7-2 shows HCA's self-reported *Inpatient Readmissions within 30 Days* PIP rate decreased 35.8 percent, from 14.8 percent during the baseline period to 9.5 percent during the second remeasurement period. A lower rate for this PIP indicates better performance. HCA noted that previously reported interventions such as the Transitions of Care program have been effective and will continue. The Contractor reported no new interventions during CYE 2014.

Maricopa Health Plan (MHP)

Table 7-3 presents the *Inpatient Readmissions within 30 Days* PIP results reported to AHCCCS by MHP. MHP noted in its PIP Report that these remeasurement results were generated using a software program, of which the source code had been certified by NCQA. However, MHP did not

specify the HEDIS measure calculated or the year(s) of HEDIS technical specifications used when calculating the rates for the remeasurement periods.

Table 7-3—*Inpatient Readmissions within 30 Days* PIP Results *for* MHP

PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2012, to Sept. 30, 2013	Remeasurement Period 2 Oct. 1, 2013, to Sept. 30, 2014	Relative Percent Change From Baseline[A]
Percentage of members with an inpatient readmission within 30 days	17.9%	11.6%	10.8%	NA

[A] HSAG opted to present this result as NA because the Contractor noted that the baseline rates cannot be reliably compared to remeasurement rates due to differences in the calculation methodologies.

Table 7-3 shows MHP's self-reported *Inpatient Readmissions within 30 Days* PIP results for the baseline period and two remeasurement periods. MHP noted in its PIP Report that the continuous enrollment criteria applied to remeasurement calculations resulted in a large decrease among the population eligible for the measure; rates cannot be reliably compared over time due to differences in calculation methodologies. The Contractor's PIP report did not include a description of interventions in place during CYE 2014, or an assessment of the interventions that may have contributed to changes in MHP's readmission rate.

Mercy Care Plan (MCP)

Table 7-4 presents the *Inpatient Readmissions within 30 Days* PIP results reported to AHCCCS by MCP. MCP noted in its PIP Report that these remeasurement results were generated from the Contractor's internal data without changes from the original PIP methodology.

Table 7-4—*Inpatient Readmissions within 30 Days* PIP Results *for* MCP

PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2012, to Sept. 30, 2013	Remeasurement Period 2 Oct. 1, 2013, to Sept. 30, 2014	Relative Percent Change From Baseline[A]
Percentage of members with an inpatient readmission within 30 days	16.8%	6.4%	9.5%	-43.4%

[A] The *Relative Percent Change From Baseline* was calculated by HSAG using Contractor-supplied PIP results and was not validated by AHCCCS.

Table 7-4 shows MCP's self-reported *Inpatient Readmissions within 30 Days* PIP rate decreased 43.4 percent, from 16.8 percent during the baseline period to 9.5 percent during the second remeasurement period. A lower rate for this PIP indicates better performance. MCP previously reported conducting an intervention in which the prior authorization process was altered to make members' discharge needs the responsibility of concurrent review staff. In the current PIP report, MCP noted this intervention was effective in reducing inpatient readmissions. This intervention has resulted in updated internal processes for the Contractor, ensuring the sustainability of the performance gains achieved under this PIP. The Contractor reported no new interventions during CYE 2014, but stated that it implemented the MCG CareWebQI system in November 2014. (Note: MCG, formerly Milliman Care Guidelines, is now part of Hearst Health Network.) This system is

intended to improve processing, monitoring, and reporting, with the goal of coaching staff in maintaining consistent review practices.

Phoenix Health Plan, LLC (PHP)

Table 7-5 presents the *Inpatient Readmissions within 30 Days* PIP results reported to AHCCCS by PHP. While PHP's PIP report comprehensively described the Contractor's actions on this PIP, it did not provide details on the data or methodology used to calculate the remeasurement results.

Table 7-5—*Inpatient Readmissions within 30 Days* PIP Results *for* PHP

PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2012, to Sept. 30, 2013[A]	Remeasurement Period 2 Oct. 1, 2013, to Sept. 30, 2014	Relative Percent Change From Baseline[B]
Percentage of members with an inpatient readmission within 30 days	14.0%	NR	9.8%	-30.0%

[A] PHP did not report a rate for Remeasurement Period 1.
[B] The *Relative Percent Change From Baseline* was calculated by HSAG using Contractor-supplied PIP results and was not validated by AHCCCS.

Table 7-5 shows PHP's self-reported *Inpatient Readmissions within 30 Days* PIP rate decreased 30.0 percent, from 14.0 percent during the baseline period to 9.8 percent during the second remeasurement period. A lower rate for this PIP indicates better performance. PHP reported on several interventions initiated during CYE 2014:

- Case managers were trained by MCG to use the Chronic Care Guidelines online tool.
- The Contractor is partnering with two large health systems to use payment reform incentives to reduce inpatient readmission rates. The goal of the partnership is to entice contracted facilities to encourage the use of best practices in discharge planning and readmission prevention.
- PHP is deploying new reports on readmission rates by age to allow for enhanced performance monitoring on this topic.

PHP also reported that during CYE 2014, it expected to implement a new medical management system that will help identify members at risk for readmission, allowing discharge planners and case managers to work together more effectively. The Contractor is also redeploying a staff member, the PHP Welcome Home coordinator, whose hospital visits to members and their caregivers help ensure members have appropriate resources upon discharge from the hospital.

UnitedHealthcare Community Plan (UHCCP)

Table 7-6 presents the *Inpatient Readmissions within 30 Days* PIP results reported to AHCCCS by UHCCP. UHCCP noted in its PIP report that these results were generated from the Contractor's HEDIS reporting data software, using the HEDIS technical specifications for the *Inpatient Utilization* measure. UHCCP did not specify which year of HEDIS technical specifications was used when calculating the Remeasurement Period 1 rate.

Table 7-6—*Inpatient Readmissions within 30 Days* PIP Results *for* UHCCP				
PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2012, to Sept. 30, 2013	Remeasurement Period 2 Oct. 1, 2013, to Sept. 30, 2014[A]	Relative Percent Change From Baseline[B]
Percentage of members with an inpatient readmission within 30 days	16.1%	13.7%	NR	NA

[A] UHCCP did not report a rate for Remeasurement Period 2.
[B] HSAG opted to present this result as NA because the Contractor noted that different calculation methodologies were used for the baseline rate and remeasurement rate.

Table 7-6 shows UHCCP's self-reported *Inpatient Readmissions within 30 Days* PIP results for the baseline period and one remeasurement period. UHCCP reported several ongoing interventions initiated during CYE 2014:

- Readmissions were added to the Rapid Impact Rounds to identify areas of improvement.
- Daily length of stay (LOS) meetings are held to identify members at day three to ensure milestones have been assessed.
- A manager audits readmissions to ensure a case manager is actively involved in the delivery of services to members.
- Additional training on critical decision making in discharge planning activities was provided to intensive care management (ICM) nurses with the objective of encouraging clinical staff to address member discharge issues while the member is in an acute care setting.

UHCCP's PIP report did not include the Contractor's assessment of how the interventions may have contributed to the change in readmission rate. However, UHCCP noted that differences in the PIP results may have resulted from differences in the calculation methodologies between AHCCCS and the Contractor.

University Family Care (UFC)

Table 7-7 presents the *Inpatient Readmissions within 30 Days* PIP results reported to AHCCCS by UFC. UFC noted in its PIP Report that these remeasurement results were generated using a software program, of which the source code had been certified by NCQA. However, UFC did not specify the HEDIS measure calculated or the year(s) of HEDIS technical specifications used when calculating the rates for the remeasurement periods.

Table 7-7—*Inpatient Readmissions within 30 Days* PIP Results *for* UFC				
PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2012, to Sept. 30, 2013	Remeasurement Period 2 Oct. 1, 2013, to Sept. 30, 2014	Relative Percent Change From Baseline[A]
Percentage of members with an inpatient readmission within 30 days	17.9%	11.6%	10.8%	NA

[A] HSAG opted to present this result as NA because the Contractor noted that the baseline rates cannot be reliably compared to remeasurement rates due to differences in the calculation methodologies.

Table 7-7 shows UFC's self-reported *Inpatient Readmissions within 30 Days* PIP results for the baseline period and two remeasurement periods. UFC noted in its PIP report that the continuous enrollment criteria applied to remeasurement calculations resulted in a large decrease among the population eligible for the measure; rates cannot be reliably compared over time due to differences in calculation methodologies. The Contractor's PIP report did not include a description of interventions in place during CYE 2014, or an assessment of the interventions that may have contributed to changes in UFC's readmission rate.

Arizona Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP)

Table 7-8 presents the *Inpatient Readmissions within 30 Days* PIP results reported to AHCCCS by DES/CMDP. DES/CMDP noted in its PIP report that remeasurement results were not available from AHCCCS and internal progress on this PIP is tracked using a different metric (i.e., the rate of bed-days per 1,000 members and the rate of readmissions per 1,000 members).

Table 7-8—*Inpatient Readmissions within 30 Days* PIP Results *for* DES/CMDP

PIP Measure	Baseline Period Oct. 1, 2010, to Sept. 30, 2011	Remeasurement Period 1 Oct. 1, 2012, to Sept. 30, 2013	Remeasurement Period 2 Oct. 1, 2013, to Sept. 30, 2014[A]	Relative Percent Change From Baseline
Percentage of members with an inpatient readmission within 30 days	9.3%	NR	NR	NA

[A] DES/CMDP did not report a rate for either remeasurement period.

DES/CMDP's PIP report included results for two different metrics related to inpatient readmissions, as the Contractor determined these metrics to be more appropriate for its population (i.e., children in foster care). DES/CMDP noted specific challenges with this PIP related to the nature of its membership, and reported that its progress on this topic could be attributed to the use of a single, dedicated concurrent review nurse, intensive case management, and thorough discharge planning.

Comparative Results for Acute Care and DES/CMDP Contractors

Findings

Due to the disparate measurement periods, lack of validation of source data, and variable calculation methods among the Acute Care Contractors and the DES/CMDP Contractor, it is not possible to reliably compare Contractors' self-reported performance on the *Inpatient Readmissions within 30 Days* PIP.

Strengths

No strengths in Contractor performance have been identified because the data reported by the Contractors were not comparable and were not validated by AHCCCS.

Opportunities for Improvement and Recommendations

AHCCCS has closed this PIP but will continue to measure performance on this topic through future performance measure reporting and validation activities, and HSAG recommends that the Contractors continue monitoring the outcomes associated with the reported interventions. As Contractor-specific strengths and opportunities could not be reliably identified from the data provided, HSAG recommends that AHCCCS fully validate Contractors' PIP submissions for inclusion in future annual EQR reports.

Summary

The *Inpatient Readmissions within 30 Days* PIP for the Acute Care Contractors and the DES/CMDP Contractor was closed mid-cycle by AHCCCS, and performance results for this PIP were limited to the Contractors' final PIP reports submitted to AHCCCS. While evaluations of individual Contractor results and comparative results across Contractors were not able to be performed with confidence because results had not been validated, the Contractor-reported remeasurement results for readmissions appear to indicate decreasing rates (improvement) as compared to baseline rates for the six Contractors that reported rates. AHCCCS and the Contractors plan to continue these improvement efforts and monitor results using the HEDIS measure for readmissions.

8. Consumer Assessment of Healthcare Providers and Systems

CAHPS—Adult and Child Survey

In 2013, as an optional EQR activity, AHCCCS elected to conduct member satisfaction surveys of adult and child Medicaid members and KidsCare members enrolled in the AHCCCS Acute Care Medicaid managed care program (i.e., Acute Care program). AHCCCS contracted with HSAG to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Surveys.[8-1]

This section of the EQR technical report presents Contractor-specific adult and child Medicaid CAHPS survey results for each of the participating Acute Care Contractors and the DES/CMDP Contractor, as well as statewide aggregate adult and child CAHPS survey results for the Acute Care program.[8-2] Additionally, statewide aggregate child CAHPS survey results for the KidsCare program are also presented. The KidsCare program CAHPS survey results are presented following the Acute Care Contractor-specific and statewide comparative results.

Methodology for Conducting CAHPS Surveys

Overview

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

Objectives

As part of its objectives to measure, report, compare, and continually improve Contractor performance, AHCCCS elected to conduct CAHPS surveys of adult and child Medicaid members and KidsCare members served by the Acute Care Contractors. The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on adult Medicaid members' and parents'/caretakers' (of Acute Care and KidsCare child members) levels of satisfaction with their healthcare experiences.

[8-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[8-2] DES/CMDP contracts with AHCCCS to provide services to the child Medicaid population only. As such, DES/CMDP was included in the CAHPS Child Medicaid Health Plan Survey administration only (i.e., adult Medicaid CAHPS results are not available for DES/CMDP).

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®)[8-3] supplemental item set to adult members, and the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the Children with Chronic Conditions (CCC) measurement set to child members. Adult members eligible for the survey were 18 years of age or older as of December 31, 2012, and child members eligible for the survey had to be 17 years or younger as of December 31, 2012.[8-4]

A mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys) was used. Adult members and parents/caretakers of child members completed the surveys from June to August 2013. The CAHPS surveys were administered in English and Spanish. Members who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Members that were not identified as Spanish-speaking received an English version of the survey.

The CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes a set of 57 core questions that yield 11 measures of satisfaction. The CAHPS 5.0 Child Medicaid Health Plan Survey with HEDIS supplemental and CCC measurement sets includes 83 core questions that yield 16 measures of satisfaction. These measures include four global ratings, five composite measures, two individual item measures, and five CCC composite measures/items (included in the CAHPS Child Survey only). The global ratings reflect overall satisfaction with the health plan, healthcare, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Getting Needed Care* and *Getting Care Quickly*). The individual item measures are individual questions that look at a specific area of care (i.e., *Coordination of Care* and *Health Promotion and Education*).

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

For each of the composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite measure response choices fell into one of three categories: (1) "Never," "Sometimes," "Usually," or "Always;" (2) "Not at all," "A little," "Some," or "A lot;" or (3) "No" or "Yes." A positive, or top-box, response for the composites was defined as a response of "Usually/Always" or "A lot/Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

For each of the individual items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A positive or top-box

[8-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[8-4] For purposes of the 2013 CAHPS surveys, the age criteria for DES/CMDP and KidsCare child members eligible for inclusion in the CAHPS Child Medicaid Health Plan Survey was modified to include members up to 21 years of age or younger as of December 31, 2012. Please note, this deviates from standard NCQA HEDIS specifications, which define eligible child members as 17 years of age or younger as of December 31 of the measurement year.

response for the individual items was defined as a response of "Usually/Always" or "Yes." The percentage is referred to as a question summary rate (or top-box response).

Additionally, in order to assess the overall performance of the Acute Care Contractors' adult and child Medicaid populations and KidsCare members, each of the CAHPS global ratings (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) and four of the CAHPS composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*) were scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[8-5] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[8-6] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating using the following percentile distributions:[8-7]

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

For purposes of this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Caution should be exercised when interpreting results for those measures with less than 100 respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Additionally, for purposes of this report, the Acute Care Contractor-specific survey findings for the adult and general child Medicaid populations were compared to 2012 NCQA CAHPS Adult and Child Medicaid national averages, respectively. The KidsCare program survey findings were compared to 2012 NCQA CAHPS Child Medicaid national averages. For the Contractor-specific and statewide KidsCare program results, a measure is highlighted when the measure's rate was 5 percentage points or more higher or lower than the NCQA national average.

It is important to note that the CAHPS 5.0 Medicaid Health Plan Surveys were released by the Agency for Healthcare Research and Quality (AHRQ) in 2012. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child CAHPS Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Adult and Child Health Plan Surveys. As a result of the transition from the CAHPS 4.0H to the CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys and changes to the *Shared Decision Making* composite measure and *Health*

[8-5] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2012.

[8-6] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, July 24, 2013.

[8-7] NCQA does not provide benchmarks and thresholds for the *Shared Decision Making* composite measure, and *Coordination of Care* and *Health Promotion and Education* individual measures; therefore, overall member satisfaction ratings could not be determined for these CAHPS measures.

Promotion and Education individual item measure, 2012 NCQA CAHPS national averages were not available for these measures; thus, comparisons to NCQA national data could not be performed.

Description of Data Obtained

HSAG calculated Contractor-specific adult and child Medicaid CAHPS survey results for eight Acute Care Contractors and child Medicaid CAHPS survey results for the DES/CMDP Contractor. The following sections describe HSAG's findings, conclusions, and recommendations for each Acute Care Contractor, as well as statewide comparative results across the Acute Care Contractors.

For the KidsCare program, HSAG calculated child CAHPS Survey results for the statewide program in aggregate. The KidsCare program findings, conclusions, and recommendations are presented following the Acute Care Contractor-specific results.

Contractor-Specific Results

Bridgeway Health Solutions (BHS)

Findings

Table 8-1 presents the 2013 CAHPS survey results for BHS' adult and general child Medicaid populations. The table displays the following information: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[8-8,8-9]

Table 8-1—Question Summary Rates and Global Proportions *for* BHS

CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	50.4%	★ 2.311	65.4%	★★ 2.565
Rating of All Health Care	48.1%	★★ 2.295	65.6%	★★★★★ 2.591
Rating of Personal Doctor	62.5%	★★★★ 2.511	73.2%	★★★★ 2.680

8-8 Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

8-9 With the transition to the CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures for both the adult and child populations; thus, comparisons to NCQA national data could not be performed.

Table 8-1—Question Summary Rates and Global Proportions *for* BHS				
CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Rating of Specialist Seen Most Often	62.8%	★★★ 2.477	67.4%+	★+ 2.516
Composite Measures				
Getting Needed Care	80.8%	★★★ 2.320	82.3%	★★★ 2.393
Getting Care Quickly	84.4%	★★★ 2.437	91.5%	★★★ 2.642
How Well Doctors Communicate	90.7%	★★★★ 2.611	95.4%	★★★ 2.717
Customer Service	84.5%	★★★ 2.459	89.6%	★★★★ 2.554
Shared Decision Making	50.3%	NA	60.4%	NA
Individual Item Measures				
Coordination of Care	83.9%	NA	79.9%	NA
Health Promotion and Education	67.8%	NA	71.2%	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

The overall member satisfaction ratings revealed that the adult Medicaid population for BHS scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on two measures: *Rating of Personal Doctor* and *How Well Doctors Communicate.*
- At or between the 50th and 74th percentiles on four measures: *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service.*
- At or between the 25th and 49th percentiles on one measure, *Rating of All Health Care.*
- Below the 25th percentile on one measure, *Rating of Health Plan.*

The overall member satisfaction ratings revealed that the general child Medicaid population for BHS scored:

- At or above the 90th percentile on one measure, *Rating of All Health Care.*

- At or between the 75th and 89th percentiles on two measures: *Rating of Personal Doctor* and *Customer Service.*
- At or between the 50th and 74th percentiles on three measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate.*
- At or between the 25th and 49th percentiles on one measure, *Rating of Health Plan.*
- Below the 25th percentile on one measure, *Rating of Specialist Seen Most Often.*

Conclusions

Based on an evaluation of BHS' Acute Care results for the adult Medicaid population, the priority areas identified were *Rating of Health Plan* and *Rating of All Health Care*. For the general child Medicaid population, the priority areas identified were *Rating of Health Plan* and *Rating of Specialist Seen Most Often.*

Recommendations

HSAG identified recommendations for improvement for BHS based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by BHS to target improvement in each of these areas.

RATING OF HEALTH PLAN

Alternatives to One-on-One Visits—To achieve improved quality, timeliness, and access to care, health plans should engage in efforts that assist providers in examining and improving their systems' ability to manage patient demand. As an example, health plans can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of healthcare services and appointments to increase physician availability. Additionally, for patients who need a follow-up appointment, a system could be developed and tested where a nurse or physician assistant contacts the patient by phone two weeks prior to when the follow-up visit would have occurred to determine whether the patient's current status and condition warrants an in-person visit, and if so, schedule the appointment at that time.

Health Plan Operations—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's healthcare "products." Healthcare microsystems include a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care.

RATING OF ALL HEALTH CARE

Access to Care—Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The health plan should attempt to reduce any hindrances a patient might encounter while seeking care. Standard practices and

established protocols can assist in this process by ensuring access to care issues are handled consistently across all practices.

Patient and Family Engagement and Advisory Councils—Since both patients and families have the direct experience of an illness or healthcare system, their perspectives can provide significant insight when performing an evaluation of healthcare processes. Therefore, health plans should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource to healthcare processes. Patient interviews on services received and family inclusion in care planning can be an effective strategy for involving members in the design of care and obtaining their input and feedback on how to improve the delivery of care.

RATING OF SPECIALIST SEEN MOST OFTEN

Planned Visit Management—The health plan should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons.

Skills Training for Specialists—The health plan can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

Care1st Health Plan of Arizona (Care1st)

Findings

Table 8-2 presents the 2013 CAHPS survey results for Care1st's adult and general child Medicaid populations. The table displays the following information: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[8-10,8-11]

Table 8-2—Question Summary Rates and Global Proportions *for* Care1st

CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	54.3%	★★ 2.389	69.2%	★★★★ 2.620
Rating of All Health Care	49.1%	★★★ 2.320	69.6%	★★★★★ 2.636
Rating of Personal Doctor	57.2%	★★ 2.423	74.0%	★★★★ 2.673
Rating of Specialist Seen Most Often	57.9%	★ 2.391	83.5%+	★★★★★+ 2.776
Composite Measures				
Getting Needed Care	78.0%	★★ 2.268	80.6%	★★★ 2.360
Getting Care Quickly	78.9%	★★ 2.376	84.5%	★ 2.523
How Well Doctors Communicate	89.6%	★★★ 2.574	90.6%	★ 2.601
Customer Service	84.2%	★★★★ 2.480	88.9%	★★★★ 2.527
Shared Decision Making	47.5%	NA	52.0%	NA
Individual Item Measures				
Coordination of Care	70.1%	NA	76.7%	NA

[8-10] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[8-11] With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

Table 8-2—Question Summary Rates and Global Proportions *for* Care1st				
CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Health Promotion and Education	63.2%	NA	66.7%	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

The overall member satisfaction ratings revealed that the adult Medicaid population for Care1st scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on one measure, *Customer Service.*
- At or between the 50th and 74th percentiles on two measures: *Rating of All Health Care* and *How Well Doctors Communicate.*
- At or between the 25th and 49th percentiles on four measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Getting Care Quickly.*
- Below the 25th percentile on one measure, *Rating of Specialist Seen Most Often.*

The overall member satisfaction ratings revealed that the general child Medicaid population for Care1st scored:

- At or above the 90th percentile on two measures: *Rating of All Health Care* and *Rating of Specialist Seen Most Often.*
- At or between the 75th and 89th percentiles on three measures: *Rating of Health Plan*, *Rating of Personal Doctor*, and *Customer Service.*
- At or between the 50th and 74th percentiles on one measure, *Getting Needed Care.*
- At or between the 25th and 49th percentiles on no measures.
- Below the 25th percentile on two measures: *Getting Care Quickly* and *How Well Doctors Communicate.*

Conclusions

Based on an evaluation of Care1st's Acute Care results for the adult Medicaid population, the priority areas identified were *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Getting Care Quickly*. For the general child Medicaid population, the priority areas identified were *Getting Care Quickly* and *How Well Doctors Communicate.*

Recommendations

HSAG identified recommendations for improvement for Care1st based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by Care1st to target improvement in each of these areas.

RATING OF SPECIALIST SEEN MOST OFTEN

Planned Visit Management—The health plan should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons.

Skills Training for Specialists—The health plan can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

RATING OF HEALTH PLAN

Alternatives to One-on-One Visits—To achieve improved quality, timeliness, and access to care, health plans should engage in efforts that assist providers in examining and improving their systems' ability to manage patient demand. As an example, health plans can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of healthcare services and appointments to increase physician availability. Additionally, for patients who need a follow-up appointment, a system could be developed and tested where a nurse or physician assistant contacts the patient by phone two weeks prior to when the follow-up visit would have occurred to determine whether the patient's current status and condition warrants an in-person visit, and if so, schedule the appointment at that time.

Health Plan Operations—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's healthcare "products." Healthcare microsystems include a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care.

RATING OF PERSONAL DOCTOR

Maintain Truth in Scheduling—Health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. Health plans could provide assistance or

instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time.

Direct Patient Feedback—Health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been used and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or email. Asking patients to describe what they liked most about the care they received during a recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative).

GETTING NEEDED CARE

Appropriate Healthcare Providers—Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate healthcare providers is imperative to assessing quality of care. Health plans should actively attempt to match patients with appropriate healthcare providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner. These efforts can lead to improvements in quality, timeliness, and patients' overall access to care.

Interactive Workshops—Health plans should engage in promoting health education, health literacy, and preventive health care among their membership. Increasing patients' health literacy and general understanding of their healthcare needs can result in improved health. Health plans can develop community-based interactive workshops and educational materials to provide information on general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations. Access to free health assessments also can assist health plans in promoting patient health awareness and preventive healthcare efforts.

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

HOW WELL DOCTORS COMMUNICATE

Communication Tools for Patients—The health plan can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.

Improve Health Literacy—Often health information is presented to patients in a manner that is too complex and technical, which can result in a patient not adhering to recommended care and poor health outcomes. To improve patient health literacy, the health plan should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for healthcare workers on how to use these materials with their patients and health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. The health plan can offer a full-day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting.

Health Choice Arizona (HCA)

Findings

Table 8-3 presents the 2013 CAHPS survey results for HCA's adult and general child Medicaid populations. The table displays the following information: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[8-12,8-13]

Table 8-3—Question Summary Rates and Global Proportions *for* HCA

CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	51.3%	★ 2.309	68.2%	★★★ 2.602
Rating of All Health Care	51.9%	★★★ 2.331	63.4%	★★★ 2.541
Rating of Personal Doctor	58.7%	★ 2.405	73.8%	★★★★ 2.667
Rating of Specialist Seen Most Often	57.1%	★ 2.408	73.2%+	★★★★+ 2.622
Composite Measures				
Getting Needed Care	79.2%	★★★ 2.296	80.4%	★★★ 2.373
Getting Care Quickly	82.0%	★★ 2.392	89.1%	★★ 2.573
How Well Doctors Communicate	85.9%	★★ 2.516	90.7%	★ 2.623
Customer Service	85.1%	★★★ 2.450	86.3%	★★★ 2.493
Shared Decision Making	51.3%	NA	49.2%	NA
Individual Item Measures				
Coordination of Care	74.2%	NA	73.6%	NA

[8-12]Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[8-13]With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

Table 8-3—Question Summary Rates and Global Proportions *for* HCA				
CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Health Promotion and Education	71.2%	NA	69.3%	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th
Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.
Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.
NA indicates results are not available for the CAHPS measure.

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

The overall member satisfaction ratings revealed that the adult Medicaid population for HCA scored:

- At or above the 75th percentile on no measures.
- At or between the 50th and 74th percentiles on three measures: *Rating of All Health Care*, *Getting Needed Care*, and *Customer Service.*
- At or between the 25th and 49th percentiles on two measures: *Getting Care Quickly* and *How Well Doctors Communicate.*
- Below the 25th percentile on three measures: *Rating of Health Plan*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often.*

The overall member satisfaction ratings revealed that the general child Medicaid population for HCA scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on two measures: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often.*
- At or between the 50th and 74th percentiles on four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Getting Needed Care*, and *Customer Service.*
- At or between the 25th and 49th percentiles on one measure, *Getting Care Quickly.*
- Below the 25th percentile on one measure, *How Well Doctors Communicate.*

Conclusions

Based on an evaluation of HCA's Acute Care results for the adult Medicaid population, the priority areas identified were *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, and *How Well Doctors Communicate*. For the general child Medicaid population, the priority areas identified were *Getting Care Quickly* and *How Well Doctors Communicate.*

Recommendations

HSAG identified recommendations for improvement for HCA based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by HCA to target improvement in each of these areas.

RATING OF HEALTH PLAN

Alternatives to One-on-One Visits—To achieve improved quality, timeliness, and access to care, health plans should engage in efforts that assist providers in examining and improving their systems' ability to manage patient demand. As an example, health plans can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of healthcare services and appointments to increase physician availability. Additionally, for patients who need a follow-up appointment, a system could be developed and tested where a nurse or physician assistant contacts the patient by phone two weeks prior to when the follow-up visit would have occurred to determine whether the patient's current status and condition warrants an in-person visit, and if so, schedule the appointment at that time.

Health Plan Operations—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's healthcare "products." Healthcare microsystems include a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care.

RATING OF PERSONAL DOCTOR

Maintain Truth in Scheduling—Health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. Health plans could provide assistance or instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time.

Direct Patient Feedback—Health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been used and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or email. Asking patients to describe what they liked most about the care they received during a recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative).

RATING OF SPECIALIST SEEN MOST OFTEN

Planned Visit Management—The health plan should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the

appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons.

Skills Training for Specialists—The health plan can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

HOW WELL DOCTORS COMMUNICATE

Communication Tools for Patients—The health plan can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.

Improve Health Literacy—Often health information is presented to patients in a manner that is too complex and technical, which can result in a patient not adhering to recommended care and poor health outcomes. To improve patient health literacy, the health plan should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for healthcare workers on how to use these materials with their patients and health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. The health plan can offer a full-day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting.

Maricopa Health Plan (MHP)

Findings

Table 8-4 presents the 2013 CAHPS survey results for MHP's adult and general child Medicaid populations. The table displays the following information: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[8-14,8-15]

Table 8-4—Question Summary Rates and Global Proportions *for* MHP

CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	53.9%	★★ 2.392	73.9%	★★★★ 2.665
Rating of All Health Care	49.6%	★★★ 2.347	67.9%	★★★★★ 2.597
Rating of Personal Doctor	59.3%	★★ 2.453	73.2%	★★★★ 2.655
Rating of Specialist Seen Most Often	63.5%	★★★ 2.510	76.0%+	★★★★+ 2.653
Composite Measures				
Getting Needed Care	81.0%	★★★★ 2.389	85.7%	★★★★ 2.469
Getting Care Quickly	77.5%	★★ 2.355	80.4%	★ 2.442
How Well Doctors Communicate	86.5%	★★ 2.524	87.9%	★ 2.551
Customer Service	88.8%	★★★★★ 2.569	87.1%	★★★★ 2.514
Shared Decision Making	49.9%	NA	53.8%	NA
Individual Item Measures				
Coordination of Care	75.9%	NA	74.5%	NA

[8-14]Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[8-15]With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

Table 8-4—Question Summary Rates and Global Proportions *for* MHP				
CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Health Promotion and Education	69.2%	NA	69.0%	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

The overall member satisfaction ratings revealed that the adult Medicaid population for MHP scored:

- At or above the 90th percentile on one measure, *Customer Service*.
- At or between the 75th and 89th percentiles on one measure, *Getting Needed Care.*
- At or between the 50th and 74th percentiles on two measures: *Rating of All Health Care* and *Rating of Specialist Seen Most Often.*
- At or between the 25th and 49th percentiles on four measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Care Quickly*, and *How Well Doctors Communicate.*
- Below the 25th percentile on no measures.

The overall member satisfaction ratings revealed that the general child Medicaid population for MHP scored:

- At or above the 90th percentile on one measure, *Rating of All Health Care*.
- At or between the 75th and 89th percentiles on five measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service.*
- At or between the 25th and 74th percentiles on no measures.
- Below the 25th percentile on two measures: *Getting Care Quickly* and *How Well Doctors Communicate.*

Conclusions

Based on an evaluation of MHP's Acute Care results for the adult Medicaid population, the priority areas identified were *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Care Quickly*, and *How Well Doctors Communicate*. For the general child Medicaid population, the priority areas identified were *Getting Care Quickly*, and *How Well Doctors Communicate.*

Recommendations

HSAG identified recommendations for improvement for MHP based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by MHP to target improvement in each of these areas.

RATING OF HEALTH PLAN

Alternatives to One-on-One Visits—To achieve improved quality, timeliness, and access to care, health plans should engage in efforts that assist providers in examining and improving their systems' ability to manage patient demand. As an example, health plans can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of healthcare services and appointments to increase physician availability. Additionally, for patients who need a follow-up appointment, a system could be developed and tested where a nurse or physician assistant contacts the patient by phone two weeks prior to when the follow-up visit would have occurred to determine whether the patient's current status and condition warrants an in-person visit, and if so, schedule the appointment at that time.

Health Plan Operations—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's healthcare "products." Healthcare microsystems include a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care.

RATING OF PERSONAL DOCTOR

Maintain Truth in Scheduling—Health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. Health plans could provide assistance or instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time.

Direct Patient Feedback—Health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been used and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or email. Asking patients to describe what they liked most about the care they received during a recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative).

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members'

perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

HOW WELL DOCTORS COMMUNICATE

Communication Tools for Patients—The health plan can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.

Improve Health Literacy—Often health information is presented to patients in a manner that is too complex and technical, which can result in a patient not adhering to recommended care and poor health outcomes. To improve patient health literacy, the health plan should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for healthcare workers on how to use these materials with their patients and health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. The health plan can offer a full-day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting.

Mercy Care Plan (MCP)

Findings

Table 8-5 presents the 2013 CAHPS survey results for MCP's adult and general child Medicaid populations. The table displays the following information: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[8-16,8-17]

Table 8-5—Question Summary Rates and Global Proportions *for* MCP

CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	58.2%	★★★ 2.437	73.8%	★★★★★ 2.683
Rating of All Health Care	49.7%	★★★ 2.330	71.0%	★★★★★ 2.646
Rating of Personal Doctor	58.0%	★★ 2.422	76.2%	★★★★★ 2.705
Rating of Specialist Seen Most Often	60.3%	★★★ 2.494	73.7%+	★★★★+ 2.642
Composite Measures				
Getting Needed Care	82.1%	★★★ 2.306	81.7%	★★★ 2.416
Getting Care Quickly	79.8%	★ 2.312	87.9%	★★ 2.585
How Well Doctors Communicate	87.6%	★★ 2.509	93.6%	★★★ 2.697
Customer Service	87.7%	★★★★ 2.484	85.9%	★★★★ 2.516
Shared Decision Making	49.8%	NA	57.3%	NA
Individual Item Measures				
Coordination of Care	70.2%	NA	78.2%	NA

[8-16] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[8-17] With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

Table 8-5—Question Summary Rates and Global Proportions *for* MCP				
CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Health Promotion and Education	70.4%	NA	71.6%	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

The overall member satisfaction ratings revealed that the adult Medicaid population for MCP scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on one measure, *Customer Service*.
- At or between the 50th and 74th percentiles on four measures*: Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Getting Needed Care*.
- At or between the 25th and 49th percentiles on two measures: *Rating of Personal Doctor* and *How Well Doctors Communicate*.
- Below the 25th percentile on one measure, *Getting Care Quickly*.

The overall member satisfaction ratings revealed that the general child Medicaid population for MCP scored:

- At or above the 90th percentile on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*.
- At or between the 75th and 89th percentiles on two measures: *Rating of Specialist Seen Most Often* and *Customer Service*.
- At or between the 50th and 74th percentiles on two measures: *Getting Needed Care* and *How Well Doctors Communicate*.
- At or between the 25th and 49th percentiles on one measure, *Getting Care Quickly*.
- Below the 25th percentile on no measures.

Conclusions

Based on an evaluation of MCP's Acute Care results for the adult Medicaid population, the priority areas identified were *Rating of Personal Doctor*, *Getting Care Quickly*, and *How Well Doctors Communicate*. For the general child Medicaid population, the priority areas identified were *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate.*

Recommendations

HSAG identified recommendations for improvement for MCP based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by MCP to target improvement in each of these areas.

RATING OF PERSONAL DOCTOR

Maintain Truth in Scheduling—Health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. Health plans could provide assistance or instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time.

Direct Patient Feedback—Health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been used and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or email. Asking patients to describe what they liked most about the care they received during a recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative).

GETTING NEEDED CARE

Appropriate Healthcare Providers—Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate healthcare providers is imperative to assessing quality of care. Health plans should actively attempt to match patients with appropriate healthcare providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner. These efforts can lead to improvements in quality, timeliness, and patients' overall access to care.

Interactive Workshops—Health plans should engage in promoting health education, health literacy, and preventive healthcare among their membership. Increasing patients' health literacy and general understanding of their healthcare needs can result in improved health. Health plans can develop community-based interactive workshops and educational materials to provide information on general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations. Access to free health assessments also can assist health plans in promoting patient health awareness and preventive health care efforts.

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors

(e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

HOW WELL DOCTORS COMMUNICATE

Communication Tools for Patients—The health plan can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.

Improve Health Literacy—Often health information is presented to patients in a manner that is too complex and technical, which can result in a patient not adhering to recommended care and poor health outcomes. To improve patient health literacy, the health plan should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for healthcare workers on how to use these materials with their patients and health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. The health plan can offer a full-day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting.

Phoenix Health Plan (PHP)

Findings

Table 8-6 presents the 2013 CAHPS survey results for PHP's adult and general child Medicaid populations. The table displays the following information: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[8-18,8-19]

Table 8-6—Question Summary Rates and Global Proportions *for* PHP

CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	52.0%	★★ 2.344	70.8%	★★★★ 2.628
Rating of All Health Care	46.4%	★ 2.248	69.1%	★★★★★ 2.635
Rating of Personal Doctor	55.9%	★ 2.385	74.2%	★★★★ 2.672
Rating of Specialist Seen Most Often	67.6%	★★★★ 2.553	73.8%	★★★★★ 2.673
Composite Measures				
Getting Needed Care	79.1%	★★ 2.264	85.8%	★★★ 2.443
Getting Care Quickly	79.3%	★★ 2.342	90.1%	★★★ 2.623
How Well Doctors Communicate	85.9%	★★ 2.491	91.9%	★★ 2.671
Customer Service	88.9%	★★★★★ 2.573	91.9%	★★★★★ 2.649
Shared Decision Making	47.5%	NA	54.6%	NA
Individual Item Measures				
Coordination of Care	70.1%	NA	80.1%	NA

[8-18] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[8-19] With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

Table 8-6—Question Summary Rates and Global Proportions *for* PHP				
CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Health Promotion and Education	66.7%	NA	71.4%	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

The overall member satisfaction ratings revealed that the adult Medicaid population for PHP scored:

- At or above the 90th percentile on one measure, *Customer Service*.
- At or between the 75th and 89th percentiles on one measure, *Rating of Specialist Seen Most Often.*
- At or between the 50th and 74th percentiles on no measures.
- At or between the 25th and 49th percentiles on four measures: *Rating of Health Plan*, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*.
- Below the 25th percentile on two measures: *Rating of All Health Care* and *Rating of Personal Doctor*.

The overall member satisfaction ratings revealed that the general child Medicaid population for PHP scored:

- At or above the 90th percentile on three measures: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Customer Service*.
- At or between the 75th and 89th percentiles on two measures: *Rating of Health Plan* and *Rating of Personal Doctor*.
- At or between the 50th and 74th percentiles on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- At or between the 25th and 49th percentiles on one measure, *How Well Doctors Communicate*.
- Below the 25th percentile on no measures.

Conclusions

Based on an evaluation of PHP's Acute Care results for the adult Medicaid population, the priority areas identified were *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. For the general child Medicaid population, the priority areas identified were *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate.*

Recommendations

HSAG identified recommendations for improvement for PHP based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by PHP to target improvement in each of these areas.

RATING OF HEALTH PLAN

Alternatives to One-on-One Visits—To achieve improved quality, timeliness, and access to care, health plans should engage in efforts that assist providers in examining and improving their systems' ability to manage patient demand. As an example, health plans can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of healthcare services and appointments to increase physician availability. Additionally, for patients who need a follow-up appointment, a system could be developed and tested where a nurse or physician assistant contacts the patient by phone two weeks prior to when the follow-up visit would have occurred to determine whether the patient's current status and condition warrants an in-person visit, and if so, schedule the appointment at that time.

Health Plan Operations—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's healthcare "products." Healthcare microsystems include a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care.

RATING OF ALL HEALTH CARE

Access to Care—Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The health plan should attempt to reduce any hindrances a patient might encounter while seeking care. Standard practices and established protocols can assist in this process by ensuring access to care issues are handled consistently across all practices.

Patient and Family Engagement and Advisory Councils—Since both patients and families have the direct experience of an illness or healthcare system, their perspectives can provide significant insight when performing an evaluation of healthcare processes. Therefore, health plans should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource to healthcare processes. Patient interviews on services received and family inclusion in care planning can be an effective strategy for involving members in the design of care and obtaining their input and feedback on how to improve the delivery of care.

RATING OF PERSONAL DOCTOR

Maintain Truth in Scheduling—Health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. Health plans could provide assistance or instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time.

Direct Patient Feedback—Health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been used and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or email. Asking patients to describe what they liked most about the care they received during a recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative).

GETTING NEEDED CARE

Appropriate Healthcare Providers—Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate healthcare providers is imperative to assessing quality of care. Health plans should actively attempt to match patients with appropriate healthcare providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner. These efforts can lead to improvements in quality, timeliness, and patients' overall access to care.

Interactive Workshops—Health plans should engage in promoting health education, health literacy, and preventive health care among their membership. Increasing patients' health literacy and general understanding of their healthcare needs can result in improved health. Health plans can develop community-based interactive workshops and educational materials to provide information on general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations. Access to free health assessments also can assist health plans in promoting patient health awareness and preventive healthcare efforts.

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when

scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

HOW WELL DOCTORS COMMUNICATE

Communication Tools for Patients—The health plan can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.

Improve Health Literacy—Often health information is presented to patients in a manner that is too complex and technical, which can result in a patient not adhering to recommended care and poor health outcomes. To improve patient health literacy, the health plan should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for healthcare workers on how to use these materials with their patients and health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. The health plan can offer a full-day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting.

UnitedHealthcare Community Plan (UHCCP)[8-20]

Findings

Table 8-7 presents the 2013 CAHPS survey results for UHCCP's adult and general child Medicaid populations. The table displays the following information: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[8-21,8-22]

Table 8-7—Question Summary Rates and Global Proportions *for* UHCCP

CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	65.4%	★★★★★ 2.562	74.4%	★★★★★ 2.694
Rating of All Health Care	58.6%	★★★★★ 2.472	75.6%	★★★★★ 2.699
Rating of Personal Doctor	64.5%	★★★★ 2.548	76.4%	★★★★★ 2.706
Rating of Specialist Seen Most Often	68.1%	★★★★★ 2.574	79.1%	★★★★★ 2.736
Composite Measures				
Getting Needed Care	84.1%	★★★★ 2.401	87.8%	★★★★★ 2.525
Getting Care Quickly	82.6%	★★★ 2.403	87.2%	★★ 2.592
How Well Doctors Communicate	89.9%	★★★★ 2.599	93.7%	★★★ 2.710
Customer Service	84.5%	★★★★ 2.486	85.9%	★★★★ 2.529
Shared Decision Making	50.6%	NA	58.6%	NA

[8-20] The health plan name for UnitedHealthcare Community Plan changed since the adult and child Acute Care populations were surveyed in 2013. UnitedHealthcare Community Plan was previously referred to as Arizona Physicians IPA.

[8-21] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[8-22] With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

Table 8-7—Question Summary Rates and Global Proportions *for* UHCCP				
CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Individual Item Measures				
Coordination of Care	77.7%	NA	79.7%	NA
Health Promotion and Education	75.1%	NA	75.8%	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th
Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.
Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.
NA indicates results are not available for the CAHPS measure.

The overall member satisfaction ratings revealed that the adult Medicaid population for UHCCP scored:

- At or above the 90th percentile on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*.
- At or between the 75th and 89th percentiles on four measures: *Rating of Personal Doctor*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service*.
- At or between the 50th and 74th percentiles on one measure, *Getting Care Quickly*.
- At or below the 49th percentile on no measures.

The overall member satisfaction ratings revealed that the general child Medicaid population for UHCCP scored:

- At or above the 90th percentile on five measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Getting Needed Care.*
- At or between the 75th and 89th percentiles on one measure, *Customer Service.*
- At or between the 50th and 74th percentiles on one measure, *How Well Doctors Communicate.*
- At or between the 25th and 49th percentiles on one measure, *Getting Care Quickly.*
- Below the 25th percentile on no measures.

Conclusions

Based on an evaluation of UHCCP's Acute Care results for the adult Medicaid population, the priority area identified was *Getting Care Quickly*. For the general child Medicaid population, the priority areas identified were *Getting Care Quickly* and *How Well Doctors Communicate.*

Recommendations

HSAG identified recommendations for improvement for UHCCP based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by UHCCP to target improvement in each of these areas.

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

HOW WELL DOCTORS COMMUNICATE

Communication Tools for Patients—The health plan can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.

Improve Health Literacy—Often health information is presented to patients in a manner that is too complex and technical, which can result in a patient not adhering to recommended care and poor health outcomes. To improve patient health literacy, the health plan should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for healthcare workers on how to use these materials with their patients and health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. The health plan can offer a full-day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting.

University Family Care (UFC)

Findings

Table 8-8 presents the 2013 CAHPS survey results for UFC's adult and general child Medicaid populations. The table displays the following information: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[8-23,8-24]

Table 8-8—Question Summary Rates and Global Proportions *for* UFC

CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	61.0%	★★★★ 2.468	72.2%	★★★★ 2.653
Rating of All Health Care	55.6%	★★★★★ 2.423	71.8%	★★★★★ 2.646
Rating of Personal Doctor	63.0%	★★★ 2.473	76.2%	★★★★★ 2.698
Rating of Specialist Seen Most Often	71.6%	★★★★★ 2.622	70.4%+	★★★+ 2.593
Composite Measures				
Getting Needed Care	82.9%	★★★★ 2.360	84.2%	★★★★ 2.484
Getting Care Quickly	78.9%	★★ 2.333	89.6%	★★★ 2.633
How Well Doctors Communicate	89.3%	★★★★ 2.589	92.3%	★★★ 2.719
Customer Service	88.5%	★★★★★ 2.564	86.6%	★★★★ 2.544
Shared Decision Making	48.1%	NA	60.2%	NA
Individual Item Measures				
Coordination of Care	76.6%	NA	79.1%	NA

[8-23] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[8-24] With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

Table 8-8—Question Summary Rates and Global Proportions *for* UFC				
CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Health Promotion and Education	66.8%	NA	71.4%	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

The overall member satisfaction ratings revealed that the adult Medicaid population for UFC scored:

- At or above the 90th percentile on three measures: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Customer Service*.
- At or between the 75th and 89th percentiles on three measures: *Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*.
- At or between the 50th and 74th percentiles on one measure, *Rating of Personal Doctor*.
- At or between the 25th and 49th percentiles on one measure, *Getting Care Quickly*.
- Below the 25th percentile on no measures.

The overall member satisfaction ratings revealed that the general child Medicaid population for UFC scored:

- At or above the 90th percentile on two measures: *Rating of All Health Care* and *Rating of Personal Doctor*.
- At or between the 75th and 89th percentiles on three measures: *Rating of Health Plan*, *Getting Needed Care*, and *Customer Service*.
- At or between the 50th and 74th percentiles on three measures: *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, and *How Well Doctors Communicate*.
- Below the 49th percentile on no measures.

Conclusions

Based on an evaluation of UFC's Acute Care results for the adult Medicaid population, the priority areas identified were *Rating of Personal Doctor* and *Getting Care Quickly*. For the general child Medicaid population, the priority areas identified were *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, and *How Well Doctors Communicate.*

Recommendations

HSAG identified recommendations for improvement for UFC based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by UFC to target improvement in each of these areas.

RATING OF PERSONAL DOCTOR

Maintain Truth in Scheduling—Health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. Health plans could provide assistance or instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time.

Direct Patient Feedback—Health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been used and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or email. Asking patients to describe what they liked most about the care they received during a recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative).

RATING OF SPECIALIST SEEN MOST OFTEN

Planned Visit Management—The health plan should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons.

Skills Training for Specialists—The health plan can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a

large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

HOW WELL DOCTORS COMMUNICATE

Communication Tools for Patients—The health plan can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.

Improve Health Literacy—Often health information is presented to patients in a manner that is too complex and technical, which can result in a patient not adhering to recommended care and poor health outcomes. To improve patient health literacy, the health plan should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for healthcare workers on how to use these materials with their patients and health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. The health plan can offer a full-day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting.

Arizona Department of Economic Security/Comprehensive Medical and Dental Program

Findings

Table 8-9 presents the 2013 CAHPS survey results for DES/CMDP's general child Medicaid population.[8-25] The table displays the following information: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[8-26,8-27]

Table 8-9—Question Summary Rates and Global Proportions *for* DES/CMDP

CAHPS Measure	General Child Results	
	2013 Rate	Star Rating and Three-Point Mean
Global Ratings		
Rating of Health Plan	63.0%	★ 2.499
Rating of All Health Care	71.0%	★★★★★ 2.625
Rating of Personal Doctor	73.9%	★★★★ 2.650
Rating of Specialist Seen Most Often	66.3%+	★★+ 2.542
Composite Measures		
Getting Needed Care	87.5%	★★★★★ 2.562
Getting Care Quickly	96.2%	★★★★★ 2.810
How Well Doctors Communicate	94.3%	★★★★ 2.747
Customer Service	93.6%+	★★★★★+ 2.641
Shared Decision Making	52.8%	NA

[8-25] As previously noted, DES/CMDP contracts with AHCCCS to provide services to the child Medicaid population only. As such, DES/CMDP was included in the CAHPS Child Medicaid Health Plan Survey administration only (i.e., adult Medicaid CAHPS results are not available for DES/CMDP).

[8-26] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[8-27] With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

Table 8-9—Question Summary Rates and Global Proportions *for* DES/CMDP		
CAHPS Measure	General Child Results	
	2013 Rate	Star Rating and Three-Point Mean
Individual Item Measures		
Coordination of Care	70.1%	NA
Health Promotion and Education	74.5%	NA
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average. Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average. NA indicates results are not available for the CAHPS measure.		
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.		

The overall member satisfaction ratings revealed that the general child Medicaid population for DES/CMDP scored:

- At or above the 90th percentile on four measures: *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service.*
- At or between the 75th and 89th percentiles on two measures: *Rating of Personal Doctor* and *How Well Doctors Communicate*.
- At or between the 50th and 74th percentiles on no measures.
- At or between the 25th and 49th percentiles on one measure, *Rating of Specialist Seen Most Often*.
- Below the 25th percentile on one measure, *Rating of Health Plan*.

Conclusions

Based on an evaluation of DES/CMDP's Acute Care results for the general child Medicaid population, the priority areas identified were *Rating of Health Plan* and *Rating of Specialist Seen Most Often*.

Recommendations

HSAG identified recommendations for improvement for DES/CMDP based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by DES/CMDP to target improvement in each of these areas.

RATING OF HEALTH PLAN

Alternatives to One-on-One Visits—To achieve improved quality, timeliness, and access to care, health plans should engage in efforts that assist providers in examining and improving their systems' ability to manage patient demand. As an example, health plans can test alternatives to

traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of healthcare services and appointments to increase physician availability. Additionally, for patients who need a follow-up appointment, a system could be developed and tested where a nurse or physician assistant contacts the patient by phone two weeks prior to when the follow-up visit would have occurred to determine whether the patient's current status and condition warrants an in-person visit, and if so, schedule the appointment at that time.

Health Plan Operations—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's healthcare "products." Healthcare microsystems include a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care.

RATING OF SPECIALIST SEEN MOST OFTEN

Planned Visit Management—The health plan should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons.

Skills Training for Specialists—The health plan can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

Comparative Results for Acute Care and DES/CMDP Contractors

HSAG calculated and reported the Acute Care and DES/CMDP Contractors' 2013 CAHPS survey results for the adult and child Medicaid populations, as applicable.[8-28]

Findings

Table 8-10 presents the 2013 adult and child Medicaid CAHPS survey results for all Acute Care Contractors and DES/CMDP for members enrolled in the Medicaid program (i.e., Acute Care program in aggregate).[8-29] The table displays the following information: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[8-30,8-31]

Table 8-10—Adult and Child Medicaid CAHPS Results *for* Acute Care and DES/CMDP Contractors

CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
Global Ratings				
Rating of Health Plan	55.9%	★★★ 2.402	70.3%	★★★★ 2.627
Rating of All Health Care	51.2%	★★★ 2.347	69.3%	★★★★★ 2.624
Rating of Personal Doctor	60.0%	★★ 2.454	74.6%	★★★★ 2.680
Rating of Specialist Seen Most Often	63.6%	★★★ 2.504	73.8%	★★★★ 2.642
Composite Measures				
Getting Needed Care	81.0%	★★★ 2.325	84.0%	★★★ 2.444
Getting Care Quickly	80.6%	★★ 2.370	88.4%	★★ 2.599

[8-28] As previously noted, DES/CMDP contracts with AHCCCS to provide services to the child Medicaid population only. As such, DES/CMDP was included in the CAHPS Child Medicaid Health Plan Survey administration only (i.e., adult Medicaid CAHPS results are not available for DES/CMDP).

[8-29] The adult Medicaid CAHPS results are based on the combined results of the eight Acute Care Contractors serving the adult Medicaid population, which include BHS, Care1st, HCA, MHP, MCP, PHP, UFC, and UHCCP (formerly APIPA). The general child Medicaid CAHPS survey results are based on the combined results of the eight Acute Care Contractors and DES/CMDP.

[8-30] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[8-31] With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

Table 8-10—Adult and Child Medicaid CAHPS Results *for* Acute Care and DES/CMDP Contractors				
CAHPS Measure	Adult Results		General Child Results	
	2013 Rate	Star Rating and Three-Point Mean	2013 Rate	Star Rating and Three-Point Mean
How Well Doctors Communicate	88.2%	★★★ 2.553	92.3%	★★ 2.671
Customer Service	86.6%	★★★★ 2.510	88.1%	★★★★ 2.546
Shared Decision Making	49.5%	NA	55.3%	NA
Individual Item Measures				
Coordination of Care	75.1%	NA	77.2%	NA
Health Promotion and Education	68.9%	NA	71.1%	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

The overall member satisfaction ratings revealed that the adult Medicaid population for the Acute Care program in aggregate scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on one measure, *Customer Service*.
- At or between the 50th and 74th percentiles on five measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *How Well Doctors Communicate*.
- At or between the 25th and 49th percentile on two measures: *Rating of Personal Doctor* and *Getting Care Quickly*.
- At or below the 25th percentile on no measures.

The overall member satisfaction ratings revealed that the general child Medicaid population for the Acute Care program in aggregate scored:

- At or above the 90th percentile on one measure, *Rating of All Health Care*.
- At or between the 75th and 89th percentiles on four measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service*.
- At or between the 50th and 74th percentiles on one measure, *Getting Needed Care*.
- At or between the 25th and 49th percentiles on two measures: *Getting Care Quickly* and *How Well Doctors Communicate*.
- Below the 25th percentile on no measures.

Conclusions

Based on an evaluation of the Acute Care program's results for the adult Medicaid population, the priority areas identified were *Rating of Personal Doctor* and *Getting Care Quickly*. For the child Medicaid population, the priority areas identified were *Getting Care Quickly* and *How Well Doctors Communicate.*

Recommendations

HSAG identified recommendations for improvement for the Acute Care program based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by the program to target improvement in each of these areas.

RATING OF PERSONAL DOCTOR

Maintain Truth in Scheduling—Health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. Health plans could provide assistance or instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time.

Direct Patient Feedback—Health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been used and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or email. Asking patients to describe what they liked most about the care they received during a recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative).

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plans can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plans in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

HOW WELL DOCTORS COMMUNICATE

Communication Tools for Patients—The health plans can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.

Improve Health Literacy—Often health information is presented to patients in a manner that is too complex and technical, which can result in a patient not adhering to recommended care and poor health outcomes. To improve patient health literacy, the health plans should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for healthcare workers on how to use these materials with their patients and health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. The health plans can offer a full-day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting.

KidsCare Results

KidsCare Program

Findings

Table 8-11 presents the 2013 CAHPS survey results for the statewide KidsCare program. The table displays the following information: 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[8-32,8-33,8-34]

Table 8-11—Child CAHPS Results *for* the KidsCare Program

Measure	2013 Rate	Three-Point Mean	Star Rating
Global Ratings			
Rating of Health Plan	68.9%	2.603	★★★
Rating of All Health Care	65.9%	2.592	★★★★★
Rating of Personal Doctor	71.9%	2.646	★★★★
Rating of Specialist Seen Most Often	68.5%	2.575	★★
Composite Measures			
Getting Needed Care	85.6%	2.420	★★★
Getting Care Quickly	88.9%	2.592	★★
How Well Doctors Communicate	92.5%	2.639	★★
Customer Service	89.9%	2.508	★★★★
Shared Decision Making	55.0%	NA	NA
Individual Item Measures			
Coordination of Care	76.5%	NA	NA
Health Promotion and Education	70.1%	NA	NA

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

[8-32] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[8-33] With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed

[8-34] For purposes of the Arizona Technical Report, the three-point mean scores are reported out to three decimal places. This differs from the 2013 KidsCare Program Member Satisfaction Report, which reported the three-point mean scores out to two decimal places.

The overall member satisfaction ratings revealed that the KidsCare program scored:

- At or above the 90th percentile on one measure, *Rating of All Health Care*
- At or between the 75th and 89th percentile on two measures: *Rating of Personal Doctor* and *Customer Service.*
- At or between the 50th and 74th percentile on two measures: *Rating of Health Plan* and *Getting Needed Care.*
- At or between the 25th and 49th percentiles on three measures: *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, and *How Well Doctors Communicate.*
- Below the 25th percentile on no measures.

Conclusions

Based on an evaluation of the KidsCare program's results, the priority areas identified were *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, and *How Well Doctors Communicate*.

Recommendations

HSAG identified recommendations for improvement for the KidsCare program based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by the KidsCare program to target improvement in each of these areas.

RATING OF SPECIALIST SEEN MOST OFTEN

Planned Visit Management—The health plans should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons.

Skills Training for Specialists—The health plans can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plans can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account

for a large percentage of patient no-shows. This analysis could assist the health plans in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

HOW WELL DOCTORS COMMUNICATE

Communication Tools for Patients—The health plans can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options.

Improve Health Literacy—Often health information is presented to patients in a manner that is too complex and technical, which can result in a patient not adhering to recommended care and poor health outcomes. To improve patient health literacy, the health plans should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for healthcare workers on how to use these materials with their patients and health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. The health plans can offer a full-day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting.