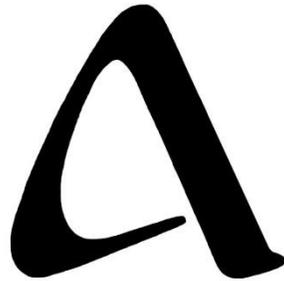


Arizona Health Care Cost Containment
System (AHCCCS)



AHCCCS

2014–2015
EXTERNAL QUALITY REVIEW
ANNUAL REPORT
for
UNITEDHEALTHCARE
COMMUNITY PLAN-CRS

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. The AHCCCS Contractor for the Children’s Rehabilitative Program (CRS) is UnitedHealthcare Community Plan-CRS (UHCCP-CRS).

As permitted by the Centers for Medicare & Medicaid Services (CMS) and as allowed under federal regulation, AHCCCS elected to conduct two of the three mandatory activities: Performance Improvement Project Performance and Organizational Assessment and Structure Performance. Following the CMS protocols, AHCCCS used valid, tested models and processes to:

- ◆ Prepare for conducting each of the activities.
- ◆ Determine MCO (i.e., “Contractor” 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 Contractor 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, 2012.¹⁻¹

¹⁻¹ 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.medicare.gov/Medicare-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[®])¹⁻² Health Plan Survey for Medicaid members enrolled in the CRS program.

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

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

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

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

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

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

- ◆ Section 2—An overview of the history of the AHCCCS program and a summary of AHCCCS' quality assessment and performance improvement (QAPI) strategy goals and objectives.
- ◆ Section 3—A description of the 2014–2015 EQR activities.
- ◆ Section 4—An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care programs and those that are specific to the CRS program.
- ◆ Section 5—An overview of UHCCP-CRS' best and emerging practices.
- ◆ Section 6 (Organizational Assessment and Structure Performance)—A presentation of findings for UHCCP-CRS in complying with select AHCCCS contract requirements, and as applicable,

¹⁻² CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HSAG’s recommendations to improve UHCCP-CRS’ performance and members’ timely access to quality care and services.

- ◆ Section 7 (Performance Measure Performance)—A presentation of the AHCCCS-selected performance measure for UHCCP-CRS and HSAG’s associated findings and recommendations.
- ◆ Section 8 (Performance Improvement Project Performance)—A presentation of UHCCP-CRS’ results for its AHCCCS-selected and required PIP and HSAG’s associated findings and recommendations.
- ◆ Section 9 (CAHPS Results)—A presentation of the CAHPS Health Plan Survey for Medicaid members enrolled in the CRS 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

Contract Year Ending (CYE) 2013 began a three-year cycle of operational reviews, and within this cycle, AHCCCS conducted an operational review for UHCCP-CRS in CYE 2014. AHCCCS reviewed the Contractor’s performance on 136 compliance standards. Based on AHCCCS’ review findings and assessment of the degree to which the Contractor complied with the standards, AHCCCS assigned the applicable performance designation to the Contractor’s performance:

- ◆ Full Compliance (FC): Standards scored as 90 through 100 percent compliant
- ◆ Substantial Compliance (SC): Standards scored as 75 through 89 percent compliant
- ◆ Partial Compliance (PC): Standards scored as 50 through 74 percent compliant
- ◆ Noncompliance (NC): Standards scored as 0 through 49 percent compliant
- ◆ Not Applicable (N/A): Standard was not applicable to the Contractor
- ◆ Information Only (I/O): Standard was assessed for information only

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

Findings

Figure 1-1 shows for UHCCP-CRS the percentages of reviewed standards in each of the 11 compliance categories, with full compliance displayed on the bottom of the stacked bars. The left-most bar in the figure (labeled “Overall”) shows the proportions for all compliance categories.

Figure 1-1—Categorized Levels of Compliance With Technical Standards for UHCCP-CRS¹⁻³

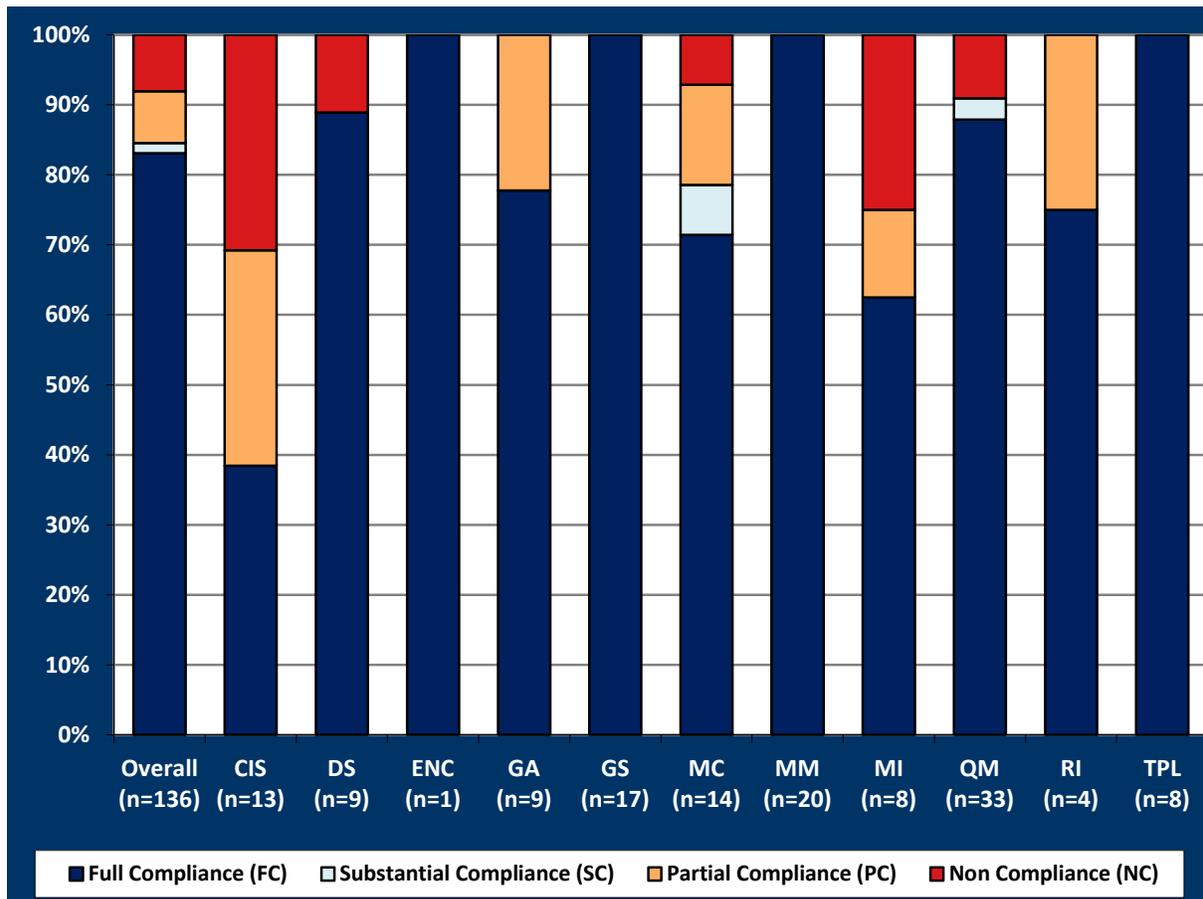


Figure 1-1 shows that UHCCP-CRS was in full compliance for 83.1 percent of the 136 reviewed standards, with moderate variation in performance across six of the 11 categories of standards and wider variation for the Claims and Information Systems category. The Contractor’s strongest performance was for standards associated with Encounters, Grievance Systems, Medical Management, and Third Party Liability, where AHCCCS scored 100 percent of the standards fully compliant. Of the 11 categories of standards, the Claims and Information Systems category showed the lowest percentage of standards in full compliance (38.5 percent). All other categories scored above 60.0 percent fully compliant for their associated standards.

A comparison of the CAPs across compliance categories highlights areas for quality improvement (QI) activities for UHCCP-CRS. Table 1-1 presents the number and proportion of CAPs required within and across the 11 categories for the compliance standards reviewed for CYE 2014.

¹⁻³ The compliance categories are abbreviated as follows: CIS=Claims and Information Systems, DS=Delivery Systems, ENC=Encounters, GA=General Administration, GS=Grievance Systems, MC=Maternal and Child Health and EPSDT, MM=Medical Management, MI=Member Information, QM=Quality Management, RI=Reinsurance, TPL=Third Party Liability.

Table 1-1—Corrective Action Plans by Category for UHCCP-CRS				
Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	13	8	61.5%	33.3%
Delivery Systems	9	1	11.1%	4.2%
Encounters	1	0	0.0%	0.0%
General Administration	9	2	22.2%	8.3%
Grievance Systems	17	0	0.0%	0.0%
Maternal and Child Health and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	14	4	28.6%	16.7%
Medical Management	20	0	0.0%	0.0%
Member Information	8	3	37.5%	12.5%
Quality Management*	33	5	15.2%	20.8%
Reinsurance	4	1	25.0%	4.2%
Third Party Liability	8	0	0.0%	0.0%
Overall	136	24	17.6%	100%

*For one CAP that was required in this category, the corresponding standard was scored in full compliance.

Table 1-1 shows that 17.6 percent of the OR standards reviewed during CYE 2014 required a CAP. The largest number of required CAPs (eight) was in the Claims and Information Systems category. These results were followed by five CAPs required for the Quality Management category, though the large number of standards within this category (i.e., 33) could have influenced this result. These results were followed by four CAPs required for the Maternal and Child Health and EPSDT category and three CAPs required for the Member Information category. Together, these four categories represent 83.3 percent of all CAPs. As of January 2015, however, AHCCCS determined that corrective actions were completed and closed for 13 of the 24 standards (54.2 percent).

Conclusions

With 84.6 percent of standards in full or substantial compliance and only 8.1 percent in noncompliance, the CYE 2014 UHCCP-CRS OR found positive results overall. The majority of CAPs were related to monitoring, reporting, and communications processes.

Recommendations

Based on AHCCCS’ review of the Contractor’s performance in CYE 2014 and the associated opportunities for improvement identified as a result of the OR, HSAG recommends the following:

- ◆ UHCCP-CRS should conduct internal reviews of operational systems to identify barriers that impact compliance with AHCCCS standards. Specifically, the Contractor should cross-reference existing policies and procedures with AHCCCS requirements and ensure, at a minimum, that they are in alignment with both the intent and content of AHCCCS standards.

- ◆ UHCCP-CRS should evaluate current monitoring programs and activities. When deficiencies are noted, the Contractor should take steps to either develop new procedures and review mechanisms, or augment existing ones. In many cases, UHCCP-CRS can apply lessons learned from improving performance for one category of standards to other categories. Specifically, UHCCP-CRS should review CAPs required from earlier ORs or other lines of business to determine best practices for identifying and correcting deficient standards, and monitoring subsequent compliance.

Performance Measures

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

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

Findings

HSAG's validation process identified concerns with UHCCP-CRS' process for calculating and producing performance measure rates. UHCCP-CRS was not using claims data to produce data for reporting on the performance measure and was also not applying continuous enrollment criteria uniformly for numerator and non-numerator compliant members.

UHCCP-CRS did not meet the AHCCCS' minimum performance measure threshold of 75 percent or the goal of 90 percent for CYE 2013.

Based on the audit findings, the measure-specific rate for the performance measure was considered not reportable.

Conclusions

Overall, UHCCP-CRS' process of calculating the measure did not produce a reportable result. The calculation of the rate did not follow the specifications for identifying services by the ISP date and instead only included members receiving services within 90 days.

Recommendations

HSAG recommends that UHCCP consider using the claims system as the data system for determining numerator compliance since there is legal documentation that a service was rendered. HSAG also recommends that since the source data for the measure calculation is coming from various systems, the source for each record should be listed in the report. UHCCP-CRS could consider using Multi-Specialty Interdisciplinary Clinic (MSIC) data for the purpose of ongoing internal process monitoring and interim reporting since there is a claims lag.

Performance Improvement Projects (PIPs)

HSAG received documentation from AHCCCS regarding UHCCP-CRS' performance on an AHCCCS-mandated PIP. In CYE 2011, AHCCCS approved a new PIP, *Electronic Health Information Performance Improvement Project for Members Receiving Children's Rehabilitative Services*,¹⁻⁴ for the Arizona Department of Health Services (ADHS), the CRS Contractor at that time. UHCCP-CRS opted to continue the PIP when it became the CRS Contractor in January 2011 (CYE 2012).

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

Findings

During CYE 2014, the *EHR* PIP was in the second remeasurement phase, and UHCCP-CRS did not have data for this PIP. While UHCCP-CRS supplied an annual PIP report to AHCCCS for CYE 2014, results from the second remeasurement period were not reported, and the Contractor explained that factors related to encounter data systems contributed to the lack of CYE 2014 data.

While UHCCP-CRS was unable to submit lab claims for the PIP in 2014, it requested a one-year extension of the PIP. AHCCCS granted this request, with the expectation that UHCCP-CRS will supply comprehensive data during the next annual plan submission.

Conclusions

The *EHR* PIP was extended by one year, and results for the first and second remeasurement periods will be presented in future annual reports.

Recommendations

As performance results for this PIP were limited to UHCCP-CRS-supplied narrative documentation, HSAG recommends that AHCCCS validate both 2014 and 2015 reported PIP results following UHCCP-CRS' next annual PIP submission, as no validation was performed this year due to lack of data from the Contractor. This would allow for retrospective validation of Remeasurement 2 and concurrent validation of Remeasurement 3, and provide important information about any real and sustained improvement over the previous two-year period. HSAG further recommends that results of both validation years be included in next year's annual EQR report of results.

¹⁻⁴ This PIP is also referred to as the *Laboratory Data in the Electronic Health Record (EHR)* PIP.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Description

The CAHPS Health Plan Surveys are standardized survey instruments that measure members' satisfaction levels with their healthcare. For 2013, HSAG administered the CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS[®])¹⁻⁵ supplemental set and the Children with Chronic Conditions (CCC) measurement set to UHCCP-CRS child members who met age and enrollment criteria. This survey was administered using a statewide sampling methodology and following standard National Committee for Quality Assurance (NCQA) survey administration protocols.¹⁻⁶ These standard protocols promote the comparability of resulting CAHPS data.

For the CRS program, the results of 16 measures of satisfaction are 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*); five composite measures (*Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making*); and two individual items (*Coordination of Care and Health Promotion and Education*). In addition, five CCC composite measures/items were assessed (*Access to Specialized Services, Family-Centered Care (FCC): Personal Doctor Who Knows Child, Coordination of Care for Children with Chronic Conditions, Access to Prescription Medicines, and FCC: Getting Needed Information*).

Findings

Table 1-2 presents the 2013 general child CAHPS survey results for the statewide CRS program. The table displays the following information: 2013 question summary rates and global proportions, three-point mean scores, and overall 2013 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.^{1-7,1-8}

¹⁻⁵ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

¹⁻⁶ For purposes of the CAHPS survey administered to UHCCP-CRS child members, the age criteria for child members eligible for inclusion in the CAHPS Child Medicaid Health Plan Survey was modified to include members up to 21 years of age or younger as of December 31, 2012. Please note, this deviates from standard NCQA HEDIS specifications, which define eligible child members as 18 years of age or younger as of December 31 of the measurement year.

¹⁻⁷ NCQA national averages for the child Medicaid population were used for comparative purposes. Given the potential differences in the demographics of these populations (i.e., general child Medicaid and CRS), caution should be exercised when interpreting these results.

¹⁻⁸ NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall member satisfaction ratings (i.e., star ratings); therefore, caution should be exercised when interpreting these results.

Table 1-2—General Child CAHPS Results for the CRS Program			
Measure	2013 Rate	Three-Point Mean	Star Rating
Global Ratings			
<i>Rating of Health Plan</i>	61.3%	2.49	★
<i>Rating of All Health Care</i>	66.9%	2.57	★★★★
<i>Rating of Personal Doctor</i>	75.4%	2.70	★★★★★
<i>Rating of Specialist Seen Most Often</i>	77.2%	2.70	★★★★★
Composite Measures			
<i>Getting Needed Care</i>	82.4%	2.37	★★★
<i>Getting Care Quickly</i>	88.3%	2.58	★★
<i>How Well Doctors Communicate</i>	92.7%	2.65	★★
<i>Customer Service</i>	86.9%	2.43	★★
<i>Shared Decision Making</i>	62.0%	NA	NA
Individual Item Measures			
<i>Coordination of Care</i>	81.0%	NA	NA
<i>Health Promotion and Education</i>	67.9%	NA	NA
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th  Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.  Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average. NA indicates results are not available for the CAHPS measure.			
Since NCQA does not provide benchmarking information for the <i>Shared Decision Making</i> composite measure and the <i>Coordination of Care</i> and <i>Health Promotion and Education</i> individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.			
With the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey and changes to the <i>Shared Decision Making</i> composite measure and <i>Health Promotion and Education</i> individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.			

Table 1-3 presents the 2013 CCC CAHPS survey results for the statewide CRS program. The table displays the following information: 2013 question summary rates and global proportions for each of the CAHPS survey measures.¹⁻⁹

¹⁻⁹ Since NCQA does not provide benchmarks and thresholds for the CCC population, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for the CCC CAHPS survey results.

Table 1-3—CCC CAHPS Results for the CRS Program	
Measure	2013 Rate
Global Ratings	
<i>Rating of Health Plan</i>	57.8%
<i>Rating of All Health Care</i>	62.3%
<i>Rating of Personal Doctor</i>	74.9%
<i>Rating of Specialist Seen Most Often</i>	72.7%
Composite Measures	
<i>Getting Needed Care</i>	81.6%
<i>Getting Care Quickly</i>	86.9%
<i>How Well Doctors Communicate</i>	91.8%
<i>Customer Service</i>	87.5%
<i>Shared Decision Making</i>	58.1%
Individual Item Measures	
<i>Coordination of Care</i>	76.9%
<i>Health Promotion and Education</i>	68.2%
CCC Composites and Items	
<i>Access to Specialized Services</i>	64.6%
<i>Family-Centered Care (FCC): Personal Doctor Who Knows Child</i>	86.6%
<i>Coordination of Care for Children with Chronic Conditions</i>	75.5%
<i>Access to Prescription Medicines</i>	88.3%
<i>FCC: Getting Needed Information</i>	89.9%
<p> Indicates a rate 5 percentage points or more above the 2012 NCQA CAHPS national average.</p> <p> Indicates a rate 5 percentage points or more below the 2012 NCQA CAHPS national average.</p>	
<p>With the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey and changes to the <i>Shared Decision Making</i> composite measure and <i>Health Promotion and Education</i> individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.</p>	

Conclusions

Based on the evaluation of the overall member satisfaction ratings (i.e., star ratings) for the general child population, priority assignments were assigned for each CAHPS measure.¹⁻¹⁰ The priority assignments are grouped into four main categories for QI: top, high, moderate, and low priority, and are based on the results of the NCQA comparisons. Table 1-4 shows how the priority assignments were determined on each CAHPS measure.

¹⁻¹⁰ The priority assignments are based on the CRS program’s general child CAHPS survey results, since NCQA does not provide benchmarks and thresholds for the CCC population.

Table 1-4—Derivation of Priority Assignments on Each CAHPS Measure	
NCQA Comparisons (Star Ratings)	Priority Assignment
★	Top
★★	High
★★★	Moderate
★★★★	Low
★★★★★	Low
NCQA does not provide benchmarking information for the <i>Shared Decision Making</i> composite measure and the <i>Coordination of Care and Health Promotion and Education</i> individual item measures; therefore, priority assignments could not be derived for these measures.	

Based on the overall member satisfaction ratings, the measures identified as areas of top and high priority are the specific areas that should be targeted for QI initiatives. The top and high priority areas identified for QI were *Rating of Health Plan*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

Recommendations

Based on the CAHPS survey measures results, 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*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

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 parents’/caretakers’ (of child members) satisfaction under the *Getting Care Quickly* measure, QI activities should target decreasing no-show appointments, using electronic communication, and using open access scheduling. To improve parents’/caretakers’ (of child members) satisfaction under the *How Well Doctors Communicate* measure, QI activities should focus on communication tools, improving health literacy, and identifying language barriers. To improve parents’/caretakers’ (of child members) satisfaction under the *Customer Service* measure, QI activities should target an evaluation of call center hours and creating an effective customer service program.

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 this waiver since 1982 when its Acute Care program began. In December 1988 AHCCCS added the Arizona Long Term Care System (ALTCS) program for individuals with developmental disabilities, and then expanded the program in January 1989 to include the elderly and physically disabled (EPD) populations. In October 1990 AHCCCS began coverage of comprehensive behavioral health services for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Through further expansion, AHCCCS added comprehensive behavioral health coverage for all Medicaid-eligible individuals.

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

The CRS integrated contract was successfully implemented on October 1, 2013. AHCCCS conducted multiple activities over a six-month period from May to October 2013 to ensure a smooth transition for the Contractor, UnitedHealthcare Community Plan.

AHCCCS' Strategic Plan

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

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

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

AHCCCS' Strategic Goals and related Strategies are as follows:

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

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

²⁻¹ 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 Serious Mental Illness [SMI]).
- ◆ Achieve statistically significant improvements on Contractor PIPs.
- ◆ Achieve statistically significant improvements on quality performance measures.
- ◆ Leverage American Indian care management program to improve health outcomes.

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

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

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

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

AHCCCS Quality Strategy

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

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

AHCCCS has had a formal QAPI plan in place since 1994; established and submitted an initial quality strategy to CMS in 2003; and has continued to update and submit revisions of the strategy as needed to CMS. AHCCCS' QAPI strategy was last revised in October 2012. AHCCCS administration oversees the overall effectiveness of its QAPI strategy with several divisions/offices within the agency sharing management responsibilities. For specific initiatives and issues, AHCCCS frequently involves other internal and/or external collaborations/participants.

Quality Strategy Scope, Goals, and Objectives

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

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

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

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

Operational Performance Standards

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

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

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

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

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

Performance Measure Requirements and Targets

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

For all lines of business, AHCCCS has developed new performance measures that became effective October 1, 2013, which aligns with the start of a new five-year contract period for CRS. 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 CYE13 measurement period. Contractors will be given data for planning and

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

Performance Improvement Project Requirements and Targets

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

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

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

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

Selecting and Initiating New Quality Improvement Initiatives

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

In selecting and initiating new quality improvement initiatives, AHCCCS:

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

Collaborates/Initiatives

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

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

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

5. Contractor Best and Emerging Practices

HSAG, through its review of AHCCCS and Contractor documentation, had the opportunity to identify noteworthy UHCCP-CRS 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.

- ◆ **UnitedHealthcare Transitions Platform:** This platform (tool) was launched to reduce emergency room visits, inpatient admissions, and readmissions. The tool automatically notifies medical practices twice a day of admissions and discharges related to inpatient and emergency department visits. If a provider's office enters follow-up visit information, the tool will make calls to patients to remind them of upcoming appointments. Utilization of the platform is open to any contracted practice.
- ◆ **Dental Collaborative:** Created a dental collaborative of several community organizations that provide oral health services in order to better identify and treat health plan members.
- ◆ **Member Advisory Committee (MAC):** The MAC obtains member input and feedback regarding quality initiatives, findings, program changes, and care provided to members. It also serves as a collaborative forum for members, community representatives, advocacy groups, and community-based providers to address member needs.
- ◆ **Provider-focused Activities:** Provider-focused efforts increased during CYE 2014 with provider visits by provider advocates, Accountable Care Communities (ACC) team, and Clinical Practice Consultants (CPC) team to identify members who need follow-up care and to mail providers quarterly gap-in-care reports.
- ◆ **Discharge Planning Assessment:** Conducted discharge planning assessment and a readmission risk assessment tool for all members being discharged. During this assessment, referrals and resources can be offered when appropriate. In addition, a referral is made to the transitional care manager upon discharge if the readmission risk assessment tool score is greater than 13. Any member currently working with a high-risk case manager will have his or her care transitions managed by an assigned case manager who receives notification of an admission.
- ◆ **Initial Visit Auditing Process:** Plan liaisons are embedded in each Multi-Specialty Interdisciplinary Clinic (MSIC), and initial clinic visits found to be noncompliant are audited by verifying the dates of the visit and the particular clinic visited, and determining if any acceptable visit occurred outside the MSIC. Data for each MSIC are then shared, and MSIC staff members have an opportunity to report additional visits found or other information for consideration to the clinic liaison on or before a determined date. The accountability and collaboration experienced during the process resulted in an increased incidence of first CRS service visits being compliant.

6. Organizational Assessment and Structure Performance

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

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

CYE 2013 commenced a new, three-year cycle of ORs, and AHCCCS conducted an OR for the Children's Rehabilitative Services (CRS) contractor, UHCCP-CRS, during CYE 2014.

Conducting the Review

CYE 2013 began a three-year cycle of ORs that will conclude in CYE 2015, and AHCCCS conducted an OR for UHCCP-CRS in CYE 2014.

The CYE 2014 review assessed UHCCP-CRS' performance in the following categories:

- ◆ Claims and Information Systems—(13 standards)
- ◆ Delivery Systems—(nine standards)
- ◆ Encounters (1 standard)
- ◆ General Administration—(nine standards)
- ◆ Grievance Systems—(17 standards)
- ◆ Maternal and Child Health and EPSDT—(14 standards)
- ◆ Medical Management—(20 scored standards and one standard for information only)
- ◆ Member Information—(eight standards)
- ◆ Quality Management—(33 standards)
- ◆ Reinsurance—(four standards)
- ◆ Third Party Liability—(eight standards)

Further details regarding the standards reviewed are listed with the Contractor's results.

Objectives for Conducting the Review

AHCCCS' objectives for conducting ORs are to:

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

HSAG's analysis focused on the following objectives:

- ◆ Determine UHCCP-CRS' compliance with select standards established by AHCCCS to comply with the requirements of the AHCCCS contract and 42 CFR 438.204(g).
- ◆ Analyze data from the review, allowing HSAG to draw conclusions as to the quality and timeliness of, and access to, care and services UHCCP-CRS furnished to its members.
- ◆ Aggregate and assess the AHCCCS-required Contractor corrective action plans (CAPs) to provide an overall evaluation of UHCCP-CRS' performance.

Methodology for Conducting the Review

While AHCCCS reviews the operational and financial performance of the Contractor throughout the year, it also conducts formal reviews on a schedule that ensures it reviews all applicable CMS and AHCCCS contract requirements at least once every three years. AHCCCS follows a CMS-approved process to conduct the ORs that is also consistent with CMS' protocol for EQROs that conduct the reviews.⁶⁻¹

AHCCCS conducted an extensive review of UHCCP-CRS' performance in meeting standards. AHCCCS provided UHCCP-CRS with the following: (1) a detailed description of the contract requirements and expectations for each of the standards that AHCCCS would review, and (2) a list

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

of documents and information that was to be available to AHCCCS for its review during the OR review process.

AHCCCS' methodology for conducting the OR included the following:

- ◆ Review activities that AHCCCS conducted to assess UHCCP-CRS' performance.
 - Reviewing documents and deliverables the Contractor was required to submit to AHCCCS.
 - Conducting interviews with key Contractor administrative and program staff. Reviews generally required three to four days, depending on the extent of the review.
- ◆ Activities AHCCCS conducted following the review, including:
 - Documenting and compiling the results of its review, preparing the draft report of findings, and issuing the draft report to UHCCP-CRS for its review and comment. In the report, each standard and substandard was individually listed with the applicable performance designation based on AHCCCS' review findings and assessment of the degree to which UHCCP-CRS was in compliance with the standards. Performance designations were as follows:
 - Full compliance (FC): 90 percent to 100 percent compliant
 - Substantial compliance (SC): 75 percent to 89 percent compliant
 - Partial compliance (PC): 50 percent to 74 percent compliant
 - Noncompliance (NC): 0 percent to 49 percent compliant
 - Not Applicable (N/A): Standard was not applicable to UHCCP-CRS
 - Information Only (IO): Standard was assessed for information only

The report sent to UHCCP-CRS also included, when applicable, AHCCCS recommendations, which began with one of the following three phrases:

- The Contractor must This statement indicates a critical noncompliant area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
- The Contractor should This statement indicates a noncompliant area that must be corrected to be in compliance with the AHCCCS contract but is not critical to the day-to-day operation of the Contractor.
- The Contractor should consider This statement is a suggestion by the review team to improve the operations of the Contractor but is not directly related to contract compliance.
- Reviewing and responding to any UHCCP-CRS challenges to AHCCCS' draft report findings and, as applicable based on AHCCCS' review of the challenges, revising the draft report.
- Issuing the final report to UHCCP-CRS describing the findings, scores, and (as applicable) required CAPs for each standard AHCCCS reviewed.

AHCCCS' review team members included employees of the Division of Health Care Management (DHCM) in Acute and ALTCS operations, reinsurance, data analysis and research, medical management, clinical quality management units; and the Office of Administrative Legal Services.

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

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

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

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

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

Using the verified results that AHCCCS obtained from conducting the OR, HSAG organized and aggregated the performance data and the required CAPs for UHCCP-CRS. HSAG then analyzed the data by performance category (e.g., Quality Management and Delivery Systems) and by each standard within a category.

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

Findings

UHCCP-CRS has contracted with AHCCCS since January 2011. AHCCCS conducted a full OR in CYE 2014, concurrent with the OR for UHCCP's Acute Care and ALTCS Elderly and Physically Disabled (EPD) lines of business.

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

compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-1—Categorized Levels of Compliance With Technical Standards for UHCCP-CRS⁶⁻²

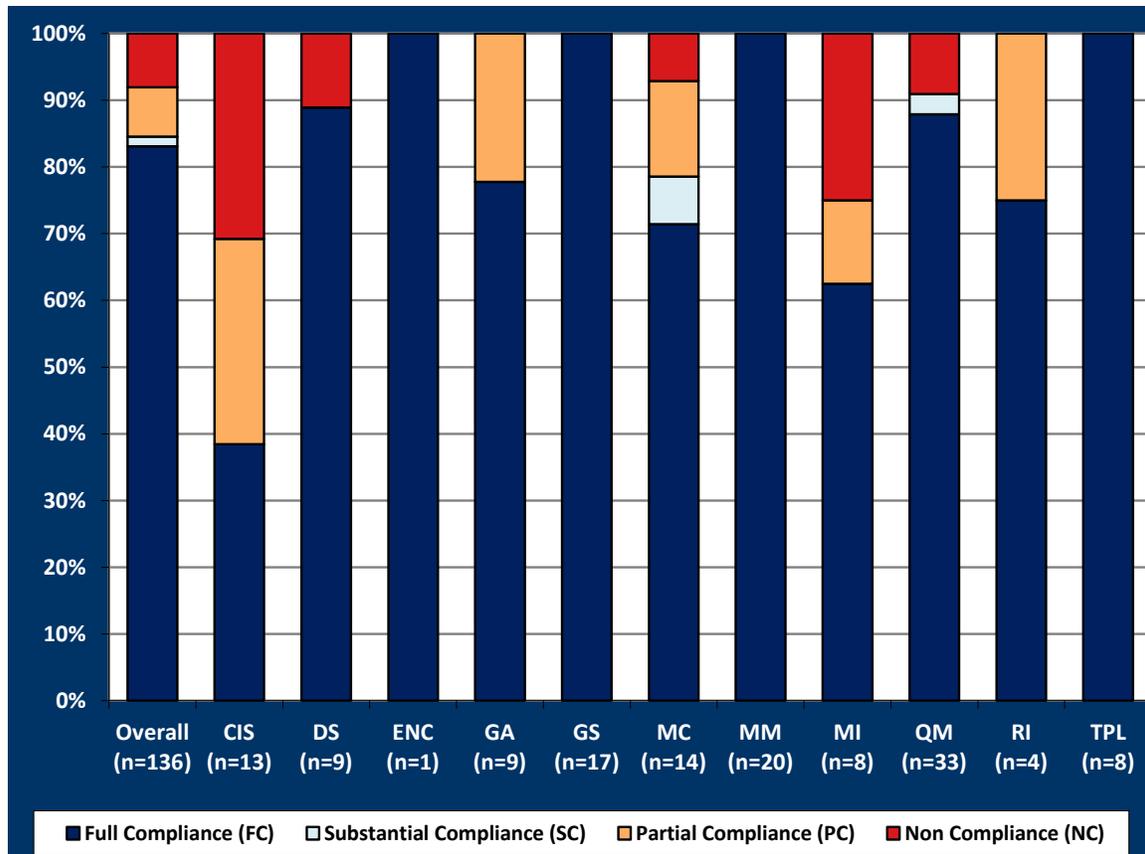


Figure 6-1 shows that UHCCP-CRS was in full compliance for 83.1 percent of the 136 reviewed standards, with moderate variation in performance across the 11 categories of standards. The Contractor’s strongest performance was for the standards associated with Encounters, Grievance Systems, Medical Management, and Third Party Liability. AHCCCS scored these categories as 100 percent fully compliant.

Of the 11 categories of standards, the Claims and Information Systems category showed the lowest percentage of standards in full compliance (38.5 percent). Notably, the Claims and Information Systems and Member Information categories showed opportunities for improvement, with 25 percent or more of their standards scoring as noncompliant. Categories with 75 percent or fewer of the reviewed standards in full compliance include Claims and Information Systems (38.5 percent), Member Information (62.5 percent), Maternal and Child Health and EPSDT (71.4 percent), and

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

Reinsurance (75.0 percent). The results within these categories suggest important opportunities for improvement.

Corrective Action Plans (CAPs)

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop and implement a CAP. Prior to implementation, Contractors submit their proposed CAPs to AHCCCS for review and approval. A Contractor may also be required to enact a CAP for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard, even if the overall standard is scored as fully compliant. Table 6-1 presents the number and proportion of CAPs required from UHCCP-CRS within and across the categories for compliance standards reviewed for CYE 2014.

Table 6-1 presents the overall compliance results for each of the 11 categories of OR standards, including the number and proportion of standards found to be less than fully compliant during the CYE 2014 OR.

Table 6-1—Corrective Action Plans By Category for UHCCP-CRS				
Category	Total # of Standards	Number of CAPs	% of Category Standards	% of Total CAPs
Claims and Information Systems	13	8	61.5%	33.3%
Delivery Systems	9	1	11.1%	4.2%
Encounters	1	0	0.0%	0.0%
General Administration	9	2	22.2%	8.3%
Grievance Systems	17	0	0.0%	0.0%
Maternal and Child Health and EPSDT	14	4	28.6%	16.7%
Medical Management	20	0	0.0%	0.0%
Member Information	8	3	37.5%	12.5%
Quality Management*	33	5	15.2%	20.8%
Reinsurance	4	1	25.0%	4.2%
Third Party Liability	8	0	0.0%	0.0%
Overall	136	24	17.6%	100%

*For one CAP that was required in this category, the corresponding standard was scored in full compliance.

Table 6-1 shows that, based on the CYE 2014 review results, 17.6 percent of the standards required corrective action. The Claims and Information Systems category had the largest number of standards requiring improvement (eight). Four categories (Claims and Information Systems, Maternal and Child Health and EPSDT, Member Information, and Quality Management) had three or more standards that required corrective action during the CYE 2014 OR. These results suggest continued opportunities for improvement.

Strengths

UHCCP-CRS showed strength in Grievance Systems, Medical Management, and Third Party Liability, all of which had 100 percent of their assessed standards scored as fully compliant. Though the Encounters category was also fully compliant, only one standard was evaluated for this OR.

Opportunities for Improvement and Recommendations

The findings demonstrated opportunities for improvement, as 24 of the standards reviewed (17.6 percent) remained less than fully compliant with AHCCCS' required policies and procedures or required corrective action. Within the Claims and Information Systems category, eight standards were less than fully compliant. Two other areas for improvement included Quality Management, with five out of 33 standards requiring corrective action, and Maternal and Child Health and EPSDT, which had four out of 14 standards below full compliance. As of January 2015, AHCCCS determined that corrective actions were completed and closed for 13 of the 24 standards (54.2 percent).

In the report generated from the Contactor's OR, AHCCCS included a list of recommendations. HSAG's review of these recommendations highlighted the following findings, with notations regarding completed corrective action plans:

◆ **Claims Information System:**

Completed Corrective Actions as of January 2015

- The Contractor must inform providers of the appropriate address for the submission of medical records associated with claims.
- The Contractor must ensure its policies and procedures include the request for approval to AHCCCS of cumulative recoupment in excess of \$50,000, for the contract year, from one provider or Tax Identification Number; and the request for approval to AHCCCS of any cumulative recoupment greater than 12 months after the date of the original payment, from one provider or Tax Identification Number.
- The Contractor must ensure enrollment and eligibility data provided by AHCCCS are accurately integrated in a timely manner.
- The Contractor must ensure that the Contractor's information system contains and pays the corrected contracted rates, and in the absence of a written negotiated rate, it and its subcontractors correctly reimburse providers.

Open Corrective Actions as of January 2015

- The Contractor must ensure its remittance advice includes an adequate description of all denials and adjustments, sufficient reasons for these denials and adjustments, reflects the accurate amount billed, includes information on provider rights for claim disputes, and includes instructions for submitting claim disputes and corrected claims.
- The Contractor must pay 10 percent per annum (calculated daily) on all professional claims paid more than 45 days after the date of receipt of the clean claim submission. The Contractor must pay interest at the rate of 1 percent per month for each portion of a month

following the 60th day of receipt of the clean claim until the date of payment. The Contractor must pay applicable interest on all claims, including overturned claim disputes.

- The Contractor must ensure it processes and pays all overturned claim disputes in a manner consistent with the decision within 15 business days of the decision.
- The Contractor must ensure that it accurately accepts and integrates provider registration data, and appropriately applies this information to its claim edit process.

◆ **Delivery Systems:**

Completed Corrective Actions as of January 2015

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

◆ **General Administration:**

Completed Corrective Actions as of January 2015

- The Contractor must revise its policies and procedures to include that required information is collected for all persons with an ownership or control interest in the Contractor and its fiscal agents, and determines on a monthly basis whether such individuals have been convicted of a criminal offense related to any program under Medicare, Medicaid, or the Title XXI services program (including the subcomponents of this standard). (Note: No CAP was required for this recommendation, as the associated standard was scored as fully compliant).
- The Contractor must revise its policies to reflect that procedures are also reviewed on an annual basis. Additionally, the Contractor must demonstrate that all policies and procedures have been reviewed annually.

Open Corrective Actions as of January 2015

- The Contractor must ensure that it performs regular audits of the organization to mitigate fraud and abuse.

◆ **Maternal and Child Health and EPSDT:**

Completed Corrective Actions as of January 2015

- The Contractor should have a process to monitor that providers document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services. The Contractor should have a process to monitor the medical necessity for sterilizations of members under 21 years of age.

Open Corrective Actions as of January 2015

- The Contractor should implement a process to coordinate services with the Women, Infants and Children or the Head Start programs.
- The Contractor should monitor, evaluate, and implement interventions aimed at reducing the number of members on a wait list for services. The Contractor must have and implement a process to coordinate with the Arizona Early Intervention Program (AzEIP) utilizing the AHCCCS/AzEIP procedure.
- The Contractor must demonstrate evidence of monitoring provider compliance in implementing interventions for members identified as being overweight, such as educational materials or nutrition referrals.

◆ **Member Information:**

Completed Corrective Actions as of January 2015

- The Contractor must ensure that it notifies affected members in a timely manner when a PCP or frequently utilized provider leaves the network.
- The Contractor should create a policy and procedure outlining notification of members when a material network change occurs. The Contractor must demonstrate that it issues member notification to affected members 30 days prior to implementing any material changes.
- The Contractor must distribute, at a minimum, two member newsletters per contract year which contain the required member information.

◆ **Quality Management:**

Completed Corrective Actions as of January 2015

- The Board of Directors of Arizona Physicians IPA, Inc., must approve the Quality Management/Quality Improvement (QM/QI) Plan, the oversight of the QM/QI Program, and its quality assessment and improvement activities in a timely manner.
- The Contractor must monitor primary care provider (PCP) medical management of behavioral health disorders. This oversight must include representation of the Contractor's CRS members.

Open Corrective Actions as of January 2015

- The Contractor must expand medical record review processes to all contracted providers that meet the criteria in the AHCCCS Medical Policy Manual (AMPM), Chapter 900.
- The Contractor must have the Behavioral Health Medical Professionals (BHMP) audit tool and process that meets the AMPM, Chapter 900 requirements implemented by September 30, 2014.
- The Contractor must have the BHMP audit tool and process that conforms to AMPM requirements implemented by September 30, 2014.

◆ **Reinsurance:**

Completed Corrective Actions as of January 2015

- The Contractor should develop procedures to ensure services were encountered correctly.

Summary

UHCCP-CRS had generally positive results in its CYE 2014 OR. Of the 136 standards reviewed, 113 were fully compliant (83.1 percent), and four of the 11 categories were scored with 100.0 percent of standards in full compliance. The Contractor was required to submit CAPs for 24 standards (17.6 percent), and the Claims and Information Systems, Member Information, Reinsurance, and Maternal and Child Health and EPSDT categories presented the greatest opportunities for improvement. Each of these categories had at least 20 percent of its standards scoring less than fully compliant. However, more than half of the required CAPs (54.2 percent) were closed as of January 2015.

7. Performance Measure Performance

Conducting the Review

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with managed care organizations (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 external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA) described at 42 Code of Regulations (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 external quality review organization (EQRO), can perform this validation. AHCCCS contracted with HSAG, an EQRO, to conduct the validation activities.

AHCCCS contracted with UnitedHealthcare Community Plan (UHCCP) to provide Children's Rehabilitative Services (CRS) to eligible Medicaid members. AHCCCS required UHCCP-CRS to calculate and report performance measure rates during fiscal year (FY) 2013. UHCCP-CRS was required to report data for the July 2012–September 2013 time period.

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 UHCCP-CRS.
- ◆ Determine the extent to which the specific performance measures calculated by UHCCP-CRS 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 UHCCP-CRS 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, 2012.⁷⁻¹

⁷⁻¹ *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 UHCCP-CRS 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 UHCCP-CRS during the pre-on-site phase.

Prior to the on-site visit, HSAG provided UHCCP-CRS 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 UHCCP-CRS 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)—UHCCP-CRS 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—UHCCP-CRS 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—UHCCP-CRS 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 UHCCP-CRS. 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 UHCCP-CRS 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 UHCCP-CRS 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. AHCCCS provided the specifications that UHCCP-CRS was required to use for calculation of the performance measure. HSAG validated the following performance measure:

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

Results/Findings

HSAG organized and analyzed validated performance measure data to draw conclusions about UHCCP-CRS' performance in providing quality, accessible, and timely care and services to its CRS members. HSAG did not include performance measure result calculations in its report to AHCCCS, because the rates were not reportable due to material bias in the calculation of the measure.

HSAG found that UHCCP-CRS did not have appropriate data integration and performance measure documentation to report valid rates.

UHCCP-CRS had an adequate process in place to ensure that a record did not already exist for the member prior to creating a new one; however, no quality oversight processes were in place to ensure the accuracy of data entry of enrollment information.

HSAG noted a lack of system edits to ensure capture of the initial visit target date. In addition, the initial visit target date was a modifiable field, meaning it could be changed after the initial visit target date was established.

The audit team identified that the continuous enrollment criteria of 90 days was not applied by UHCCP-CRS correctly. UHCCP-CRS identified that enrollment for Medicaid is checked only for members who did not receive the CRS visit within 90 days. Continuous enrollment criteria are not applied to members who had received their visit within 90 days. There is a concern that this may have inflated the rate by including numerator positive members who no longer had Medicaid.

The ISP process was demonstrated during primary source verification with a field to capture the ISP needed visit date. The plan is only calculating compliance for the measure from the time of enrollment to a CRS visit within 90 days. The interpretation of the specification as outlined by AHCCCS for compliance would be a visit prior to or on the date of the ISP date and if there is no date identified then within 90 days. The impact to the measure rate is that it is overinflated.

Members identified as noncompliant for the measure were sent to the Multi-Specialty Interdisciplinary Clinics (MSICs) for further intervention and research. UHCCP-CRS uses the information provided by the MSIC as submitted on the spreadsheet as the data to produce the rates. The audit of the process noted that the validity of the rates rests on the data being obtained from the MSIC sites and can lend itself to error.

CAPs

HSAG identified no corrective action taken by AHCCCS related to performance measures during the review period.

It was noted that UHCCP-CRS did not meet the AHCCCS' minimum performance measure threshold of 75 percent or the goal of 90 percent for CYE 2013.

Strengths

UHCCP-CRS had an active process to collect data for the purposes of reporting the measure. The UHCCP-CRS team stated that the reason that claims data were not used and a workaround had been instituted was because of a claims lag in receipt of data from providers.

UHCCP-CRS had a strong focus on ensuring that multiple avenues of data collection were employed to obtain data for measure compliance.

Opportunities for Improvement

HSAG noted opportunities for improvement regarding the quality oversight process to ensure the accuracy of data entry processing of enrollment information.

UHCCP-CRS designed a proprietary system called Diamond to house claims, encounter, and membership data. However, data from the Diamond system were not used for UHCCP-CRS reporting except as supplemental data. HSAG recommends that because the Diamond system allows for automated processing of the 834 files, the continuous enrollment criterion be verified using

eligibility data obtained from the Diamond system rather than from the Service Activity Manager (SAM) database. Otherwise, UHCCP-CRS needs to be able to demonstrate reconciliation between the two systems.

Since the claims system provides legal documentation that a service was rendered, HSAG recommends that UHCCP-CRS consider using the claims system as the data system for determining numerator compliance. The MSIC data could still be used for ongoing process monitoring and interim reporting since there is a claims lag.

The specifications required UHCCP-CRS to make some interpretation and assumptions, which created some questions as to whether the rates were calculated as AHCCCS intended. For example, the measure indicates “within 90 days.” The specification could be made clearer to state before or on the 90th day or less than 91 days. In addition, the specifications do not specify what should be the anchor for the measure for the reporting time frame. UHCCP-CRS interpreted the specification with the assumption that it uses enrollment plus the 90 days when reporting the rate; therefore, the rate represents members enrolled from July 2012–August 2013.

Summary

HSAG’s key findings and recommendations are as follows:

Findings:

- ◆ Continuous enrollment was not properly calculated by UHCCP-CRS.
- ◆ The calculation of the rate did not follow the specifications for identifying services by the ISP date and instead only included members receiving services within 90 days.
- ◆ Primary source verification showed that the visit provided by the MSIC could not be validated in claims.

Recommendations:

- ◆ In future measure calculations, UHCCP-CRS needs to identify the eligible population, applying continuous enrollment before looking for numerator compliance.
- ◆ UHCCP-CRS should use eligibility data from its Diamond system rather than the SAM database since the Diamond system allows for automated processing of the 834 files, or the Contractor needs to be able to demonstrate reconciliation between the two systems.
- ◆ UHCCP-CRS should consider using the claims system as the data system for determining numerator compliance since there is legal documentation that a service was rendered.
- ◆ UHCCP-CRS could consider using MSIC data for ongoing internal process monitoring and interim reporting since there is a claims lag.

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 performance improvement projects (PIPs) designed to achieve favorable effects on health outcomes and member satisfaction; and (2) focuses on clinical and/or nonclinical areas that involve the following:

- ◆ Measuring performance using objective quality indicators
- ◆ Implementing system interventions to achieve improvement in quality
- ◆ Evaluating the effectiveness of 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 in the aggregate to produce new information on quality of care each year.

One of the three EQR-related activities mandated by the federal Medicaid managed care requirements and described at 42 CFR 438.358(b)(1) is the annual validation of MCO and PIHP PIPs required by a state and underway during the preceding 12 months. The requirement at 42 CFR 438.358(a) allows a state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory and optional EQR-related activities. AHCCCS typically conducts the functions associated with 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 EQR report. However, due to significant data processing/system changes and challenges for this Contractor and its laboratory services vendor, UHCCP-CRS was unable to report data to AHCCCS for PIP validation for the period under review. AHCCCS granted UHCCP-CRS a one-year extension with the expectation that the Contractor will provide comprehensive data for the next annual PIP submission.

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 approved a new PIP, *Electronic Health Information Performance Improvement Project for Members Receiving Children's Rehabilitative Services*,⁸⁻¹ for the Arizona Department of Health Services, the children's rehabilitative services (CRS) Contractor at that time. UnitedHealthcare Community Plan (UHCCP-CRS) opted to continue the PIP when it became the CRS Contractor in January 2011 (CYE 2012).

The measurement periods for data collection are as follows:

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

This is an ongoing PIP and will continue into CYE 2015.

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 data process for encounters beginning in CYE 2014, combined with a lack of laboratory data submitted by the Contractor, resulted in a lack of data for this PIP's second remeasurement period. 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 UHCCP-CRS' 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 UHCCP-CRS and AHCCCS.

Results

AHCCCS provided to HSAG its CYE 2014 Contractor PIP Report for CRS for the *Electronic Health Information Performance Improvement Project for Members Receiving Children's Rehabilitative Services (EHR)*. The PIP initially focused on system development and implementation to advance the use of electronic health records by CRS providers. Progress toward these goals was measured by assessing the percentage of CRS members with lab data in the EHR system within 90 days of enrollment into CRS. During its four-year existence, however, this PIP has

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

been impacted by advances in EHR technology coupled with contractual changes by CRS (e.g., a transition from multiple lab vendors to a single vendor).

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

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

While the Contractor was unable to submit lab claims for the PIP in 2014, it requested a one-year extension of the PIP. This request was granted by AHCCCS, with the expectation that UHCCP-CRS will supply comprehensive data during the next annual PIP submission.

Findings

Baseline and first remeasurement results for the *EHR* PIP for UHCCP-CRS were presented in previous annual EQR reports (AHCCCS contracted with a different EQRO for previous reports). Results for the second remeasurement period were not available from the Contractor for this report. Narrative descriptions in the Contractor's annual PIP report indicated that UHCCP-CRS monitored the status of the lab data necessary for this PIP during CYE 2014 and conducted root cause analyses to identify the source of the data deficiencies.

Strengths

HSAG recognizes a strength for UHCCP-CRS in continuing to pursue this PIP based on the value to members and providers of having direct, timely access to lab data values in the EHR system.

Opportunities for Improvement and Recommendations

As performance results for this PIP were limited to UHCCP-CRS-supplied narrative documentation, HSAG recommends that AHCCCS validate both 2014 and 2015 reported PIP results following UHCCP-CRS' next annual PIP submission, as no validation was performed this year due to lack of data from the Contractor. This would allow for retrospective validation of Remeasurement 2 and concurrent validation of Remeasurement 3, and provide important information about any real and sustained improvement over the previous two-year period. HSAG further recommends that results of both validation years be included in next year's annual EQR report of results.

Summary

Performance results for the second remeasurement period of the *EHR* PIP for UHCCP-CRS were not supplied to AHCCCS by the Contractor, and the PIP has been extended by one year.

9. Consumer Assessment of Healthcare Providers and Systems

In CYE 2013, as an optional EQR activity, AHCCCS elected to conduct member satisfaction surveys of child Medicaid members enrolled in the AHCCCS CRS program (UHCCP-CRS was the Contractor for the program). AHCCCS contracted with HSAG to administer and report the results of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Surveys. The *2013 Children's Rehabilitative Services Program Member Satisfaction Report* presented statewide aggregate child Medicaid CAHPS survey results for the CRS program. This section of the EQR technical report presents a summary of those report findings.

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 CAHPS surveys of child Medicaid members served by UHCCP-CRS. The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on parents'/caretakers' (of UHCCP-CRS child 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 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the Children with Chronic Conditions (CCC) measurement set to child members. Child members eligible for the survey had to be 21 years or younger as of December 31, 2012.⁹⁻¹

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

⁹⁻¹ For purposes of the 2013 CAHPS survey, the age criteria for UHCCP-CRS child members eligible for inclusion in the CAHPS Child Medicaid Health Plan Survey was modified to include members up to 21 years of age or younger as of December 31, 2012. Please note, this deviates from standard NCQA HEDIS specifications, which define eligible child members as 17 years of age or younger as of December 31 of the measurement year.

The CAHPS 5.0 Child Medicaid Health Plan Survey with HEDIS supplemental and CCC measurement sets includes 83 core questions that yield 16 measures of satisfaction. These measures include four global ratings, five composite measures, two individual item measures, and five CCC composite measures/items. 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 UHCCP-CRS program’s general child 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.⁹⁻² The resulting three-point mean scores were compared to NCQA’s HEDIS Benchmarks and Thresholds for Accreditation.⁹⁻³ 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:^{9-4,9-5}

⁹⁻² National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

⁹⁻³ National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, July 24, 2013.

⁹⁻⁴ NCQA does not provide benchmarks and thresholds for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual measures; therefore, overall member satisfaction ratings could not be determined for these CAHPS measures.

⁹⁻⁵ NCQA does not provide benchmarks and thresholds for the CCC population; therefore, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) could not be determined for the CCC population.

- ★★★★★ 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

The survey findings for the general child and CCC populations were compared to 2012 NCQA CAHPS Child Medicaid national averages. For the 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.⁹⁻⁶

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 Child CAHPS Health Plan Survey in August 2012, which is referred to as the CAHPS 5.0H Child Health Plan Survey. As a result of the transition from the CAHPS 4.0H to the CAHPS 5.0H Child 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

HSAG calculated general child and CCC CAHPS Survey results for the statewide CRS program in aggregate. The following sections describe HSAG's findings, conclusions, and recommendations.

⁹⁻⁶ For the general child population CAHPS survey results, NCQA national averages for the child Medicaid population were used for comparative purposes. Given the potential differences in the demographics of these populations (i.e., general child Medicaid and CRS), caution should be exercised when interpreting these results.

Results/Findings

Table 9-1 presents the 2013 CAHPS survey results for the statewide CRS program’s general child population. The table displays the following information: measure, 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.^{9-7, 9-8, 9-9}

Table 9-1—General Child CAHPS Results for UHCCP-CRS			
Measure	2013 Rate	Three-Point Mean	Star Rating
Global Ratings			
<i>Rating of Health Plan</i>	61.3%	2.49	★
<i>Rating of All Health Care</i>	66.9%	2.57	★★★★
<i>Rating of Personal Doctor</i>	75.4%	2.70	★★★★★
<i>Rating of Specialist Seen Most Often</i>	77.2%	2.70	★★★★★
Composite Measures			
<i>Getting Needed Care</i>	82.4%	2.37	★★★
<i>Getting Care Quickly</i>	88.3%	2.58	★★
<i>How Well Doctors Communicate</i>	92.7%	2.65	★★
<i>Customer Service</i>	86.9%	2.43	★★
<i>Shared Decision Making</i>	62.0%	NA	NA
Individual Item Measures			
<i>Coordination of Care</i>	81.0%	NA	NA
<i>Health Promotion and Education</i>	67.9%	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 for the general child population revealed that UHCCP-CRS scored:

- ◆ At or above the 90th percentile on two measures: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*.

⁹⁻⁷ NCQA’s benchmarks and thresholds for the child Medicaid population were used to derive the overall member satisfaction ratings (i.e., star ratings); therefore, caution should be exercised when interpreting these results.

⁹⁻⁸ Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

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

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

Table 9-2 presents the 2013 CAHPS survey results for the statewide CRS program’s CCC population. The table displays the 2013 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response) for each of the CAHPS survey measures.^{9-10, 9-11}

Table 9-2—CCC CAHPS Results for UHCCP-CRS	
Measure	2013 Rate
Global Ratings	
<i>Rating of Health Plan</i>	57.8%
<i>Rating of All Health Care</i>	62.3%
<i>Rating of Personal Doctor</i>	74.9%
<i>Rating of Specialist Seen Most Often</i>	72.7%
Composite Measures	
<i>Getting Needed Care</i>	81.6%
<i>Getting Care Quickly</i>	86.9%
<i>How Well Doctors Communicate</i>	91.8%
<i>Customer Service</i>	87.5%
<i>Shared Decision Making</i>	58.1%
Individual Item Measures	
<i>Coordination of Care</i>	76.9%
<i>Health Promotion and Education</i>	68.2%
CCC Composites and Items	
<i>Access to Specialized Services</i>	64.6%
<i>Family-Centered Care (FCC): Personal Doctor Who Knows Child</i>	86.6%
<i>Coordination of Care for Children with Chronic Conditions</i>	75.5%
<i>Access to Prescription Medicines</i>	88.3%
<i>FCC: Getting Needed Information</i>	89.9%
 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.	

⁹⁻¹⁰ Since NCQA does not provide benchmarking information for the CCC population, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

⁹⁻¹¹ With the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2012 NCQA national averages are not available for these measures; thus, comparisons to NCQA national data could not be performed.

The question summary rates and global proportions for the CCC population revealed that the UHCCP-CRS program scored:

- ◆ At or above the national average on five measures: *Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Customer Service, and FCC: Getting Needed Information.*
- ◆ Below the national average on nine measures: *Rating of Health Plan, Rating of All Health Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Access to Specialized Services, FCC: Personal Doctor Who Knows Child, Coordination of Care of Children with Chronic Conditions, and Access to Prescription Medicines.*

Conclusions

Based on an evaluation of the results for the general child population, the priority areas identified were *Rating of Health Plan, Getting Care Quickly, How Well Doctors Communicate, and Customer Service.*

Recommendations

HSAG identified recommendations for improvement for UHCCP-CRS based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted by UHCCP-CRS 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 UHCCP-CRS program could 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 could be developed and tested where a nurse or physician assistant contacts the patient by phone two weeks prior to when the follow-up visit would have occurred to determine whether the patient's current status and condition warrants an in-person visit, and if so, schedule the appointment at that time.

Health Plan Operations—It is important for UHCCP-CRS to view its organization as a collection of microsystems (such as providers, administrators, and other staff who provide services to members) that provide UHCCP-CRS' 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 health plan staff to provide high-quality, patient-centered care.

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

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

Open Access Scheduling—UHCCP-CRS could encourage providers to explore open access scheduling. An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician’s schedule open for same-day appointments. Open access scheduling has been shown to have the following benefits: (1) reduces delays in patient care; (2) increases continuity of care; and (3) decreases wait times and number of no-shows resulting in cost savings.

HOW WELL DOCTORS COMMUNICATE

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

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

Language Barriers—UHCCP-CRS 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.

CUSTOMER SERVICE

Call Centers—An evaluation of current call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center can be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

Creating an Effective Customer Service Training Program—UHCCP-CRS efforts to improve customer service should include implementing a training program to meet the needs of the program's unique work environment. Direct patient feedback should be disclosed to employees to emphasize why certain changes need to be made. Additional recommendations from employees, managers, and business administrators should be provided to serve as guidance when constructing the training program. It is important that employees receive direction and feel comfortable putting new skills to use before applying them within the work place.