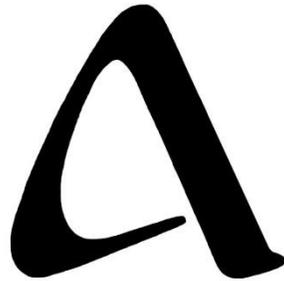


Arizona Health Care Cost Containment  
System (AHCCCS)



**AHCCCS**

2014–2015  
EXTERNAL QUALITY REVIEW  
ANNUAL REPORT  
*for*  
ARIZONA DEPARTMENT OF  
HEALTH SERVICES/DIVISION OF  
BEHAVIORAL HEALTH SERVICES

July 2015



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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 in previous years and as permitted by the Centers for Medicare & Medicaid Services (CMS) and as allowed under federal regulation, AHCCCS elected to conduct two of the three mandatory activities and, following the CMS protocols, used valid, tested models and processes to:

- ◆ Prepare for conducting each of the activities.
- ◆ Determine MCO and PIHP (i.e., “Contractors” within the AHCCCS system) compliance with operational performance standards.
- ◆ Collect Contractor encounter and other data and use the data to directly calculate the AHCCCS required PIPs.
- ◆ Prepare Contractor-specific reports of its findings related to each of the activities, and as applicable, require its Contractors to prepare and submit proposed corrective action plans to AHCCCS for review and approval.

AHCCCS contracted with Health Services Advisory Group, Inc. (HSAG), to perform a validation of the AHCCCS-selected performance measures, the third mandatory activity. To perform this activity, HSAG conducted the validation activities as outlined in CMS’ publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.<sup>1-1</sup>

<sup>1-1</sup> Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: 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 19, 2013.

AHCCCS also contracted with HSAG to conduct the optional activity of administering and reporting the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®1-2</sup>) Health Plan Survey for Medicaid members enrolled in the statewide Seriously Mentally Ill (SMI) program.

AHCCCS contracted with HSAG, as its EQRO, to use the results obtained from the three activities to prepare this annual technical report. This report presents findings from conducting each of the activities, as well as HSAG's analysis and assessment of the Contractor's, Arizona Department of Health Services/Division of Behavioral Health Services' (ADHS/DBHS'), performance and, as applicable, recommendations to improve this Contractor's performance.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR 438.354(b) and (c). HSAG has extensive experience and expertise in both conducting the mandatory activities and in using the information that either HSAG derived from directly conducting the activities or that a State Medicaid agency derived from conducting the activities. HSAG uses the information and data to draw conclusions and make recommendations about the quality and timeliness of, and access to, care and services the State's MCOs and PIHPs 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 activities HSAG conducted, to prepare and provide its EQRO annual technical report on ADHS/DBHS to AHCCCS. 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 ADHS/DBHS.
- ◆ Recommendations for improving ADHS/DBHS' service quality, timeliness, and access.

This is the first year that HSAG has prepared the annual report for ADHS/DBHS for AHCCCS. The report complies with requirements set forth at 42 CFR 438.364.

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

- ◆ Section 2—An overview of the history of the AHCCCS program and a summary of AHCCCS' quality assessment and performance improvement (QAPI) strategy goals and objectives.
- ◆ Section 3—A description of the 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 ADHS/DBHS.
- ◆ Section 5—An overview of ADHS/DBHS' best and emerging practices.

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<sup>1-2</sup> CAHPS<sup>®</sup> is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- ◆ Section 6 (Organizational Assessment and Structure Performance)—A presentation of findings for ADHS/DBHS in complying with select AHCCCS contract requirements, and as applicable, HSAG’s recommendations to improve ADHS/DBHS’ performance and members’ timely access to quality care and services. (Note: AHCCCS’ OR-related activities during contract year ending (CYE) 2014 were limited to oversight of corrective action plans (CAPs) resulting from the CYE 2012 OR findings.).
- ◆ Section 7 (Performance Measure Performance)—A presentation of rates for AHCCCS-selected performance measures for ADHS/DBHS and HSAG’s associated findings and recommendations.
- ◆ Section 8 (Performance Improvement Project Performance)—A presentation of ADHS/DBHS’ results for its AHCCCS-selected and required PIP and HSAG’s associated findings and recommendations.
- ◆ Section 9 (CAHPS Results)—A presentation of the CAHPS Health Plan Survey for Medicaid members enrolled in the statewide SMI program.

## Overview of the 2014–2015 External Review

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

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

### *Organizational Assessment and Structure Standards*

CYE 2012 concluded a three-year cycle of OR reviews, and within this cycle, AHCCCS conducted ORs for ADHS/DBHS during CYE 2010 and CYE 2012. The results of the CYE 2012 OR were reported in the CYE 2013 EQR report. AHCCCS’ OR-related activities during CYE 2014 were limited to oversight of CAPs resulting from the CYE 2012 OR findings.

### **Findings**

During CYE 2014, AHCCCS accepted 19 CAPs submitted by ADHS/DBHS as a result of the CYE 2012 OR results. AHCCCS accepted an additional 10 CAPs pending follow-up activities (e.g., receipt and approval of specific documentation). These CAPs address recommendations for all standards reported as less than fully compliant during the CYE 2012 OR.

### **Conclusions**

Most of the CAPs were related to monitoring, reporting, and communications processes. If ADHS/DBHS continues to implement targeted corrective actions and improve performance, it should be able to achieve a higher percentage of fully compliant standards during AHCCCS’ next cycle of operational reviews.

## Recommendations

HSAG did not provide recommendations for ADHS/DBHS as a result of the limited scope of the CYE 2014 OR review activities.

## Performance Measures

HSAG validated one performance measure developed and selected by AHCCCS for the measurement period July 1, 2012–September 30, 2013.

*Access to Care: Routine Appointment for Ongoing Services Within 23 Days of Initial Assessment (Assessment to First Service).*

## Findings

HSAG's validation process identified no concerns with ADHS/DBHS' process for calculating and producing performance measure rates. ADHS/DBHS provided AHCCCS with query data counts that HSAG was able to reproduce by quarter for both adult and child populations.

ADHS/DBHS met AHCCCS' performance measure standard of 90 percent for all quarters and the fiscal year (FY) 2013 annual rate for the adult population. ADHS/DBHS met the performance measure standard of 90 percent for all quarters and the FY 2013 annual rate, with the exception of second quarter, FY 2013, with a rate of 89.7 percent for the child population.

## Conclusions

Overall, ADHS/DBHS demonstrated that greater than 90 percent of adult and child members assessed as needing behavioral health services from the initial assessment received a follow-up service within 23 days.

Despite meeting performance targets, HSAG did identify some opportunities to improve the specifications of performance measures in the future to ensure that they are specific enough to meet the intent and remove the need for calculation assumptions. In addition, HSAG noted that the Regional Behavioral Health Authorities' (RBHAs') performance varied with some RBHAs not meeting performance targets.

## Recommendations

HSAG recommends that ADHS/DBHS implement a formal process to address RBHA performance that falls below performance targets.

## Performance Improvement Projects (PIPs)

HSAG received documentation from AHCCCS regarding its oversight of ADHS/DBHS' performance on an AHCCCS-mandated PIP. In CYE 2011, AHCCCS began the baseline measurement of a collaborative PIP for the Acute Care Contractors, RBHAs, and ADHS/DBHS: *Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services.*

This PIP focused on improving coordination of care provided to AHCCCS members who receive both medical and behavioral health services through the exchange of prescribing and other clinical information between medical and behavioral health providers, in order to reduce morbidity and/or mortality among these members.

## Findings

Baseline results for the *Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services* PIP for ADHS/DBHS were presented in the previous annual EQR report, and results for the first and second remeasurement periods were not available from AHCCCS. While the PIP was in the second remeasurement phase during CYE 2014, advancements in sharing of “blind spot” data by AHCCCS with all Contractors that serve the members advanced the work of the PIP. The PIP data sharing interventions were institutionalized by AHCCCS, and AHCCCS mandated that Contractors must use the data in order to achieve optimal care coordination results for members served by more than one Contractor or government program.

## Conclusions

The *Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services* PIP for ADHS/DBHS was closed mid-cycle by AHCCCS as a result of institutionalizing the PIP activities at the AHCCCS level, and performance results for this PIP were limited to the Contractor’s final PIP Report to AHCCCS. ADHS/DBHS’ consistent, collaborative work with the Acute Care Contractors and RBHAs was identified as a strength.

## Recommendations

Since this PIP was closed mid-cycle by AHCCCS, opportunities for improvement in Contractor performance are not identified. As performance results for this PIP were limited to Contractor-supplied documentation, it should be noted that activities and interventions implemented as part of the PIP or other initiatives have the potential to become standard operating procedure by the AHCCCS program, particularly when they are indicating positive outcomes. AHCCCS will continue to implement programs that have the potential to improve member outcomes and not be limited by PIP (four-year) cycle requirements.

## **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)—Statewide Seriously Mentally Ill Program**

### Description

The CAHPS Health Plan Surveys are standardized survey instruments that measure members’ satisfaction levels with their healthcare. In 2013, HSAG administered the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®1-3</sup>) supplemental set to adult members who met age and enrollment criteria. This survey was administered using a statewide sampling methodology and following standard survey

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<sup>1-3</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

administration protocols in accordance with National Committee for Quality Assurance (NCQA) specifications. These standard protocols promote the comparability of resulting CAHPS data.

For the adult survey, 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*).

## Findings

Table 1-1 presents the 2013 Adult Medicaid CAHPS survey aggregate results for the statewide SMI 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.<sup>1-4,1-5</sup>

Table 1-1—Adult Medicaid CAHPS Results for the SMI Program			
Measure	2013 Rate	Three-Point Mean	Star Rating
<b>Global Ratings</b>			
<i>Rating of Health Plan</i>	43.0%	2.18	★
<i>Rating of All Health Care</i>	38.9%	2.10	★
<i>Rating of Personal Doctor</i>	51.2%	2.30	★
<i>Rating of Specialist Seen Most Often</i>	53.6%	2.35	★
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	77.6%	2.20	★★★
<i>Getting Care Quickly</i>	78.3%	2.28	★
<i>How Well Doctors Communicate</i>	81.8%	2.36	★
<i>Customer Service</i>	83.2%	2.38	★★★
<i>Shared Decision Making</i>	47.0%	NA	NA
<b>Individual Item Measures</b>			
<i>Coordination of Care</i>	64.4%	NA	NA
<i>Health Promotion and Education</i>	69.7%	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.			

<sup>1-4</sup> NCQA national averages for the adult Medicaid population were used for comparative purposes. Given the potential differences in the demographics of these populations (i.e., adult Medicaid and SMI), caution should be exercised when interpreting these results.

<sup>1-5</sup> NCQA’s benchmarks and thresholds for the adult Medicaid population were used to derive the overall member satisfaction ratings (i.e., star ratings); therefore, caution should be exercised when interpreting these results.

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 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 SMI program’s 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 1-2 shows how the priority assignments were determined for the SMI program on each CAHPS measure.

Table 1-2—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 <i>Shared Decision Making</i> composite measure and the <i>Coordination of Care</i> and <i>Health Promotion and Education</i> individual item measures; therefore, priority assignments could not be derived for these measures.	

Based on the evaluation of the SMI program’s overall member satisfaction ratings for the adult Medicaid population, the measures identified as areas of top priority are the specific areas that should be targeted for quality improvement initiatives. For the SMI program, the top priority areas identified for quality improvement were *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, and *How Well Doctors Communicate*.

## Recommendations

Based on the SMI 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 Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, and *How Well Doctors Communicate*.

To improve overall performance on the *Rating of Health Plan* global rating, QI activities should target identifying alternatives to one-on-one physician visits and health plan operations. To improve

member's satisfaction on *Rating of All Health Care* global rating, QI activities should focus on identifying potential barriers to patient's access to care, patient and family engagement and advisory councils, and integrated care. To improve performance on the *Rating of Personal Doctor* global rating, QI activities should target maintaining truth in scheduling and patient-direct feedback. 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 member satisfaction regarding the *Getting Care Quickly* measure, QI activities should target decreasing no-show appointments and using electronic communication. To improve satisfaction related to the *How Well Doctors Communicate* measure, QI activities should focus on communication tools and improving health literacy.

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

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

### History of the AHCCCS Medicaid Managed Care Program

AHCCCS has operated throughout its 32-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 its waiver since 1982 when its Acute Care program began. In December 1988 AHCCCS added the Arizona Long Term Care System (ALTCSS) 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 ADHS/DBHS, a managed care organization (MCO) that serves as the single State authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health system. ADHS/DBHS subcontracts with four RBHAs that provide behavioral health services to six geographic service areas (GSAs) and five of Arizona's American Indian tribes that provide behavioral health services to persons living on reservations. Each RBHA contracts with a network of service providers similar to health plans to deliver a range of behavioral healthcare services, treatment programs for adults with substance abuse disorders, adults with serious mental illness, and children with serious emotional disturbance. Within the AHCCCS program, the ADHS/DBHS is called "Contractor."

## AHCCCS' Strategic Plan

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

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

AHCCCS Strategic Goals and related Strategies were 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 Children's Rehabilitative Services (CRS), Comprehensive Medical and Dental Program (CMDP), and the 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.

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<sup>2-1</sup> AHCCCS Strategic Plan 2015–2019, December 2014.

Available at: <http://www.azahcccs.gov/reporting/PoliciesPlans/strategicplan.aspx>. Accessed on: April 28, 2015.

**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 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 integration 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. The 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 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 Medicaid managed care act requirements and AHCCCS contract standards. AHCCCS conducts operational reviews (ORs) and reviews Contractor deliverables to meet the requirements of the Medicaid managed care regulations (42 CFR 438.364). AHCCCS also conducts the reviews to determine the extent to which each Contractor complied with other federal and State regulations as well as AHCCCS contract requirements and policies. As part of the ORs, AHCCCS staff review Contractor progress in implementing recommendations made during prior operational and financial reviews (OFRs) 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.

For example, AHCCCS sought and received CMS approval to amend the current 1115 waiver, allowing for integration of physical and behavioral health services for a select population by requiring ADHS/DBHS to serve as the only managed care plan for both acute and behavioral conditions for AHCCCS acute care members with SMI in Maricopa County.

This request sought to maintain alignment for Medicare/Medicaid members (dual eligibles) with SMI individuals who are currently enrolled in acute care health plans that are also Special Needs Plans (SNPs). This was accomplished by requiring ADHS/DBHS to become a Medicare Dual Special Needs Plan (D-SNP) and passively enrolling those Medicare/Medicaid members into the D-SNP. This will improve care coordination and health outcomes for individuals with SMI in Maricopa County, increase the ability for ADHS/DBHS to collect and analyze data to assess the health needs of its members, improve the current fragmented healthcare delivery system, reduce costs by decreasing hospitalizations, and promote sharing of information between physical and behavioral health providers. This SMI-integrated RBHA was implemented on April 1, 2014. AHCCCS tracks the progress of the SMI-integrated RBHA using ADHS/DBHS quarterly reports and specific performance measures.

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

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

## ***Performance Measure Requirements and Targets***

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

For all lines of business, AHCCCS has developed new performance measures that became effective October 1, 2013, which aligns with the start of the five-year contract period for Acute Care plans,

the newly integrated CRS, and the SMI plans. This also allows AHCCCS to align with the CMS measure sets for the Children's Health Insurance Program Reauthorization Act (CHIPRA) Core Measure Set, the Adult Core Measure Set, and Meaningful Use.

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

AHCCCS has undergone extensive planning efforts, including barrier and risk identification, in its effort to implement the performance measure transition. To assist in the transition and to reduce risks that AHCCCS identified, AHCCCS is using HSAG to perform the measurement calculations for the CYE 2013 measurement period. Contractors will be given data for planning and implementation efforts. Workgroups, new reporting mechanisms, increased opportunities for technical assistance, and a more transparent reporting process are all efforts to assist the plans prior to the end of the measurement period, allowing them to make the necessary adjustments and payment reform initiatives that align with the performance measure thresholds. Finally AHCCCS has contracted with a vendor that is capable and interested in partnering to develop and implement measures from the CMS Core and other measures sets in addition to maintaining the traditional HEDIS measures.

### ***Performance Improvement Project Requirements and Targets***

AHCCCS' QAPI strategy described the agency's requirements and processes to ensure that Contractors conduct PIPs, which the QAPI defined as "a planned process of data gathering, evaluation, and analysis to design and implement interventions or activities that are anticipated to have a positive outcome"—i.e., to improve the quality of care and service delivery. AHCCCS encourages its Contractors to conduct PIPs for topics that they select based on their population and data (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 to ensure institutionalization of the interventions. AHCCCS requires Contractors to submit reports evaluating their data and interventions and propose new or revised interventions, if necessary.

### Mandatory Activities

As permitted by CMS, within federal regulation, and described in Section 1, Executive Summary, AHCCCS performed the functions associated with two of the three CMS mandatory activities for ADHS/DBHS and contracted with HSAG to perform the third mandatory activity as noted below:

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

### Optional Activities

AHCCCS also contracted with HSAG to conduct the following optional activity:

- ◆ Administer and report the results of the CAHPS Health Plan Survey for Medicaid members enrolled in the statewide SMI 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 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 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 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 its 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.

### **Collaborates/Initiatives**

During the reporting period, AHCCCS participated in the following initiatives pertaining to ADHS/DBHS. (Note: This is not an all-inclusive list.)

- ◆ AHCCCS received CMS approval to amend the current 1115 waiver, allowing for integration of physical and behavioral health services for a select population by requiring ADHS/DBHS to serve as the only managed care plan for both acute and behavioral conditions for AHCCCS acute care members with SMI in Maricopa County.
- ◆ AHCCCS created a specialty RBHA model with expanded responsibility for members who have a SMI in Maricopa County to deliver integrated care. The RBHA provides behavioral health services to children and adults with general mental health and substance abuse needs and is

required to be a Medicare Advantage plan. The integrated RBHA contract with MMIC was implemented on April 1, 2014.

- ◆ AHCCCS' amendment to the 1115 waiver maintained alignment for Medicare/Medicaid members (dual eligibles) with SMI individuals who are currently enrolled in acute care health plans that are also SNPs. This was accomplished by requiring ADHS/DBHS to become a Medicare D-SNP and passively enrolling those Medicare/Medicaid members into the D-SNP. This will improve care coordination and health outcomes for individuals with SMI in Maricopa County, increase the ability for ADHS/DBHS to collect and analyze data to assess the health needs of its members, improve the fragmented healthcare delivery system, reduce costs, and promote sharing of information between physical and behavioral health providers.
- ◆ ADHS/DBHS participate in a collaborative PIP for e-prescribing. The purpose of the PIP is to increase the number of prescribers electronically prescribing prescriptions and to increase the percentage of prescriptions that are submitted electronically to improve member safety. The goal aligns with the payment reform e-prescribing initiative, which is to demonstrate a statistically significant increase in the number of providers submitting electronic prescriptions and the number of electronic prescriptions submitted.
- ◆ ADHS/DBHS required its contractors to complete provider profiling quarterly. Minimum data elements included ADHS/DBHS performance measures, grievance system data, morbidity and mortality measures, and utilization management measures. Contractors are required to develop a provider profile for each subcontractor and take corrective actions for any identified deficiencies. These actions are expected to improve member outcomes; support quality practice; and effect positive change for the contractor, providers, service sites, and members.
- ◆ ADHS/DBHS required the RBHAs to submit quarterly pharmacy utilization reports that allow staff to analyze the medication encounters and the resultant costs per utilizing adult/child per month. These data are reviewed and discussed by several pharmacy and utilization committees to detect trends for over- and underutilization of medications. This system allows for the identification of psychotropic medication prescribing patterns, as well as potentially problematic medication regimes for all members.
- ◆ ADHS/DBHS required RBHAs to conduct on-site provider monitoring for all of their subcontractors at least annually. The purpose is to ensure the RBHAs are monitoring the service delivery system and provider network in their contracted GSAs. Contractors are required to develop a mechanism for conducting a focused review of provider sites as identified through trended data. RBHAs are required to implement processes for verifying the accuracy and timeliness of reported data, interrater reliability exercises, and the standardized collection of service information.
- ◆ ADHS/DBHS required RBHAs to incorporate the FOCUS PDSA (Plan-Do-Study-Act) model for continuous quality improvement in CAPs and include: (1) measurable goals and objectives; (2) interventions, activities, and tasks; (3) responsible parties; and (4) start and completion dates for each activity and task. The RBHAS must include systemic interventions that include, but are not limited to, training, policy review and revision, technical assistance, and focused reviews. CAPs must use evidence-based practices, when available, in the reported interventions to meet and/or exceed performance expectations. ADHS/DBHS approves and monitors all CAPs and mandates that CAP performance is reported quarterly.

## 5. Contractor Best and Emerging Practices

HSAG, through its review of AHCCCS and Contractor documentation, had the opportunity to identify noteworthy ADHS/DBHS 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.

- ◆ AHCCCS created a specialty RBHA model with expanded responsibility for members who have a SMI in Maricopa County to deliver integrated care. The RBHA provides behavioral health services to children and adults with general mental health and substance abuse needs and is required to be a Medicare Advantage plan. The integrated RBHA contract with MMIC was implemented on April 1, 2014.
- ◆ ADHS/DBHS requires Contractors to conduct on-site provider monitoring for all subcontractors at least annually. One purpose of this requirement is to assure that the Tribal/ Regional Behavioral Health Authorities (T/RBHAs) are monitoring the service delivery system and provider network in their contracted GSAs. More frequent provider monitoring may take place for subcontractors demonstrating performance below minimum standards and as data analysis and program trends indicate. Contractors are required to develop a mechanism for a focused review of provider sites as identified through trended data. As part of their provider monitoring, Contractors are required to implement processes for verifying the accuracy and timeliness of reported data, interrater reliability exercises, and the standardized collection of service information. Contractors are to include detailed provider monitoring plans in their annual quality management plans, including a schedule and frequency of provider monitoring activities and tools.
- ◆ ADHS/DBHS requires Contractors to incorporate the FOCUS PDSA model for continuous quality improvement in CAPs. CAPs must include: (1) measurable goals and objectives; (2) interventions, activities, and tasks; (3) responsible parties; and (4) start and completion dates for each activity and task identified in the submitted CAP. The Contractors must include systemic interventions that include, but are not limited to training, policy review and revision, technical assistance, and focused reviews. Contractor CAPs must use evidence-based practices when available, in the reported interventions to meet and/or exceed performance expectations. ADHS/DBHS approves and monitors all Contractor CAPs and mandates that Contractors report CAP performance quarterly.
- ◆ ADHS/DBHS requires its contractors to complete provider profiling quarterly. Minimum data elements include ADHS/DBHS performance measures, grievance system data, morbidity and mortality measures, and utilization management measures. Contractors are required to develop a provider profile for each subcontractor and take corrective actions for any identified deficiencies. This action is intended to improve member outcomes; support quality practice; and effect positive change for the contractor, providers, service sites, and members. These provider profiles are available on a Contractor dashboard.
- ◆ ADHS/DBHS requires the RBHAs to submit quarterly pharmacy utilization reports that staff members use to develop charts and graphs which allow them to analyze the medication encounters and the resultant costs per utilizing adult/child per month. These data are reviewed and discussed in the Pharmacy and Therapeutics Committee, the Morbidity and Mortality/Utilization Management (MM/UM) Committee, and the RBHA UM Committee to

detail trends for over- and underutilization of medications. This comprehensive tracking and monitoring system allows for the identification of psychotropic medication prescribing patterns, as well as potentially problematic medication regimes for all members.

## 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 federal requirement by conducting ORs of its Contractors' performance in complying with federal and AHCCCS' contract requirements at least once every three years.

CYE 2012 concluded a three-year cycle of OR reviews, and within this cycle, AHCCCS conducted ORs for ADHS/DBHS during CYE 2010 and CYE 2012. The results of the CYE 2012 OR were reported in the CYE 2013 EQR report. AHCCCS' OR-related activities during CYE 2014 were limited to oversight of CAPs resulting from the CYE 2012 OR findings. Specifically, AHCCCS accepted 19 CAPs submitted by ADHS/DBHS during CYE 2014, and accepted an additional 10 CAPs pending follow-up activities (e.g., receipt and approval of specific documentation). These CAPs address recommendations for all standards reported as less than fully compliant during the CYE 2012 OR.

### Conducting the Review

CMS requires that states, through their contracts with MCOs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of three mandatory EQR activities required by the Balanced Budget Act of 1997 (BBA) described at 42 CFR §438.358(b)(2).

The purpose of performance measure validation (PMV) is to ensure that MCOs have sufficient systems and processes in place to provide accurate and complete information for calculating valid performance measure rates according to the specifications required by the state. The state, its agent that is not an MCO, or an EQRO, can perform this validation. AHCCCS contracted with HSAG, an EQRO, to conduct the validation activities.

AHCCCS contracted with ADHS/DBHS to provide mental health services to AHCCCS members. AHCCCS required ADHS/DBHS to calculate and report performance measure rates during fiscal year (FY) 2013. ADHS/DBHS was required to report data for the July 2012–September 2013 time period that included five quarters of data in order to align the ADHS and AHCCCS contracts.

### Objectives for Conducting the Review

The primary objectives of HSAG’s PMV process were to:

- ◆ Evaluate the accuracy of the performance measure data collected by ADHS/DBHS.
- ◆ Determine the extent to which the specific performance measures calculated by ADHS/DBHS followed the specifications established for the selected performance measure.

In addition, AHCCCS requested that HSAG ensure that specifications and related dates were appropriately interpreted by ADHS/DBHS and to review the processes that were in place during the reporting period of July 2012–September 2013, recognizing that the processes have changed since that time. AHCCCS requested this information to help inform and update program decisions for conducting PMV in subsequent years.

### Methodology for Conducting the Review

HSAG conducted the validation activities as outlined in CMS’ publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.<sup>7-1</sup>

<sup>7-1</sup> Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: 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 19, 2013.

HSAG prepared a documentation request packet that was submitted to ADHS/DBHS outlining the steps in the PMV process. The packet included a request for source code used to generate the performance measure, a completed Information Systems Capabilities Assessment Tool (ISCAT), any additional supporting documentation necessary to complete the audit, a timetable for completion, and instructions for submission. Based on the performance measure definition, HSAG customized the ISCAT to collect the necessary data. In addition, HSAG responded to PMV-related questions received directly from ADHS/DBHS during the pre-on-site phase.

Prior to the on-site visit, HSAG provided ADHS/DBHS with an agenda describing all on-site activities and indicating the type of staff needed for each session. HSAG also conducted a pre-on-site conference call with ADHS/DBHS to discuss on-site logistics and expectations, important deadlines, and any outstanding ISCAT-related questions.

The following list describes the types of data collected and how HSAG conducted an analysis of these data:

**Information Systems Capabilities Assessment Tool (ISCAT)**—ADHS/DBHS was required to submit a completed ISCAT that provided information on its information systems, processes used for collecting and processing data, and processes used for performance measure calculation. Upon receipt by HSAG, the ISCAT underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification. Where applicable, HSAG used the information provided in the ISCAT to begin completion of the review tools.

**Source code (programming language) for performance measure generation**—ADHS/DBHS was required to submit computer programming language/source code it used to generate the performance measure being validated. HSAG completed a line-by-line review on the supplied source code to ensure compliance with the State-defined performance measure specification. HSAG identified areas of deviation from the specification, evaluating the impact to the measure and assessing the degree of bias (if any).

**Supporting documentation**—ADHS/DBHS submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

HSAG conducted an on-site visit with ADHS/DBHS. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site activities are described as follows:

**Opening session**—The opening session included introductions of the validation team and key ADHS/DBHS staff members involved in the PMV activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.

**Evaluation of system compliance**—The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance measure, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT, HSAG conducted interviews with key ADHS/DBHS staff members familiar with the processing, monitoring, and calculation of the performance measure. HSAG used the interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.

**Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for reporting the performance measure rates. HSAG performed primary source verification to further validate the output files; however, this review was not conducted using actual source data. HSAG also reviewed any supporting documentation provided for data integration. This session also addressed data control and security procedures as well.

**Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the on-site visit, and reviewed the documentation requirements for any post-on-site activities.

HSAG validated one performance measure developed and selected by AHCCCS for the measurement period July 1, 2012–September 30, 2013: *Access to Care: Routine Appointment for Ongoing Services Within 23 Days of Initial Assessment (Assessment to First Service)*. AHCCCS provided the specifications that ADHS/DBHS was required to use for calculation of the performance measure.

## Results

HSAG organized and analyzed validated performance measure data to draw conclusions about ADHS/DBHS’ performance in providing quality, accessible, and timely care and services to its AHCCCS members.

AHCCCS required ADHS/DBHS to report its results by quarter, and by adult and child populations.

ADHS/DBHS results are displayed in Table 7-1 and Table 7-2—Access to Care Performance Measure Results for adults and children, respectively.

Table 7-1—Access to Care Performance Measure Results—Adult					
Q1FY13	Q2FY13	Q3FY13	Q4FY13	Q5FY13	FY 2013 Annual
92.3%	91.2%	92.0%	90.5%	90.6%	91.3%

**Table 7-2—Access to Care Performance Measure Results—Child**

Q1FY13	Q2FY13	Q3FY13	Q4FY13	Q5FY13	FY 2013 Annual
90.9%	89.7%	91.3%	90.5%	90.1%	90.5%

### Findings

HSAG’s validation process identified no concerns with the process ADHS/DBHS used for calculating and producing performance measure rates. ADHS/DBHS provided AHCCCS query data counts that HSAG was able to reproduce by quarter for both adult and child populations.

HSAG noted that the specifications allowed some need for assumptions and interpretations for calculation of the measure. For example, ADHS/DBHS used the codes within the operational definition provided by AHCCCS to identify an assessment; however, since the specifications did not indicate a provider type, ADHS/DBHS used assessments completed by both licensed and non-licensed staff during the review period.

The only performance measure specifications provided to HSAG for the validation review were provided by ADHS/DBHS. Therefore, it was difficult for the HSAG audit team to determine whether the specifications that ADHS/DBHS used were consistent with AHCCCS’ intent and expectations for measure calculation. ADHS/DBHS was the initial developer of the methodology used for the Access to Care measure, with approval from AHCCCS. However, the measure was transitioned to an AHCCCS-established methodology beginning in CYE 2014 that focuses on more closely aligning with national measure sets by measuring access to professional services by members.

ADHS/DBHS met AHCCCS’ performance measure standard of 90 percent for all quarters as well as the FY 2013 annual rate for the adult population. ADHS/DBHS met the performance measure standard of 90 percent for all quarters and the FY 2013 annual rate, except quarter 2, FY 2013, with a rate of 89.7 percent for the child population.

### CAPs

HSAG identified no corrective action taken by AHCCCS related to performance measures during the review period, as ADHS/DBHS met the AHCCCS performance measure standard in both the adult and child populations.

### Strengths

While ADHS/DBHS has not undergone formal PMV for this measure in the past, the organization was able to report valid rates. The audit team found good documentation of its processes during the review period.

ADHS/DBHS met performance targets for all quarters for the adult population and for all but one quarter for the child population.

## Opportunities for Improvement

While the HSAG audit team found the performance rates to be valid and reportable, HSAG did note some opportunities for improvement related to the clarity of the performance measure specifications.

HSAG noted that despite meeting performance targets for most quarters, and annually, RBHA's performance somewhat varied.

The HSAG audit team was not clear as to why only members who received an assessment within 45 days were included in the measure. The measure specification as currently written excluded members who received an assessment after 45 days. This exclusion resulted in more than 1,700 members being excluded from the report. ADHS/DBHS may need to provide an explanation to AHCCCS on the reasons for the creation of the measure specification methodology that excluded members who received an assessment after 45 days.

## Summary

HSAG provides the following recommendations based on the evaluation of ADHS/DBHS' performance:

- ◆ ADHS/DBHS should implement a formal process to address RBHA performance that falls below performance targets.
- ◆ ADHS/DBHS should include all members who received an assessment regardless of whether the assessment was completed within 45 days.

## 8. 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 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 the interventions
- ◆ Planning and initiating activities for increasing and sustaining improvement

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

The annual validation of MCO and PIHP PIPs required by a state and in progress during the preceding 12 months is one of the three EQR-related activities mandated by the Medicaid managed care act and described at 42 CFR 438.358(b)(1). The requirement at 42 CFR 438.358(a) allows a state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory and optional EQR-related activities. AHCCCS elected to conduct the functions associated with the mandatory Medicaid managed care act activity of validating its Contractors' PIPs. In accordance with, and satisfying, the requirements of 42 CFR 438.364(a)(1), AHCCCS contracted with HSAG as an EQRO to use the information AHCCCS obtained from its PIP data collection, calculation, and validation activities during the contract year ending in 2014 to prepare this section of the annual report.

### Conducting the Review

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

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

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

In CYE 2011, AHCCCS implemented a new PIP, *Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services*, for the behavioral health services Contractor, ADHS/DBHS. The baseline measurement period covered CYE 2012, which includes data from the CYE 2011 measurement period: October 1, 2010, through September 30, 2011. This was followed by an intervention year and two remeasurement periods, CYE 2014 (data from the CYE 2013 measurement period: October 1, 2012, through September 30, 2013) and CYE 2015 (data from the CYE 2014 measurement period: October 1, 2013, through September 30, 2014).

## Methodology for Conducting the Review

AHCCCS developed a methodology to measure performance and followed quality control processes to ensure the collection of valid and reliable data. The study indicators AHCCCS selected for this PIP were based on current clinical knowledge or health services research. The PIP methodology stated the study question, the population(s) included, any sampling methods, and methods to collect the data.

While AHCCCS typically collects data from the encounter subsystem of its Prepaid Medical Management Information System (PMMIS), system limitations stemming from a change in the encounter data process for behavioral health encounters beginning in CYE 2014 resulted in a lack of data for this PIP's first and second remeasurement periods. Subsequent validation studies to evaluate the completeness, accuracy, and timeliness of the data were also delayed as a result of the aforementioned operational change.

Although AHCCCS has an established methodology in place to validate ADHS/DBHS's PIP, it was not possible to apply it for this reporting period.

The remainder of this section describes HSAG's findings, conclusions, and recommendations for ADHS/DBHS and AHCCCS.

## Results

AHCCCS provided to HSAG its CYE 2014 Contractor PIP Report for ADHS/DBHS for the *Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services* PIP. This collaborative PIP focused on improving coordination of care provided to AHCCCS members who receive both medical and behavioral health services through the exchange of prescribing and other clinical information between medical and behavioral health providers, in order to reduce morbidity and/or mortality among these members. Acute care contractors and RBHAs also participated in this PIP.

The *Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services* PIP was in the second remeasurement phase during CYE 2014, and was closed by AHCCCS. Operational and quality considerations factored into AHCCCS' decision to close this PIP mid-cycle, and specific factors included:

- ◆ “Blind Spot” Data Sharing efforts by AHCCCS focused on ensuring encounter data are shared between Acute Care Contractors and the RBHAs.
- ◆ Evidence of standardized care coordination processes and ongoing communication between Acute Care Contractors and the RBHAs.
- ◆ Organizational changes in member enrollment that resulted in a greater number of higher-risk members receiving care under the integrated plan, with more members anticipated to move to an integrated model of care in the future.
- ◆ An assessment of AHCCCS resources committed to the PIP, especially the IT commitment in light of the previously mentioned organizational changes positively impacting members' care coordination.

## Findings

Baseline results for the *Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services* PIP for ADHS/DBHS were presented in the previous annual EQR report, and results for the first and second remeasurement periods were not available from AHCCCS. Specifically, AHCCCS changed the encounter data process beginning in CYE 2014 such that RBHAs report encounter data to AHCCCS, which then supplies the encounter data to ADHS/DBHS. Unforeseen system limitations prevented AHCCCS from providing data to ADHS/DBHS, and ADHS/DBHS was subsequently unable to generate PIP results. While AHCCCS anticipates supplying all data to ADHS/DBHS in the future, the data could not be supplied in a timely fashion with respect to ADHS/DBHS' reporting requirements. It should be noted that while other Contractors may have supplied self-reported performance results for this PIP, ADHS/DBHS' PIP report focused on a narrative evaluation of improvement strategies.

In lieu of performance results, AHCCCS supplied meeting materials used during the CYE 2014 Coordination of Care PIP meetings, hosted by ADHS/DBHS, to illustrate the intervention activities underway during CYE 2014. ADHS/DBHS hosted the meetings, and meeting minutes and inter-meeting email status updates show collaborative tasks throughout CYE 2014. Tasks were distributed among voluntary subgroups and addressed the following topics:

- ◆ Technical specifications for data exchange
- ◆ Prescriber notification of identified coordination of care issues
- ◆ Development of a tool for auditing prescribers
- ◆ Provider and/or member education

Tracking of stakeholders' progress in developing data exchange capabilities was of special significance. Stakeholders' progress through established milestones (e.g., establishing Data Use Agreements, successfully sharing member lists) was routinely shared with the group.

## Strengths

As this PIP required coordinated technological and organizational changes from each Contractor, HSAG recognizes ADHS/DBHS' consistent, collaborative work with varied stakeholders and the stated commitment to continue this process beyond the PIP as strengths for this PIP.

## Opportunities for Improvement and Recommendations

Since this PIP was closed mid-cycle by AHCCCS, opportunities for improvement in Contractor performance have not been identified. As performance results for this PIP were limited to Contractor-supplied documentation, HSAG recommends that AHCCCS fully validate future PIPs following AHCCCS' established procedures (i.e., consistent with the CMS PIP Validation protocol).

## Summary

The *Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services* PIP for ADHS/DBHS was closed mid-cycle by AHCCCS, and performance results for this PIP were limited to the Contractor's final PIP Report to AHCCCS. ADHS/DBHS' consistent, collaborative work with the Acute Care Contractors and RBHAs was identified as a strength.

## 9. Consumer Assessment of Healthcare Providers and Systems Results

### CAHPS—Adult Survey

In 2013, as an optional EQR activity, AHCCCS elected to conduct member satisfaction surveys of adult Medicaid members enrolled in the AHCCCS SMI Medicaid managed care program. AHCCCS contracted with HSAG to administer and report the results of the CAHPS Health Plan Surveys. This report presents statewide aggregate adult Medicaid CAHPS survey results for the SMI program.

### 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 program performance, AHCCCS elected to conduct a CAHPS survey of adult Medicaid members served by the SMI program. The primary objective of the CAHPS survey was to effectively and efficiently obtain information on adult Medicaid members' levels of satisfaction with their healthcare experiences.

#### 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 HEDIS supplemental item set to adult members. Adult members eligible for the survey were 18 years of age or older as of December 31, 2012.

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 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 who 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. These measures include four global ratings, five composite measures, and two individual item measures. 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 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, to assess the overall performance of the SMI program’s adult Medicaid population, 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.<sup>9-1</sup> The resulting three-point mean scores were compared to NCQA’s HEDIS Benchmarks and Thresholds for Accreditation.<sup>9-2</sup> 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:<sup>9-3</sup>

- ★★★★★ 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

<sup>9-1</sup> National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

<sup>9-2</sup> National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, July 24, 2013.

<sup>9-3</sup> 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 derived for these CAHPS measures.

For purposes of this report, the SMI program survey findings were compared to 2012 NCQA CAHPS Adult Medicaid national averages. For the SMI 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.<sup>9-4</sup>

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 a new HEDIS version of the Adult CAHPS Health Plan Survey in August 2012, which is referred to as the CAHPS 5.0H Adult Health Plan Survey. As a result of the transition from the CAHPS 4.0H to the CAHPS 5.0H Adult Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health 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

For the SMI program, HSAG calculated adult Medicaid CAHPS Survey results for the statewide program in aggregate. The following sections describe HSAG's findings, conclusions, and recommendations for the SMI program.

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<sup>9-4</sup> NCQA national averages for the adult Medicaid population were used for comparative purposes. Given the potential differences in the demographics of these populations (i.e., adult Medicaid and SMI), caution should be exercised when interpreting these results.

## Results/Findings

Table 9-1 presents the 2013 CAHPS survey results for the statewide SMI 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.<sup>9-5,9-6,9-7</sup>

Table 9-1—Adult CAHPS Results for the SMI Program			
Measure	2013 Rate	Three-Point Mean	Star Rating
<b>Global Ratings</b>			
<i>Rating of Health Plan</i>	43.0%	2.18	★
<i>Rating of All Health Care</i>	38.9%	2.10	★
<i>Rating of Personal Doctor</i>	51.2%	2.30	★
<i>Rating of Specialist Seen Most Often</i>	53.6%	2.35	★
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	77.6%	2.20	★★
<i>Getting Care Quickly</i>	78.3%	2.28	★
<i>How Well Doctors Communicate</i>	81.8%	2.36	★
<i>Customer Service</i>	83.2%	2.38	★★
<i>Shared Decision Making</i>	47.0%	NA	NA
<b>Individual Item Measures</b>			
<i>Coordination of Care</i>	64.4%	NA	NA
<i>Health Promotion and Education</i>	69.7%	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.			

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

- ◆ At or above the 50th percentile on no measures.
- ◆ At or between the 25th and 49th percentiles on two measures: *Getting Needed Care* and *Customer Service*.

<sup>9-5</sup> NCQA’s benchmarks and thresholds for the adult Medicaid population were used to derive the overall member satisfaction ratings (i.e., star ratings); therefore, caution should be exercised when interpreting these results.

<sup>9-6</sup> 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.

<sup>9-7</sup> 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.

- ◆ Below the 25th percentile on six measures: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Care Quickly, and How Well Doctors Communicate.*

## Conclusions

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

## Recommendations

HSAG identified recommendations for improvement for the SMI 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 SMI program 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, the SMI program should engage in efforts that assist providers in examining and improving their systems' ability to manage patient demand. As an example, the program 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 should 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 programs 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 program's healthcare "products." Healthcare microsystems include a team of health providers, the patient/population to whom care is provided, an 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 program staff to provide high-quality, patient-centered care.

### ***RATING OF ALL HEALTH CARE***

**Access to Care**—The SMI program 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 SMI program 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, the SMI program 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.

**Integrated Care**—The SMI program may want to expand its current efforts of integrating mental healthcare services into a disease management program approach. The program could work with health plans to establish teams of healthcare staff and case managers who work collaboratively to ensure the patient’s overall healthcare needs are being met. Behavioral health providers would work closely with the patient’s primary care physician (PCP) and/or other healthcare specialists involved in the patient’s care. Care managers could assist by providing follow-up care, disorder education, and self-management strategies to patients. By utilizing a disease management program approach, health plans allow providers the opportunities to integrate screening, treatment, and referrals for behavioral health conditions. These efforts can lead to improvements in quality, timeliness, and patients’ overall access to care.

### ***RATING OF PERSONAL DOCTOR***

**Maintain Truth in Scheduling**—The SMI program should 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. The SMI program should 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**—The SMI program should 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. The SMI program 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 SMI program 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 these patients are receiving the appropriate attention at the appropriate time. This triggering system should 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 SMI program should 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 SMI program should 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 should assist the SMI program in determining targeted, potential resolutions.

**Electronic Communication**—Electronic forms of communication between patients and providers should 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 should 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 SMI program should work with health plans to 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 should 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 SMI program 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 should 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 should be implemented to ease the inclusion of health literacy into physician practice. The SMI program could offer a full-day

workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting.

**Language Barriers**—The SMI program can consider hiring interpreters who serve as full-time staff members at provider offices with a high volume of non-English speaking patients to ensure accurate communication among patients and physicians. Offering an in-office interpretation service promotes the development of relationships between the patient and family members with their physician. With an interpreter present to translate, the physician will have a more clear understanding of how to best address the appropriate health issues, and the patient will feel more at ease. Having an interpreter on-site is also more time efficient for both the patient and physician, allowing the physician to stay on schedule.