



**B.24 – Current External Quality Review Organization  
& Copy of CAP**

MERCY CARE PLAN  
ACUTE  
AHCCCS OPERATIONAL AND FINANCIAL REVIEW  
CONTRACT YEAR ENDING 2009



March 16, 2009-March 18, 2009

Conducted by the Arizona Health Care Cost Containment System



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

**TABLE OF CONTENTS**

**INTRODUCTION.....3**

**STAFF PARTICIPATION .....4**

**SCORING METHODOLOGY .....11**

**QUALITATIVE SUMMARY OF FINDINGS.....12**

**QUANTITATIVE SUMMARY OF FINDINGS.....15**

**MEMBER INFORMATION AND ADMINISTRATIVE SERVICES.....24**

**CASE MANAGEMENT.....33**

**MEDICAL MANAGEMENT.....45**

**AUTHORIZATION AND GRIEVANCE SYSTEM.....64**

**MATERNAL AND CHILD HEALTH AND EPSDT .....107**

**QUALITY MANAGEMENT .....124**

**DELIVERY SYSTEMS AND PROVIDER RELATIONS.....165**

**FINANCIAL MANAGEMENT .....173**

**CLAIMS AND INFORMATION SYSTEMS .....180**

**ENCOUNTERS AND REINSURANCE .....189**



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

**INTRODUCTION**

The Arizona Health Care Cost Containment System (AHCCCS) has served Arizona's most needy since 1982. The Agency's vision is "to shape tomorrow's managed care system with today's experience, quality and innovation." As a component of achieving this vision, AHCCCS regularly reviews its Contractors to ensure that their operations, finances and performance are in compliance with Federal and State law; rules and regulations; and the AHCCCS Contract. The reviewers use a process approved by the Centers for Medicare and Medicaid Services (CMS) based upon the terms of the contract with AHCCCS.

The primary objectives of the Mercy Care Plan CYE09 Operational and Financial Review are to:

- Determine if the Contractor satisfactorily meets AHCCCS' requirements as specified in the Acute Care contract YH09-0001, AHCCCS policies and the Arizona Administrative Code.
- Increase AHCCCS knowledge of the Contractor's operational and financial procedures.
- Provide technical assistance and identify areas where improvements can be made; as well as identifying areas of noteworthy performance and accomplishments.
- Review progress in implementing recommendations made during prior Reviews.
- Determine if the Contractor is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures.
- Perform Contractor oversight as required by the CMS in accordance with AHCCCS' 1115 waiver.
- Provide information to an External Quality Review Organization (EQRO) for its use as described in 42 CFR 438.364.

A copy of this report was provided to the Contractor for review on June 3, 2009. The Contractor is given a period of two weeks in which to file a challenge to any findings it does not feel are accurate based on the evidence available at the time of review.

After this challenge period, the Final Report was issued to the Contractor on June 25, 2009. Upon issuance of the Final Report, the Contractor is required to maintain the confidentiality of the information, including the standard criteria and findings of the Review Team until such time as AHCCCS determines; in order to maintain the integrity of the process until all Contractors have been reviewed.



**AHCCCS OFR Standards  
 CYE 2009  
 MERCY CARE PLAN  
 EXECUTIVE SUMMARY**

**STAFF PARTICIPATION**

The CYE09 AHCCCS Review Team included employees of the Division of Health Care Management (DHCM) in: Acute Care, Reinsurance, Data Analysis and Research, Medical Management, Clinical Quality Management; and the Office of Administrative Legal Services (OALS).

AHCCCS STAFF PARTICIPATION	NAME	TITLE
MEMBER INFORMATION AND ADMINISTRATIVE SERVICES	Elizabeth Stackfleth	Compliance Officer
	John Black	Compliance Officer
	P.J. Schoenstene	Compliance Officer
	Rodd Mas	Acute Operations Manager
	Carla Kot	HCG Assistant Director
	Mary Steigenwald	HCG Assistant Director
CASE MANAGEMENT	Carol Sanders	Case Manager
	John Black	Compliance Officer
MEDICAL MANAGEMENT	Linda Vrabel	Medial Management Specialist
	Maureen Wade	Medical Management Manager
	Elizabeth Stackfleth	Acute Compliance Officer
	Rodd Mas	Acute Operations Manager
	Carla Kot	HCG Assistant Director
	Mary Steigenwald	HCG Assistant Director
AUTHORIZATION AND GRIEVANCE SYSTEM	Elizabeth Stackfleth	Compliance Officer
	John Black	Compliance Officer
	Rodd Mas	Acute Operations Manager
	Maureen Wade	Medical Management Manager
	Linda Vrabel	Medical Management Specialist



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

AHCCCS STAFF PARTICIPATION	NAME	TITLE
	Joseph Ruiz Carla Kot Mary Steigerwald	Hearing Officer HCG Assistant Director HCG Assistant Director
MATERNAL AND CHILD HEALTH AND EPSDT	Gloria Navarro-Valverde Connie Williams Kim Elliott Elizabeth Stackfleth Rodd Mas Carla Kot Mary Steigerwald	MCH Specialist  Supervisor, CQM Manager, CQM Acute Compliance Officer Acute Operations Manager HCG Assistant Director HCG Assistant Director
CLINICAL QUALITY MANAGEMENT	Charles LeVancier Rochelle Tigner Connie Williams Susan Luark Kim Elliott Alexandra O'Hannon Elizabeth Stackfleth Rodd Mas Carla Kot Mary Steigerwald	Specialist, CQM Quality Improvement Manager Supervisor, CQM Supervisor, CQM Manager, CQM Behavioral Health Manager Acute Compliance Officer Acute Operations Manager HCG Assistant Director HCG Assistant Director
DELIVERY SYSTEMS AND PROVIDER RELATIONS	Elizabeth Stackfleth John Black P.J. Schoenstene Rodd Mas Carla Kot	Compliance Officer Compliance Officer Compliance Officer Acute Care Operations Manager HCG Assistant Director



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

AHCCCS STAFF PARTICIPATION	NAME	TITLE
	Mary Steigerwald	HCG Assistant Director
CLAIMS AND INFORMATION SYSTEMS	David Bjorn Lori Petre	Compliance Officer Data & Research Manager
ENCOUNTERS AND REINSURANCE	Brent Ratterree Patricia Peers	Encounter Manager Reinsurance Supervisor



**AHCCCS OFR Standards  
 CYE 2009  
 MERCY CARE PLAN  
 EXECUTIVE SUMMARY**

**Mercy Care Plan**  
 4350 E. Cotton Center Blvd.  
 Building D  
 Phoenix, AZ 85040

Mercy Care Plan has been contracted with AHCCCS since 1983 for the acute program and serves eligible enrolled member in the following Geographic Service Areas (GSA) by program:

**ACUTE**

GSA 14	Cochise Graham Greenlee
GSA 13	Maricopa
GSA 10	Pima (capped)

CONTRACTOR STAFF PARTICIPATION		NAME	TITLE
MEMBER INFORMATION AND ADMINISTRATIVE SERVICES		Cathy Waldbillig	Director Member and Enrollment Services
		Brian Horgeshimer Kristine Newman	Compliance Officer Compliance Manager
CASE MANAGEMENT		Kristine Newman	Compliance Manager
		Brian Horgeshimer Patti Simpson	Compliance Officer Compliance Officer, Schaller Anderson
MEDICAL MANAGEMENT		Gina Confitti, MD Sue Benedetti	Interim Medical Director VP, Medical Management



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

CONTRACTOR STAFF PARTICIPATION	NAME	TITLE
	Juman Abjubara Shauna Sly  Faye Cox Brian Horgeshimer Kristine Newman	VP, QM & Special Programs  Prior Authorization Clinical Supervisor Complaint & Appeal Manager Compliance Officer Compliance Manager
AUTHORIZATION AND GRIEVANCE SYSTEM	Gina Confitti, MD Sue Benedetti Juman Abjubara Shauna Sly  Faye Cox Brian Horgeshimer Kristine Newman	Interim Medical Director VP, Medical Management VP, QM & Special Programs Prior Authorization Clinical Supervisor Complaint & Appeal Manager Compliance Officer Compliance Manager
MATERNAL AND CHILD HEALTH AND EPSDT	Gina Confitti, MD Sue Benedetti Juman Abjubara Dan Jansen Cindy Johnson Nissa Anderson Tad Gary Arlene Warren Terri Wolfgang Kristine Newman Brian Horgeshimer	Interim Medical Director VP, Medical Management VP, QM & Special Programs Director, Prevention & Wellness Manager, Case Management EPSDT Coordinator Behavioral Health Coordinator QM Manager Credentialing Operations Mgr Compliance Manager Compliance Officer



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

CONTRACTOR STAFF PARTICIPATION		NAME	TITLE
		Patti Simpson	Compliance Officer, Schaller Anderson
<b>CLINICAL QUALITY MANAGEMENT</b>		Gina Confitti, MD Sue Benedetti Juman Abjubara Dan Jansen Cindy Johnson Nissa Anderson Tad Gary Arlene Warren Terri Wolfgang Kristine Newman Brian Horgeshimer Patti Simpson	Interim Medical Director VP, Medical Management VP, QM & Special Programs Director, Prevention & Wellness Manager, Case Management EPSDT Coordinator Behavioral Health Coordinator QM Manager Credentialing Operations Mgr Compliance Manager Compliance Officer Compliance Officer, Schaller Anderson
<b>DELIVERY SYSTEMS AND PROVIDER RELATIONS</b>		Penny Marshall  Cathy Waldbillig  Kristine Newman Brian Horgeshimer	Director Network Development & Contracting Director Member and Enrollment Services Compliance Manager Compliance Officer
<b>FINANCIAL MANAGEMENT</b>		N/A	
<b>CLAIMS AND INFORMATION SYSTEMS</b>		N/A	
<b>ENCOUNTERS AND REINSURANCE</b>		N/A	



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

CONTRACTOR STAFF PARTICIPATION		
NAME	TITLE	



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

**SCORING METHODOLOGY**

**The Contractor was scored in each area using the following ratings:**

Full Compliance	The Contractor is 90-100% in compliance with the standard requirements based on weighted findings.
Substantial Compliance	The Contractor is 75-89% in compliance with the standard requirements based on weighted findings.
Partial Compliance	The Contractor is 50-74% in compliance with the standard requirements based on weighted findings.
Non-Compliance	The Contractor is 0-49% in compliance with the standard requirements based on weighted findings.
Not Applicable	The standard does not apply to the Contractor and/or the standard is not a contractual requirement and/or there have been no instances in which the requirement applied.

**Based on the findings of the review, one of three Recommendations were made:**

The Contractor must...	This indicates critical non-compliance in an area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
The Contractor should...	This indicates non-compliance in an area that must be corrected to be in compliance with the AHCCCS contract, but is not critical to the everyday operation of the Contractor.
The Contractor should consider...	This is a suggestion by the Review Team to improve operations of the Contractor, although it is not directly related to contract compliance.

The standards used by the reviewers were provided to the Contractor approximately two weeks prior to the onsite review. The Review Team performed an extensive document review, conducted interviews with appropriate Contractor personnel and observed the staff when necessary. Unless otherwise noted, the Contractor had the appropriate written policies for each of the areas reviewed.



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

**QUALITATIVE SUMMARY OF FINDINGS**

A brief summary and performance assessment of each program area follows:

**Member Information and Administrative Services**

The Contractor is in full compliance with all acute care standards. Grievances are tracked, trended, and analyzed. Telephone performance standards are tracked.

**Case Management**

Overall the Contractor has adequate procedures in place for implementing and monitoring an effective case management program. The Contractor will however have to change their Assisted Living Facility Room and Board procedure to address requirements for minimum R&B charges.

**Medical Management**

The Contractor has included in the Medical Management Meeting minutes as a standing agenda item UM Data analysis; however, there is no documentation of any actions or interventions implemented as a result of the trends found during the analysis.

**Authorization and Grievance System**

The Contractor has processes to timely acknowledge appeals and claim disputes. The appeal and claim dispute process conducted by the Contractor includes documentation of the research and medical reviews. Overturned denials have documentation of authorization updates.

The Contractor has achieved a total Notice of Action Letter audit score of >90% for 3 consecutive months in Acute Care. The Contractor has an adequate process in place for the issuance of a Notice of Extension letter but the letter does not include the date the request will expire in additional information is not received.

**Maternal and Child Health and EPSDT**

The Contractor's efforts to provide quality health care are demonstrated by the Contractor's active participation with state agencies and community partners. The Contractor collaborates with Arizona Early Intervention Program (AZEIP) to educate AZEIP providers in appropriate registration, contracting and billing processes as well as working with TAPI to



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

develop a process to reimburse county health departments for providing services such as immunizations to Medicaid members.

**Clinical Quality Management**

The Contractor has an effective process for verifying the credentials of contracted providers. The medical record review process is well organized via policy and procedure, implementation and corrective action plans when warranted. Consistency in documenting the referral of abuse, neglect and exploitation cases to regulatory agencies would strengthen the contractor's quality of care process. The Contractor is performing well in AHCCCS-mandated Performance Improvement Projects and Performance Measures; however, it must reverse significant declines in the Acute-care measures of Timeliness of Prenatal Care and Chlamydia Screening, and improve all of its Acute-care Performance Measure rates to meet AHCCCS Minimum Performance Standards.

**Delivery Systems and Provider Relations**

The Contractor must update its policies with regard to tracking and trending provider inquiries, in addition to responding to provider inquiries within the contractual required timeframe. Written notices must be sent in a timely manner when the Contractor learns of the resignation of a provider. There is an adequate network of practitioners in the field of eye care.

**Financial Management**

The Contractor is in full compliance with all standards. Quarterly, monthly, and annual financial statements are complete and timely. Claims are paid in a timely manner, and interest is paid appropriately.

**Claims and Information Systems**

The Contractor has established processes and procedures to monitor the accuracy of claims payments and data integrity. Sample sizes for this review do not represent statistically significant appraisal of certain areas such as integration of AHCCCS supplied information; however, the processes to identify and correct errors upon identification are evident.

**Encounters and Reinsurance**

To ensure timely, accurate, and complete submission of encounters, the Contractor has appropriate and integrated systems in place to track and audit encounter data. The Contractor should update all reinsurance desktop procedures and their transplant manual to reflect the current processes required by contract.

**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**





**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

**QUANTITATIVE SUMMARY OF FINDINGS**

KEY	
FC	FULL COMPLIANCE
SC	SUBSTANTIAL COMPLIANCE
PC	PARTIAL COMPLIANCE
NC	NON COMPLIANCE
NA	NOT APPLICABLE
IO	INFORMATIONAL STANDARD IN 2009

SECTION	STANDARD	FINDING	RECOMMENDATION
<b>Member Information and Administrative Services</b>			
	MI 1	FC	None
	MI 2 ( Acute Only)	FC	None
	MI 3 ( Acute Only)	FC	None
	MI 4 (Acute Only)	FC	None
<b>Medical Management</b>			
	MM 1	FC	None
	MM 2	NC	The Contractor must document any actions/interventions and/or any changes made as a result of the actions or interventions based on data reviewed and reported through the Medical Management Committee.
	MM 3	FC	None
	MM 4	FC	The Contractor should consider including testing for consistent application of criteria when evaluating requests for transplant services in their Inter-Rater Reliability testing.
	MM 5	FC	None
	MM 6	PC	The Contractor must evaluate the Practice Guidelines annually through a multi-disciplinary process to determine if the guidelines remain applicable, and represent the best and most current



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

				practice standards.
	MM 7		FC	None
	MM 8		PC	The Contractor must report the interventions and any changes made to those interventions based on the outcomes or evaluation of those interventions. This must be documented in the meeting minutes.
	MM 9		FC	None
	MM 10		FC	None
	MM 11 (Acute Only)		SC	The Contractor must develop the methodology to identify providers willing to provide medical home services and make reasonable efforts to offer access for members to these providers.
<b>Authorization and Grievance System</b>				
	GS 1A (Acute Only)		SC	The Contractor must make the standardized authorization criteria available to members upon request.
	GS 2A (Acute Only)		FC	None
	GS 3A (Acute Only)		FC	None
	GS 4A (Acute Only)		SC	The Contractor should include in policy and procedure that the requesting provider is notified for an order change when an "expedited" authorization request does not meet the criteria for expedited authorization in order to determine why the provider has requested an expedited review.
	GS 5A (Acute Only)		SC	The Contractor must include in their Notice of Extension Letter a statement that the decision will be made as expeditiously as the member's condition requires and no later than the date that the extension is set to expire. The Contractor must include in their Notice of Extension letter the date the request will expire if the additional information is not received.
	GS 6		FC	None
	GS 7		FC	None
	GS 8		FC	None
	GS 9		FC	None



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

GS 10	FC	None
GS 11	FC	None
GS 12	FC	None
GS 13	FC	None
GS 14	FC	None
GS 15	FC	None
GS 16	FC	None
GS 17	FC	None
GS 18	FC	None
GS 19	FC	None
GS 20	FC	None
GS 21	FC	None
GS 22	FC	None
GS 23	FC	None
GS 24	FC	None
GS 25	FC	None
GS 26	FC	None
<b>Maternal and Child Health and EPSDT</b>		
MCH 1	FC	None
MCH 2	FC	None
MCH 3	PC	The Contractor must ensure all primary care providers delivering care to EPSDT aged members utilize the age appropriate EPSDT Tracking Forms during each EPSDT visit and implement processes to ensure those providers not using the EPSDT Tracking Forms are compliant with using the forms.
MCH 4	FC	None
MCH 5	FC	None
MCH 6	SC	The Contractor should have a process to coordinate with WIC and the member's guardian when issues related to WIC services are identified.



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

	MCH 7 (Acute Only)	FC	None
	MCH 8	FC	None
	MCH 9	FC	None
	MCH 10 (Acute Only)	FC	None
	MCH 11 (Acute Only)	NA	None
	MCH 12	NA	None
	<b>Quality Management</b>		
	QM 1	FC	None
	QM 2	FC	None
	QM 3	FC	None
	QM 4	FC	None
	QM 5	FC	None
	QM 6	FC	None
	QM 7A (Acute Only)	SC	The Contractor must meet the AHCCCS MPS for all contractual performance measures and improve its rates for those that are currently below the AHCCCS MPS. MCP has submitted CAPs for performance measures through the Notice to Cure process, and is not required to submit a separate CAP for this standard.
	QM 8 A (Acute Only)	FC	None
	QM 9	FC	None
	QM 10	FC	None
	QM 11	FC	None
	QM 12A (Acute Only)	PC	The Contractor must ensure contracted PCPs update the member's behavioral health provider when there are changes in the member's diagnoses or prescribed medication and appropriately transition members being treated for ADHD, depression and anxiety to the RBHA to maintain continuity of care.
	QM 13	FC	None
	QM 14A (Acute Only)	SC	The Contractor must develop a process to ensure contracted PCPs

**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**



			respond to requests for information about members receiving behavioral health services from behavioral health providers is sent by the PCP within 10 days of receiving the request. The Contractor must document the status of the correction plan including re-evaluation to confirm the effectiveness of the plan.
	QM 15		None
	QM 16		None
	QM 17 (Acute Only)		None
	QM 18 (Acute Only)		None
	QM 19 (Acute Only)		None
	QM 20 (Acute Only)		None
	QM 21 (Acute Only)		None
	QM 22 (Acute Only)		None
	QM 23 (Acute Only)		None
	QM 24 (Acute Only)	NC	The Contractor must have a mechanism in place to identify members who have completed step therapy and are returning to the care of their PCPs for the treatment of depression, anxiety, or ADHD.  The Contractor must monitor its PCPs to ensure that they prescribe medications in consistency with those prescribed by the RBHA providers when a member has completed step therapy.  The Contractor must require PCPs to consult with, or obtain information from the RBHA providers for members who report having tried several medications/have participated in step therapy for the treatment of depression, anxiety, or ADHD prior to their current medication regime.  The Contractor must authorize medications originally prescribed by a RBHA provider for members who have completed step therapy.



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

QM 25	FC	None
<b>Delivery Systems and Provider Relations</b>		
DS 1	SC	The Contractor must update its policy to reflect the correct timeframe for resolving provider inquiries. In addition, the Contractor must resolve all inquiries within the required timeframe of 30 business days.
DS 2 (Acute Only)	NC	The Contractor must update its policies and desktop procedures to include specific information on providing transportation for members with ongoing treatment needs. The reference to “blanket” transportation in the policy is not sufficient.
DS 3 (Acute Only)	FC	None
DS 4 (Acute Only)	PC	The Contractor must take corrective action when necessary based on the survey report results.
<b>Claims and Information Systems</b>		
CIS 1	FC	None
CIS 2 (Acute Only)	FC	None
CIS 3 (Acute Only)	FC	None
CIS 4 (Acute Only)	SC	The Contractor should continue efforts to promote electronic payment to electronic submitters as they are most likely to adopt.
CIS 5 (Acute Only)	FC	None
CIS 6	FC	The Contractor should clarify in policy what periodicity will be for each line of business.
CIS 7	SC	The Contractor should develop processes for the validation of integrated member files against AHCCCS supplied data.
CIS 8 (Acute Only)	FC	None
<b>Encounters and Reinsurance</b>		
ENC 1	FC	None
ENC 2	FC	None
ENC 3	FC	None
ENC 4	FC	None



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
EXECUTIVE SUMMARY**

ENC 5	FC	None
ENC 6	FC	None
ENC 7	FC	None
ENC 8	FC	None
ENC 9 A (Acute Only)	FC	None
ENC 10	FC	None
ENC 11	FC	None
ENC 12 (Acute Only)	FC	None
RI 1	FC	The Contractor should consider applying the transplant stage balancing processes as detailed in their procedures.
RI 2	SC	The Contractor should ensure the coordination between their medical management, encounters, and reinsurance finance units to produce an acceptable outcome for the contract requirement of transplant services as it pertains to CN1/subcap code.
RI 3	NC	The Contractor should update their desktop procedures to include the specific contract language for notification of any type of reinsurance overpayments within the contracted time frame. The Contractor should apply a report for monitoring the appropriateness of the reinsurance revenue received against paid claims data.
RI 4	NA	None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
Member Information and Administrative Services**

**Standard  
MI 1**

**Member Newsletters contain the information required by Contract. [Contract Section D, Paragraph 18; 42CFR438.10]**

**Findings: FULL COMPLIANCE**

The Contractor has produced and distributed the appropriate number of newsletters (as determined by the timing of the review).

The newsletters contain information on/for:

✓	Chronic illness self-management. (10%)
✓	Preventive measures such as flu-shots. (10%)
	Cultural Competency other than translation information. (10%)
✓	Tobacco cessation. (10%)
	HIV/AIDS testing for pregnant members. (10%)
	Medicare Part D members. (10%)

**Documents Reviewed**

Fall 2008 Member Newsletter  
Winter 2009 Member Newsletter  
Member Newsletter Topics for 2009

**Comments**

The Contractor submitted Member Newsletter Topics for the Spring and Summer 2009 newsletters. These newsletters will contain information on HIV/AIDS testing for pregnant members, cultural competency other than translation information and information for Medicare Part D members.

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
Member Information and Administrative Services**

**Standard**

**MI 2 (Acute Only)**

**Member Services, Transportation, and Prior Authorization staff have access to, and utilize, appropriate mapping services when assigning PCPs; scheduling appointments; and referring members to services and/or service providers. [Contract Section D, Paragraph 16]**

**Findings: FULL COMPLIANCE**

The Contractor does maintain policies and procedures on the use of mapping services to determine appropriate service locations. (34%)

Desk Reference and/or training materials contain information on mapping services. (33%)

Reviewer was able to observe or confirm through independent interview that mapping services are accessible and utilized by staff in the three departments mentioned in the standard. (33%)

**Documents Reviewed**

- Member Services Manual-Chapter 15-Transportation
- Training SharePoint Material
- Policy – 4500.02 –Member/Provider Association
- Policy MS 601 – Transportation
- Member Services Representative Interview

**Comments**

None

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
Member Information and Administrative Services**

**Standard**  
**MI 3 (Acute Only)**  
**The Contractor has accurate mechanisms in place to track telephone performance measures as defined in paragraph 25 of the contract. [Contract Section D, Paragraph 25]**

**Findings: FULL COMPLIANCE**  
The Contractor maintains policies and procedures on tracking telephone performance measures. (50%)

The Contractor can produce the data upon request. (50%)

**Documents Reviewed**  
Desktop Procedure: Administrative Performance Standards Reporting  
Avaya Call Management System Report

**Comments**  
None

**Recommendations**  
None



AHCCCS OFR Standards  
CYE 2009

Mercy Care Plan  
Member Information and Administrative Services

**Standard**

**MI 4 (Acute Only)**

The Contractor analyzes and trends and acts upon member inquiry and grievance data. [Contractor Section D, Paragraph 26; ACOM Policy 406]

**Findings: FULL COMPLIANCE**

The Contractor has evidence of analyzing and trending member inquiries and grievances. (75%)

The Contractor has evidence of implementing corrective action based on member inquiry and grievance data when appropriate. (25%)

**Documents Reviewed**

- Monthly Key Service Indicator Report
- Acute Member Grievance & PCP Change Summary Report – 1<sup>st</sup> Qtr. 2009
- Acute Member Grievance & PCP Change Summary Report – Annual 2008
- Member Services Summary 2008
- Quality Management Oversight Meeting Minutes – February 2009

**Comments**

None

**Recommendations**

None



**Standard  
 MM 1**

**The Contractor has implemented procedures for utilization management program requirements, which are consistent with AHCCCS standards, provider monitoring and an evaluation of services. [AMPM Chapter 1000; 42CFR438.240]**

**Findings: FULL COMPLIANCE**

The Contractor has implemented processes for monitoring and evaluating utilization of services for which the plan has identified variances (both under- and over-utilization) in utilization patterns.

The Contractor does assess the quality of services provided when utilization data variances are present (under- and over-utilization).

The Contractor does have a criterion that outlines the variance criteria that would identify members and providers who require intervention in order to correct mis-utilization patterns.

The Contractor does act on identified variances (high or low utilization).

**Documents Reviewed**

- UM Evaluation CY08; pages 12-14 and pages 35-37
- Pharmacy Utilization Management Policy #7600.15
- QM-UM Meeting Minutes- January 2008 through December 2008
- Pharmacy Reports
- Monthly UM and QM data reports
- Over/Under Utilization Policy 7000.35

**Comments**

None

**Recommendations**

None



**Standard  
 MM 2**

**The Contractor reviews utilization data; reports trends and variances; implements, analyzes and evaluates interventions and acts on the recommendations of the Medical Management Committee. [AMPM Chapter 1000; 42CFR438.240]**

**Findings: NON COMPLIANCE**

The Contractor does not have Medical Management Committee meeting minutes which reflect the following:

<input type="checkbox"/>	Reporting of data over time reflecting any trends. (25%)
<input checked="" type="checkbox"/>	Addresses any untoward trends and minutes reflect analysis and plans for interventions. (25%)

The Contractor does not report on the previous meetings recommendations; analyzes interventions and makes changes based on the recommendations. (50%)

**INFORMATIONAL FINDING FOR 2009**

The Contractor does not evaluate the most effective and efficient use of facilities and services that are consistent with the members' needs and professionally recognized standards of care.

**Documents Reviewed**

- QM-UM Meeting Minutes- January 2008 through December 2008
- Pharmacy Reports
- Monthly UM and QM data reports
- Medical Management Interview

**Comments**

The Contractor does not consistently document previous meeting recommendations; the meeting minutes frequently state that data is informational. There is no documentation of the actions/interventions implemented or any changes made as a result of the actions when a trend was found. During the Medical Management interview, the Contractor's staff stated that they hold small internal meetings to discuss any trends identified or plans for



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MEDICAL MANAGEMENT**

interventions. These meetings are informal and no minutes are kept.

**Recommendations**

The Contractor must document any actions/interventions and/or any changes made as a result of the actions or interventions based on data reviewed and reported through the Medical Management Committee.



**Standard  
MM 3**

**The Contractor identifies and intervenes on member or provider profiling data that demonstrates a variance.  
[AMPM Chapter 1000]**

**Findings: FULL COMPLIANCE**

The Contractor demonstrates the application of Contractor criteria for identification and intervention of over utilization of facility services made by a member.

The Contractor demonstrates the application of Contractor criteria for identification and intervention of over/under utilization of facility services made by a provider.

The Contractor does refer any utilization issues to the Medical Management Committee, or appropriate committee for review.

The Contractor has a process for acting on any issues of authorization timeliness and the analysis of this on potential adverse member care.

**Documents Reviewed**

ER Utilization report  
MCP Acute/LTC Controlled Substances Poly-Prescriber/Poly-Pharmacy Report  
PCP Profile Top FP Report  
Physician Profiles Presentation  
QMOC Physician Profile Presentation dated May 15 and June 19, 2008  
Over/Under Utilization Policy 7000.35

**Comments**

Utilization issues are reported to the Service Improvement Committee and/or the QM Oversight Committee in lieu of the Medical Management Committee.

**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MEDICAL MANAGEMENT**



**Recommendations**  
None



**Standard  
MM 4**

**The Contractor has implemented and monitors a comprehensive inter-rater reliability plan to ensure consistent application of criteria for clinical decision making. [AMPM Chapter 1000; 42CFR438.236]**

**Findings: FULL COMPLIANCE**

The Contractor has written policies regarding inter-rater reliability for staff involved with the application of clinical criteria for:

_X_	Prior Authorization Staff (10%)	_X_	Retrospective Review Staff (10%)
_X_	Concurrent Review Staff (10%)	_X_	Medical Director(s) (10%)

The Contractor evaluates the consistency with which the individuals/groups below, involved in clinical decision making, apply standardized criteria and in accordance with any adopted practice guidelines:

_X_	Prior Authorization Staff (10%)	_X_	Retrospective Review Staff (10%)
_X_	Concurrent Review Staff (10%)	_X_	Medical Director(s) (10%)

The Contractor takes action when staff does not demonstrate consistency in the authorization or approval/denial of services. (10%)

The Contractor does not apply criteria for authorization in a consistent manner when evaluating requests for transplant service. (10%)

**Documents Reviewed**

Inter-rater Reliability Policy 7000.10  
 Mercy Care Plan Inter-Rater Reliability Assessment 2008

**Comments**

The Contractor's Inter-rater Reliability policy and 2008 findings of staff testing did not include testing on the application of criteria for evaluating transplant services. This specialized area is high risk and high cost to the Contractor and requires specialized expertise in applying criteria as exemplified by the Contractor by the establishment of a specific transplant area with staff who deal



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MEDICAL MANAGEMENT**

daily with the oversight and management of these members.

**Recommendations**

The Contractor should consider including testing for consistent application of criteria when evaluating requests for transplant services in their Inter-Rater Reliability testing.



**Standard  
 MM 5**

**The Contractor has an effective concurrent review process, which includes a component for reviewing the medical necessity of inpatient stays. [CYE 09 Contract; AMPM Chapter 1000; 42CFR438.236]**

**Findings: FULL COMPLIANCE**

The Contractor utilizes standardized criteria for length of stay determinations.

The Contractor has documented timeframes and frequencies for conducting inpatient reviews.

The Contractor has policies that describe the relevant clinical information that is to be obtained when making hospital length of stay decisions or level of care determinations.

The Contractor ensures that any decision to authorize an inpatient stay for duration or scope that is less than requested is made by a physician who has appropriate clinical expertise in treating the member's condition or disease.

The Contractor has a process for the oversight of the concurrent review process.

**INFORMATIONAL FINDING FOR 2009**

The Contractor has more extensive criteria for cases that its experience shows are:

x	Associated with higher costs
x	Associated with the frequent furnishing of excessive services
x	Attended by physician whose patterns of care frequently are found to be questionable

**Documents Reviewed**

Concurrent Review Policy 7200.5  
 UM Evaluation and Plan

Desktop Procedure for Concurrent Review-Denial, Reduction, Termination of Financial responsibility: Inpatient Services for MCP

**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MEDICAL MANAGEMENT**



**Comments**  
None

**Recommendations**  
None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MEDICAL MANAGEMENT**

**Standard  
MM 6**

**The Contractor adopts and disseminates practice guidelines that comply with all Federal Regulations. The Contractor adopts and monitors provider compliance with national practice guidelines and/or local standards of practice. [AMPM Chapter 1000; 42CFR438.236]**

**Findings: PARTIAL COMPLIANCE**

The Contractor has practice guidelines that comply with the following criteria: (34%)

<u>  </u> x	Based on valid and reliable clinical evidence or a consensus of health care professionals in the field
<u>  </u> x	Consider the needs of the Contractor's members
<u>  </u> x	Are adopted in consultation with contracting health care professionals and or National Practice Standards (note: in the absence of national practice guidelines, the guidelines are developed in consultation with health care professionals and through a review of peer-reviewed articles in medical journals published in the United States.)

The Contractor demonstrates a process by which practice guidelines are disseminated to all affected providers and upon request to members, or potential members. (33%)

The Contractor does not evaluate the Practice Guidelines annually through a multi-disciplinary process to determine if the guidelines remain applicable, and represent the best and most current practice standards. (33%)

**Documents Reviewed**

QM/JM April 2008 Meeting Minutes

Clinical Practice Guidelines: Congestive Heart Failure; Diabetes; Asthma; Chronic Obstructive Pulmonary Disease Disease Management Clinical Practice Guideline Policy 7550.15

**Comments**

The Contractor's Disease Management Clinical Practice Guidelines policy states that guidelines are reviewed and researched at least every two years. The Provider Manual states that Practice Guidelines are reviewed annually. There



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MEDICAL MANAGEMENT**

was no documentation provided that demonstrated that the Clinical Practice Guidelines had been approved annually.

**Recommendations**

The Contractor must evaluate the Practice Guidelines annually through a multi-disciplinary process to determine if the guidelines remain applicable, and represent the best and most current practice standards.



**Standard  
MM 7**

**The Contractor has adopted and implemented a policy for the evaluation of new technologies that complies with AHCCCS standards. [AMPM Chapter 1000]**

**Findings: FULL COMPLIANCE**

The Contractor has a policy for evaluating new technologies or the application of existing technology to a new clinical use that is inclusive of consideration of coverage decisions by Medicare intermediaries, carriers, and/or Medicare, Federal or State Medicaid coverage decisions.

The Contractor has implemented a process for review of new technology based on authorization requests that may be time dependent.

The Contractor has documented compliance with the policy that reflects the decision process and the basis for the decision on coverage.

**Documents Reviewed**  
Technology Assessment Policy 7000.20

**Comments**  
None

**Recommendations**  
None



**Standard  
MM 8**

**The Contractor promotes health maintenance and coordination of care through disease management programs that is based on data that includes high utilization, high risk, high volume and/or high cost. [AMPM Chapter 1000]**

**Findings: PARTIAL COMPLIANCE**

The Contractor has implemented disease management programs and the selection was based on high utilization data, high risk, high volume or high cost factors.

The Contractor has measurable outcomes for their disease management plan.

The Contractor has planned interventions based on evidence based medicine for the program.

The Contractor does not evaluate and revise its disease management processes as a result of quarterly reviews.

The Contractor does not have documentation of the changes made based on recommendations of the Medical Management meetings.

**Documents Reviewed**

Disease Management Policy 7550.05

Disease management Clinical Practice Guidelines 7550.15

Monthly UM/QM meeting minutes January 2008 through January 2009.

**Comments**

The Disease Management database, Case Tracker™, used in conjunction with the Predictive database is used to identify members and track interventions and outcomes. The Disease Management Program is reviewed and evaluated annually by the Disease Management and Steering Committee who then may develop other specific program goals for the coming year. The goals are based on opportunities for improvement identified in the annual evaluation as well as on nationally identified trends for improvement. The Contractor is not documenting the evaluation of these interventions or any changes made as a result of the interventions.



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MEDICAL MANAGEMENT**

**Recommendations**

The Contractor must report the interventions and any changes made to those interventions based on the outcomes or evaluation of those interventions. This must be documented in the meeting minutes.



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MEDICAL MANAGEMENT**

**Standard  
MM 9**

**The Contractor has structured compensation for Utilization Management activities so that decision makers are not incentivized to deny, limit, or discontinue medically necessary services to any enrollee. [42CFR 438.210]**

**Findings: FULL COMPLIANCE**

The Contractor has policy language meeting the requirements of 42 CFR 438.210(e).

If the Contractor delegates this function to an independent entity, the subcontract contains language consistent with policy. (NA)

**Documents Reviewed**

Provider Manual  
UM Annual Plan and Evaluation

**Comments**

The Provider Manual states that Mercy Care Plan does not reward practitioners or other individuals involved in utilization review, for issuing denials of coverage or service.

**Recommendations**

None



**Standard  
MM 10**

**The Contractor has policies for monitoring Nursing Facility stays by enrolled members. [Contract Section D, Paragraph 10]**

**Findings: FULL COMPLIANCE**

The Policies do require notification to AHCCCS as soon as the member has been residing in a Nursing Facility for 75 days.

The Policies have been updated to contain the correct notification method required by Contract YH09-0001.

**Documents Reviewed**

Desktop Procedure for Concurrent Review  
Concurrent Review Policy 7200.05  
AHCCCS Notification of a Medicaid-Funded Admission form

**Comments**

Members residing in nursing facilities are reviewed weekly. During the Medical Management Interview, the Contractor's staff stated that the MCP authorization system keeps track of the number of days the member has used for nursing facility stays so it is available to the reviewing nurse.

**Recommendations**

None



**Standard**

**MM 11 (Acute Only)**

The Contractor promotes continuity and coordination of care through an ongoing source of care appropriate to the member's needs. The Contractor identifies their special needs/at risk population and ensures that the members have care coordination/case management services available. [Contract; AMPM Chapter 1000; 42CFR438.236]

**Findings: SUBSTANTIAL COMPLIANCE**

The Contractor ensures that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as having primary responsibility for coordinating the health care services furnished to the enrollees. (11%)

The Contractor has developed and implemented processes to identify its special needs/at risk members, including behavioral health and CRS members in the Acute Care program. (11%)

The Contractor demonstrates a process for identifying and tracking members who qualify for Catastrophic Transplant or Inpatient Reinsurance. (11%)

The Contractor assesses member requests for transplant, include clear documentation of the reason for denial and meet the criteria outlined by the Contractor in accordance with the AHCCCS policy. (11%)

The Contractor monitors and ensures that all Acute Care enrollees with special health care needs direct access to a specialist appropriate for the enrollees' conditions and identified needs. (11%)

The Contractor documents care coordination for all Acute care members who are identified as special health care needs. (11%)

The Contractor coordinates all services it provides to a member with any services the member receives from other entities, including behavioral health services the member receives through an ADHS/RBHA provider and Children's Rehabilitative Services (CRS) provided through ADHS/CRSA. (11%)



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MEDICAL MANAGEMENT**

The Contractor does not have methodology to identify providers willing to provide medical home services and has reasonable efforts to offer access for members to these providers. (11%)

The Contractor has a process for monitoring the effectiveness of the care coordination/case management of special health care needs enrolled in the Acute Care Plan. (11%)

**Documents Reviewed**

Desktop Procedure for Coordination of Behavioral Health Services  
Acute Care Behavioral Health Coordination and Monitoring 8000.25  
Case Management Policy 7500.05

**Comments**

The Contractor has documented several methods of identifying Acute Care members with special needs and those in need of case management and care coordination. During the Medical Management Interview Dr. Conflitti stated that she has an appointment with a group of physicians to discuss their use for the MCP Medical Home services. MCP is in the beginning stages of developing a medical home model for their members. One example of how the Contractor monitors the effectiveness of the care coordination/case management of special health care needs members is through the Case Traker Key Indicator Report.

**Recommendations**

The Contractor must develop the methodology to identify providers willing to provide medical home services and make reasonable efforts to offer access for members to these providers.



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM

**Standard**

**GS 1 A (Acute Only)**

**The Contractor has a structure and process in place for the review of prior authorization requests. [CYE 09 Contract; AMPM Chapter 1000; 42CFR438.210 and .114]**

**Findings: SUBSTANTIAL COMPLIANCE**

The Contractor has a structure in place to process prior authorization requests. (8%)

The Contractor has a policy that identifies what services require prior authorization and a demonstrated process for communicating the information with providers. (8%)

The Contractor utilizes standardized criteria when making prior authorization decisions. (8%)

The Contractor does not make the standardized authorization criteria available to members upon request. (8%)

The Contractor ensures that any decision to deny, reduce, or terminate a medical service is made by a qualified health care professional who has the clinical expertise to make the decision. (8%)

The Contractor consults with the requesting provider when appropriate. (8%)

In 69% (40 of 58) of the NOA letters reviewed, from June 2008 through September 2008, the clinical decisions that resulted in an adverse action have the rationale for the decision clearly documented and reflected in the Notice of Action letter. (13%)

In 100% (58 of 58) of the PA files reviewed, from June 2008 through September 2008, the denial decisions were made by a qualified health care professional and the rationale for the decision is clearly documented. (13%)

**For the current contract year the NOA audit tool has been changed with each question being assigned a point value. The following findings are for the period from October 2008 through January 2009.**

In 94% (1085 of 1155 points) of the NOA letters reviewed the clinical decisions that resulted in an adverse action have the



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

rationale for the decision clearly documented and reflected in the Notice of Action letter. (13%)

In 100% (310 of 310 points) of the PA files reviewed the denial decisions were made by a qualified health care professional and the rationale for the decision is clearly documented. (13%)

***Pima and Maricopa County ACUTE Contractors Only***

The Contractor has resources available to assist homeless clinics with obtaining prior authorization and referrals to specialists.

**Documents Reviewed**

Notice of Action (NOA) Letters and supporting documentation from June 2008 through January 2009  
Member Handbook  
Provider Handbook  
Prior Authorization Policy 7100.5, MCP UM Plan 2009

**Comments**

During the Grievance Interview the Contractor's staff indicated that all homeless shelters are contracted. They also stated that they have never had a request from a homeless shelter to assist them in getting a PA or referral to specialist but a request from a homeless shelter would be treated as any other request from a contracted provider. If the member had a case manager they would also contact and involve the case manager.

**Recommendations**

The Contractor must make the standardized authorization criteria available to members upon request.



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM

**Standard**

**GS 2 A (Acute Only)**

**The Contractor provides the member with a written Notice of Action that identifies the requested service, the purpose of the service, the adverse action being taken, and the member-specific reason that the action is being taken in an easily understood format. [42 CFR 438 Subpart F; ACOM Policy 414]**

**Findings: FULL COMPLIANCE**

69% (40 of 58) of the reviewed files, from June 2008 through September 2008, contained a Notice of Action letter that clearly describes a member-specific reason based on the member's condition that the service is not being authorized in the amount; duration; and/or scope that was requested. (16.6%)

100% (58 of 58) of the reviewed files, from June 2008 through September 2008, contained a Notice of Action that clearly describes the service that was requested. (16.6%)

95% (55 of 58) of the reviewed files, from June 2008 through September 2008, contained a Notice of Action that clearly describes the purpose of that service. (16.6%)

**For the current contract year the NOA audit tool has been changed with each question being assigned a point value. The following findings are for the period from October 2008 through January 2009.**

94% (1085 of 1155 points) of the reviewed files contained a Notice of Action letter that clearly describes a member-specific reason based on the member's condition that the service is not being authorized in the amount; duration; and/or scope that was requested. (16.6%)

94% (155 of 165 points) of the reviewed files contained a Notice of Action letter that clearly describes the service that was requested. (16.6%)

100% (165 of 165 points) of the reviewed files contained a Notice of Action letter that clearly describes the purpose of that requested service. (16.6%)



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

**Documents Reviewed**

Notice of Action Letters and the supporting documentation for June 2008 through January 2009  
Member Handbook  
Prior Authorization Policy 7100.5.

**Comments**

The Contractor has improved their scores for the time period October 2008 through January 2009 and could now be on bi-annual NOA audit. The Contractor has requested AHCCCS MM to continue the monthly NOA reviews. AHCCCS MM meets with MCP monthly for technical assistance of the NOA letters reviewed.

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

**Standard**

**GS 3 A (Acute Only)**

The Contractor provides the member with a written notice that explains member rights, including the right to have services continue during the appeal process; the legal basis for the decision; and complies with the AHCCCS Notice of Action template. [Attachment H(1); ACOM Policy 414; ARS 36-2903.01; AAC R9-34; 42CFR438.10, .404, .408]

**Findings: FULL COMPLIANCE**

The Contractor provides the member with a written notice that explains (10%):

<input checked="" type="checkbox"/>	The member's right to file an appeal
<input checked="" type="checkbox"/>	Procedures for filing an appeal, requesting a state fair hearing, and expedited appeals
<input checked="" type="checkbox"/>	The availability of assistance from the Contractor to file an appeal

The Contractor's written notice explains the member's right to have existing services continue, how to request continued services, and when a member may be required to pay for the costs. (10%)

The Contractor provides the member with a minimum of ten (10) calendar days notice prior to discontinuing an existing service. (10%)

100% (55 of 55) of the reviewed files, from June 2008 through September 2008, contained a Notice of Action letter that is in compliance with the AHCCCS template that includes the member's rights; the right to continuation of services; an explanation of the timeframes for filing appeals; the fact that services will be discontinued; the date that services will be discontinued if they are currently being provided; and legal resources available to the member to assist with the appeal process. (17.5%)

81% (47 of 58) of the reviewed files, from June 2008 through September 2008, contained a Notice of Action letter that states the correct legal basis for the decision. (17.5%)

**For the current contract year the NOA audit tool has been changed with each question being assigned a point**



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

**value. The following findings are for the period from October 2008 through January 2009.**

100% (165 of 165 points) contained a Notice of Action letter that is in compliance with the AHCCCS template that includes the member's rights; the right to continuation of services; an explanation of the timeframes for filing appeals; the fact that services will be discontinued; the date that services will be discontinued if they are currently being provided; and legal resources available to the member to assist with the appeal process. (17.5%)

88% (290 of 330 points) contained a Notice of Action letter that states the correct legal basis for the decision. (17.5%)

**Documents Reviewed**

Notice of Action Letter Audits and supporting documentation submitted to AHCCCS for time frame June 2008 through January 2009  
Desktop Procedure: Prior Authorization Notice of Action  
Member Handbook  
Prior Authorization Policy 7100.5

**Comments**

The Contractor has improved their scores for the time period October 2008 through January 2009 and could now be on bi-annual NOA audit. The Contractor has requested AHCCCS MM to continue the monthly NOA reviews. AHCCCS MM meets with MCP monthly for technical assistance of the NOA letters reviewed.

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM

**Standard**

**GS 4A (Acute Only)**

The Contractor makes prior authorization decision within 14 days for a standard request and within 3 days for an urgent (expedited) request and notifies the appropriate parties (requesting provider and member) of the outcome of the decision. [Contract Attachment H(1) Acute; ARS 36-2903; AAC R9-34; 42CFR438.10, .404, .406, .408, .410]

**Findings: SUBSTANTIAL COMPLIANCE**

The Contractor monitors and reports the timeliness of all prior authorization decisions to the Medical Management quarterly meeting members and act upon any areas requiring improvement. (6%)

The Contractor notifies the requesting provider in writing of an adverse decision in accordance with the 3 day or 14 day standard. (6%)

The Contractor notifies the requesting provider when an “expedited” authorization request does not meet the criteria for expedited authorization in order to determine why the provider has requested expedited review and adjusts the request if appropriate. (6%)

The Contractor documents when an “expedited” request is determined to not to meet criteria for expedited review and is transferred to the standard 14 day review process and clearly indicates that the request has been changed by the requesting provider. (6%)

83% (48 out of 58) of the reviewed files, from June 2008 through September 2008, contained a Notice of Action letter that is compliant with regard to timeframes for standard or expedited review. (19%)

67% (18 of 27) of the reviewed files, from June 2008 through September 2008, contained a Notice of Action letter that is compliant when it is determined in the best interest of the member, a Notice of Extension and a subsequent Notice of Action upon expiration of the review period. (19%)

**For the current contract year the NOA audit tool has been changed with each question being assigned a point value. The following findings are for the period from October 2008 through January 2009.**



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

100% (300 of 300 points) of the reviewed files contained a Notice of Action letter that is compliant with regard to timeframes for standard or expedited review. (19%)

100% (150 of 150 points) of the reviewed files contained a Notice of Action letter that is compliant when it is determined in the best interest of the member, a Notice of Extension and a subsequent Notice of Action upon expiration of the review period. (19%)

**Documents Reviewed**

- Monthly Grievance Reports: June 2008 through January 2009
- Notice of Action letters and supporting documentation: June 2008 through January 2009
- QM/UM Monthly Meeting Minutes
- TAT reports from MM/UM meetings
- Prior Authorization Policy 7100.5
- 38 Member Appeal files

**Comments**

The Contractor's Prior Authorization Policy (7100.5) did not address notifying the requesting provider when an "expedited" authorization request does not meet the criteria for expedited authorization in order to determine why the provider has requested an expedited review. In the Provider Manual under "Urgent Requests", the manual states that MCP may change an "urgent" request to a routine request if the "urgent" request does not meet criteria for "urgent status". The member would be notified with the new timeframes to process the request. The provider must change the order in order to comply with the new timelines. The Contractor's Prior Authorization Policy 7100.5 did not address when an "expedited" request is determined to not meet criteria for expedited review and is transferred to the standard 14 day review process and the request order has been changed by the requesting provider

**Recommendations**

The Contractor should include in policy and procedure that the requesting provider is notified for an order change when an "expedited" authorization request does not meet the criteria for expedited authorization in order to determine why the provider has requested an expedited review.



**AHCCCS OFR Standards**  
**CYE 2009**  
**Mercy Care Plan**  
**AUTHORIZATION AND GRIEVANCE SYSTEM**

**Standard**

**GS 5 A (Acute Only)**

The Contractor issues an Extension Notice letter to the member, which contains the reason for any extension, when either the member requests an extension to the service authorization review period or the Contractor requires additional information in order to make a decision. The Extension Notice letter indicates that the period will be extended by 14 days or no longer than 28 total days from receipt of the initial service request. [Attachment H (1), H(2) Acute; ARS 36-2903; AAC R9-34; 42CFR438.10, 404, 406, 408, 410]

**Findings: SUBSTANTIAL COMPLIANCE**

The Contractor provides the member with written notice that includes the timeframes by which the decision process will be extended. (10%)

The Contractor's written Notice of Extension includes:

_ x _	The reason for the decision to extend the timeframe and the information that is being requested or is needed to make the service decision (10%)
_ x _	The length of the extension (10%)
_ x _	The member's right to file a grievance (complaint) if the member disagrees with the decision to extend the review period (10%)
_ _	A statement that the decision will be made as expeditiously as the member's condition requires and no later than the date that the extension is set to expire (10%)

84% (49 of 58) of the extended reviews, from June 2008 through September 2008, were completed within 14 days of the issuance of a Notice of Extension (no more than 28 days total) whether standard or expedited review was initially requested. (12.5%)

67% (18 of 27) of the reviewed files, from June 2008 through September 2008, contained a Notice of Extension letter that is in compliance with the AHCCCS standards that includes the reason for the extension; the correct timeframes for making a decision; and the right to grieve the decision to extend the review period. (12.5%)



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

**For the current contract year the NOA audit tool has been changed with each question being assigned a point value. The following findings are for the period from October 2008 through January 2009.**

100% (150 of 150 points) extended reviews were completed within 14 days of the issuance of a Notice of Extension (no more than 28 days total) whether standard or expedited review was initially requested. (12.5%)

100% (150 of 150 points) of the reviewed files contained a Notice of Extension letter that is in compliance with the AHCCCS standards that includes the reason for the extension; the correct timeframes for making a decision; and the right to grieve the decision to extend the review period. (12.5%)

**Documents Reviewed**

Notice of Action Letter Audits

Notice of Extension letters and supporting documentation: June 2008 through January 2009

Grievance and Appeals Monthly reports: June 2008 through January 2009

MCP Extension letter template.

**Comments**

The Contractor's Notice of Extension letter did not include a date that the request would expire if the additional information is not received.

**Recommendations**

The Contractor must include in their Notice of Extension Letter a statement that the decision will be made as expeditiously as the member's condition requires and no later than the date that the extension is set to expire. The Contractor must include in their Notice of Extension letter the date the request will expire if the additional information is not received.



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

**Standard  
GS 7**

**The Contractor provides written notice to members, facilities and providers, at least 2 working days before a continued inpatient stay authorization is set to expire. [ARS 36-2903; AAC R9-34; 42CFR438.10, 404]**

**Findings: FULL COMPLIANCE**

The Contractor notifies the following parties when denying a continued inpatient stay:

x	The Hospital or Facility
x	The attending physician
x	The member or responsible party (member's representative)

The Contractor provides notification to the member when an inpatient stay will be denied and the member remains in the facility.

**Documents Reviewed**

Desktop Procedure Concurrent Review-Denial, Reduction, Termination of Financial Responsibility: Inpatient services for MCP

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM

**Standard**  
**GS 9**

**The Contractor confirms all provider claim disputes with a written acknowledgement of receipt. [Contract Paragraph 25, Attachment H(2); 42CFR438.406]**

**Findings: FULL COMPLIANCE**

The Contractor issues a written acknowledgement letter within 5 days of receipt on all claim disputes filed.

**Documents Reviewed**

Claim Dispute Standards 3000.66  
25 acute claim disputes

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM

**Standard  
GS 10**

**The Contractor has a process for internal communication and coordination when an appeal or claim dispute decision is reversed. [Contract Paragraph 5 Acute, Attachment H(1), H(2), 42CFR438.424]**

**Findings: FULL COMPLIANCE**

The Contractor has a process for internal communication and coordination when an appeal or claim dispute decision is reversed.

**Documents Reviewed**

Member Appeal System Standard 3000.37  
10 expedited appeals  
25 standard appeals

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM

**Standard**

**GS 13**

**The Contractor resolves claim disputes and mails written Notice of Decisions no later than 30 days after receipt of the dispute unless an extension is requested or approved by the provider. [Attachment H(2) Acute; 42CFR438.408]**

**Findings: FULL COMPLIANCE**

The Contractor resolves claim disputes within 30 days of receipt.

The Contractor issues a written Notices of Decision to resolve claim disputes.

Extension letters are issued when the Contractor requires additional time to make a decision or the provider requests additional time to provide supporting documentation/testimony.

The Contractor maintains evidence of the provider's acknowledgement or approval when an extension is taken.

**Documents Reviewed**

Provider Manual

Claim Disputes Standards 3000.56

25 acute claim disputes

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM

**Standard  
GS 14**

**The Contractor issues Notices of Decision that include all information required by AHCCCS. [Attachment B(2), Attachment H(2); 42CFR438.408]**

**Findings: FULL COMPLIANCE**

The Contractor Notice of Decision includes all information required by the contract with AHCCCS.

**Documents Reviewed**

Claim Disputes Standards 3000.66  
25 acute claim disputes

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM

**Standard  
GS 15**

**The Contractor maintains claim dispute records as required by the contract and Arizona Administrative Code R9-34.**

**Findings: FULL COMPLIANCE**

The Contractor maintains claim dispute records as required by the contract.

**Documents Reviewed**

Claim Disputes Standards 3000.66, Operating Protocols  
25 acute claim disputes

**Comments**

None

**Recommendations**

None



**Standard  
GS 17**

**The Contractor continues or reinstates an enrollee's benefits when an appeal is pending under the appropriate circumstances as required by Federal Regulation. [42CFR438.420]**

**Findings: FULL COMPLIANCE**

The Contractor continues or reinstates an enrollee's benefits when an appeal is pending if all of the following are true:

- A. The member files a timely appeal
- B. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- C. The services were ordered by an authorized provider
- D. The original period covered by the initial authorization has not expired
- E. The member requests continuation of services

**Documents Reviewed**

Member Appeal System Standard 3000.37, Request for Continued Benefits During the Appeal Process  
 10 expedited appeals  
 25 standard appeals

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM

**Standard  
GS 18**

**If the Contractor or Director's Decision reverses a decision to deny, limit, or delay services that were not furnished while an appeal or hearing was pending, the Contractor authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires. [42CFR438.424]**

**Findings: FULL COMPLIANCE**

The Contractor has policies that require the prompt, or as expeditiously as the member's condition requires, authorization or provision of services should the initial determination to deny, limit, or delay a service is reversed by appeal or Director's Decision.

**Documents Reviewed**

Member Appeal System Standard 3000.37, Request for Continued Benefits During the Appeal Process  
10 expedited appeals  
25 standard appeals

**Comments**

None

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

**Standard  
GS 19**

The Contractor has a structure in place to approve, and reimburse for the provision of, services to member’s having liable third party coverage and does not deny authorization or reimbursement when it is aware that the liable third party will not cover the condition or service. [AMPM Chapter 1000; ACOM Policy 201, 202; ARS 36-2903; AAC R9-1001; 42CFR433.135]

**Findings: FULL COMPLIANCE**

The Contractor does not deny medically necessary services for third party liability when it is aware that the service is not covered by the other party.

The Contractor does not require a letter of denial from a possibly liable third party prior to reimbursing for a covered service when it knows that the third party will not reimburse due to coverage limitations or timely filing rules.

The Contractor establishes the coverage status of a service with a possibly liable third party instead of requiring this of the member.

The Contractor arranges for the timely provision of covered services when it is known that the third party will not provide the service.

**Documents Reviewed**

TPL referral form  
Third Party Liability Tool Kit  
Prior Authorization Policy 7100.05

**Comments**

None

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

**Standard  
GS 20**

**The Contractor's member appeal policies allow for, and require notification of the member of, all rights granted under 42 CFR 406(b).**

**Findings: FULL COMPLIANCE**

The member is given reasonable opportunity to present evidence, and allegations or fact or law, in person as well as in writing.

The member and/or their representative is given the opportunity before and during the appeal process to review the case file, including medical records, and any other documents and records considered during the appeal process.

The enrollee and/or his representative or legal representative is included as a party to the appeal.

**Documents Reviewed**

Member Appeal System Standard 3000.37, Appeal Process  
10 expedited appeals  
25 standard appeals  
Notice of Action  
Acknowledgement of Appeal Letter

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM

**Standard  
GS 21**

**The Contractor's grievance process follows the requirements of CFR 438.408 (b)(1) and the Contract.**

**Findings: FULL COMPLIANCE**

Standard grievances are resolved with a written notice.

Grievances are acknowledged within five (5) days.

Grievances are resolved with 90 days.

Grievance is correctly defined in Policy.

**Documents Reviewed**  
Member Grievance Policy MS701

**Comments**  
None

**Recommendations**  
None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

**Standard  
GS 23**

**The Contractor has a structure and process for assuring that emergency services are provided in an amount, duration and scope to achieve the purpose for which services are needed. [42CFR438.114, 42CFR422.113, 42CFR422.133]**

**Findings: FULL COMPLIANCE**

The Contractor does not require prior authorization for emergency services.

The Contractor approves payment for the treatment of an emergency medical condition in which a representative of the Contractor instructs the enrollee to seek emergency services.

**Documents Reviewed**

- Appeals files
- Emergency Service and Post Stabilization Policy 7000.65
- Prior Authorization Policy 7100.5
- Acute Member Handbook
- Provider Manual

**Comments**

None

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

**Standard  
GS 24**

**The Contractor does not deny payment for emergency services that have met the standards outlined by the Federal Regulations for emergent care/services. [AMPM Chapter 1000; 42CFR438.114]**

**Findings: FULL COMPLIANCE**

The Contractor does not deny payment for emergent services when the following criteria has been met: (11%)

The medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in the following

- A. Placing the health of the individual (or with respect to a pregnant woman, of her unborn child) in serious jeopardy.
- B. Serious impairment to bodily functions
- C. Serious dysfunction of any bodily organ or part

The Contractor does not deny emergency services when the emergency room provider, hospital, or fiscal agent has notified the member's Contractor within 10 calendar days of presentation for emergency services. (11%)

The Contractor does not deny payment for emergency services regardless of whether the entity that furnishes the services is contracted. (11%)

The Contractor does not deny payment for emergency services or limit emergency services on the basis of a list of diagnoses or symptoms. (11%)

The Contractor does not deny post stabilization care services (provided under the definition of an emergency medical condition) in order to maintain the stabilized condition or to improve or resolve the patient's condition when: (11%)

- A. Post stabilization care services were not approved by the Contractor within one hour of a prior



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

authorization requested by the treating provider or the Contractor could not be contacted for authorization.

B. The Contractor representative and the treating physician cannot reach an agreement concerning the enrollee's care and the contracted physician is not available for consultation.

The Contractor does not deny payment when the attending emergency physician has not determined that the member is sufficiently stabilized for transfer or discharge. (11%)

**Documents Reviewed**

- Appeals files
- Emergency Service and Post Stabilization Policy 7000.65
- Prior Authorization Policy 7100.5
- Concurrent Review Policy

**Comments**

The Contractor does report to the Medical Management Committee identified utilization issues for analysis and intervention but does not document in the Medical Management Meeting Minutes any actions or interventions taken as a result of the findings from their analysis

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
AUTHORIZATION AND GRIEVANCE SYSTEM**

**Standard  
GS 26**

**The Contractor must conduct post delivery of services medical necessity reviews based on reasonable medical evidence or a consensus of relevant health care professionals. [AMPM Chapter 1000; 42 CFR 438.114]**

**Findings: FULL COMPLIANCE**

The Contractor does have criteria describing what services require retrospective review, the time frames for the completion of such reviews, and the appropriate clinical staff involved in the reviews.

The Contractor does document the outcome of any retrospective review and the rationale for the decision by the appropriate clinical staff.

The Contractor does report to the Medical Management or appropriate committee any identified utilization issues for analysis and intervention.

**Documents Reviewed**

QM/UM Monthly Meeting Minutes  
Retrospective Medical Claims Review Policy  
Desktop procedure for Retrospective Review of Admissions and Continued Stays  
Prior Authorization Policy 7100

**Comments**

None

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT**

**Standard  
MCH 1**

**The Contractor provides EPSDT/Well Child services according to the AHCCCS EPSDT Periodicity Schedule. [AMPM Chapter 400, Policy 430; 42CFR441.58]**

**Findings: FULL COMPLIANCE**

The Contractor informs all primary care providers (PCPs) about EPSDT services, including federal, state, and AHCCCS medical policy requirements. (20%)

The Contractor has policies and procedures to monitor, evaluate and improve EPSDT participation. (20%)

The Contractor has implemented provider and member outreach activities to increase EPSDT/Well Child participation rates. (20%)

The Contractor measures the effectiveness of individual outreach activities and implements process improvement activities if not effective. (20%)

The Contractor provides targeted outreach to members who miss/no-show their EPSDT appointments. (20%)

**Documents Reviewed**

- Provider Manual: Chapter 6
- CYE 2009 Annual EPSDT / Dental Plan
- Provider Newsletter: Winter 2009
- Site visit talking points tool (included in the EPSDT/ Dental Annual Plan)
- Dental Policy 7700.10
- Multidisciplinary Team Meeting Minutes 2/4/08
- MCP Corrective Action Plan: Well Child Visits in the First 15 Months of Life

**Comments**

None

**AHCCCS OFR Standards  
CYE 2009**

**Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT**



**Recommendations**  
None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT**

**Standard  
MCH 2**

**The Contractor monitors member compliance with obtaining EPSDT services. [AMPM Chapter 400, Policy 430; 42CFR441.56]**

**Findings: FULL COMPLIANCE**

The Contractor monitors whether EPSDT/Well Child visits are provided to all eligible members according to the AHCCCS Periodicity Schedule. (25%)

The Contractor has implemented a process to increase member utilization of EPSDT/Well Child visits. (25%)

The Contractor measures, monitors, and implements activities to improve member participation rates for age appropriate screening, according to the most current periodicity schedule, such as (but not limited to): (50%)

X	Blood lead screening (10%)
X	Blood lead testing (10%)
X	Tuberculosis screening (10%)
X	Developmental assessments (10%)
X	BMI/Growth percentile (10%)
x	Behavioral Health Screening

**Documents Reviewed**

- EPSDT Quarterly report 2007-2008
- EPSDT / Dental Annual Plan CYE 09
- Desktop Procedure: EPSDT Completion Audit Protocol
- Quarter 1 CYE 09 EPSDT Form Completeness Audit
- List of Providers who did not complete a Blood Lead Test
- CQM-QM 12 AMRR Samples



**AHCCCS OFR Standards  
CYE 2009**

**Mercy Care Plan**

**MATERNAL AND CHILD HEALTH AND EPSDT**

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT

**Standard  
MCH 3**

**The Contractor monitors provider compliance with providing EPSDT services. [AMPM Chapter 400, Policy 430]**

**Findings: PARTIAL COMPLIANCE**

The Contractor monitors; tracks and evaluates provider compliance with providing EPSDT/Well Child services to all eligible members according to the most current periodicity schedule. (20%)

The Contractor reviews medical records for provider compliance with completing all the elements of the EPSDT Tracking Form during each Well Child visit. (20%)

The Contractor has implemented processes to improve provider participation rates in providing EPSDT/Well Child services. (20%)

The Contractor does not monitor providers' use of the AHCCCS-approved EPSDT Tracking Forms. (20%)

The Contractor does not implement interventions when necessary to improve the rate of use of the AHCCCS-approved EPSDT Tracking Forms. (20%)

**Documents Reviewed**

Network Newsletters: Spring 2008 and Winter 2009

Provider Manual p. 30

EPSDT / Dental Annual Plan p. 13

QM Annual Plan pp. 40-41

Desk top procedure for Monitoring Provider Use of Current EPSDT Tracking Form

Fax to providers regarding use of correct EPSDT Form

Tracking Outreach Efforts report

**Comments**

The Contractor's medical record review process, with a limited sample of providers and records, makes the assumption



**AHCCCS OFR Standards  
CYE 2009**

**Mercy Care Plan**

**MATERNAL AND CHILD HEALTH AND EPSDT**

that all contracted EPSDT providers are providing age appropriate EPSDT screenings and services by auditing medical records (every three years) and 10 EPSDT Tracking Forms of only high volume provider groups (quarterly). However, the medical record review audit tool used by the Contractor's delegated entity to conduct onsite medical record reviews during 2008 did not contain an indicator to determine if an EPSDT Tracking Form was used and does not contain an indicator to assess whether or not the provider assessed the child for risk of exposure to lead (verbal lead screening). The Contractor's, Interpretation of PCP Medical Record Review Audit Tool, was revised in October 2008 to include the EPSDT Tracking Form and electronic record including all of the elements of the EPSDT Tracking Form.

**Recommendations**

The Contractor must ensure all primary care providers delivering care to EPSDT aged members utilize the age appropriate EPSDT Tracking Forms during each EPSDT visit and implement processes to ensure those providers not using the EPSDT Tracking Forms are compliant with using the forms.



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT**

**Standard  
MCH 4**

**The Contractor ensures that oral health/dental services are provided according to the AHCCCS Medical Policy Manual, AHCCCS Dental Periodicity Schedule. [AMPM Chapter 400, Policy 430]**

**Findings: FULL COMPLIANCE**

- The Contractor monitors providers to determine if oral health/dental services are provided according to the AHCCCS Dental Periodicity Schedule. (25%)
- The Contractor has member outreach activities to increase utilization of oral health/dental services. (25%)
- The Contractor monitors and evaluates the effectiveness of oral health/dental outreach activities. (25%)
- The Contractor ensures that an oral health screening is provided by the PCP, or other practitioners, during the EPSDT visit. (25%)

**Documents Reviewed**

- Member handbook pg 13
- EPSDT / Dental Annual Plan CYE 09
- EPSDT Quarterly report CYE 08
- AMRR CYE 08, (BLANK TOOL)
- Dental Services Program Policy number 7700.10
- Dental Site Visit Talking Points tool
- Desktop Procedure: EPSDT Completion audit protocol

**Comments**

None

**Recommendations**

None



**Standard  
MCH 5**

The Contractor ensures providers participate with the Arizona State Immunization Information System (ASIIS) and Vaccine for Children (VFC) programs according to the state and federal requirements. [AMPM Chapter 400, Policy 430; ARS 36-135]

**Findings: FULL COMPLIANCE**

The Contractor monitors EPSDT providers for participation in:

<input checked="" type="checkbox"/>	Arizona State Immunization Information System (ASIIS) (40%)
<input checked="" type="checkbox"/>	Vaccine for Children (VFC) program (40%)

The Contractor has a process to reimburse County Health Departments for administration of vaccines to the Contractor's enrolled children. (20%)

**Documents Reviewed**

- Desk Top procedure for VFC monitoring
- Sample letter to provider
- Desktop procedure for use of ASIIS data
- Interview Discussion

**Comments**

None

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT**

**Standard  
MCH 6**

**The Contractor coordinates with related agencies and programs (VFC, ASIIS, WIC, CRS, and RBHA) for services, according to federal and state requirements. [AMPM Chapter 400, Policy 430]**

**Findings: SUBSTANTIAL COMPLIANCE**

The Contractor coordinates with the following related agencies and programs:

<input type="checkbox"/>	Women, Infants, and Children Supplemental Nutritional Program (WIC) (16%)
<input checked="" type="checkbox"/>	Children's Rehabilitative Services (CRS) (17%)
<input checked="" type="checkbox"/>	Regional Behavioral Health Authority (RBHA) (17%)
<input checked="" type="checkbox"/>	Vaccines for Children (VFC) (17%)
<input checked="" type="checkbox"/>	Arizona State Immunization Information System (ASIIS) (17%)
<input checked="" type="checkbox"/>	Head Start (16%)

**Documents Reviewed**

- Tracking log of outreach activities
- Contractor's website
- Case Management Referral Sources list
- QM Evaluation CRS CYE '08, pp102-103
- QM Evaluation CYE 08, p 100
- WIC Flyer
- WIC letter to parents
- Desk Top procedure for Head Start Coordination
- QM Evaluation CYE'08 p.100

**Comments**

The Contractor makes referrals to WIC and sends letters to the parents of members who are identified on the EPSDT Tracking Form as being referred to WIC; however there is no evidence that the Contractor coordinates with WIC and the parents when there are issues related to quantity limits, special formulas, or non WIC covered formulas.



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT**

**Recommendations**

The Contractor should have a process to coordinate with WIC and the member's guardian when issues related to WIC services are identified.



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT

<b>Standard</b> <b>MCH 7 (Acute Only)</b> <b>The Contractor coordinates with Arizona Early Intervention Program (AZEIP) according to federal and state requirements. [AMPM Chapter 400, Policy 430]</b>	
<b>Findings: FULL COMPLIANCE</b> The Contractor has a process to educate providers about AZEIP including the need for providers to request authorization for medically necessary services from the Contractor. (34%)	
The Contractor has a process to coordinate with AZEIP utilizing the AHCCCS/AZEIP procedure. (33%)	
The Contractor has a process to ensure AHCCCS registered AZEIP providers are reimbursed for providing medically necessary therapies to EPSDT enrolled members regardless of contract status if the Contractor does not have providers available in the service area. (33%)	
<b>Documents Reviewed</b> Desktop Procedure: Coordination with Arizona Early Intervention Program (AZEIP) EPSDT / Dental Annual Plan Desktop Procedure for AZEIP AZEIP referral letter Tracking log of outreach activities	
<b>Comments</b> None	
<b>Recommendations</b> None	



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT**

**Standard  
MCH 9**

**The Contractor provides medically necessary supplemental nutrition to eligible members of EPSDT age. [AMPM Chapter 400, Policy 430]**

**Findings: FULL COMPLIANCE**

The Contractor has implemented a process for transitioning a child (who is receiving nutritional therapy) to or from another Contractor, or another service program (i.e. WIC). (50%)

The Contractor ensures that medical necessity for commercial oral nutritional supplements is determined on an individual basis by the member's PCP or attending physician using:

<u>X</u>	At least the criteria specified in the AMPM (25%)
<u>X</u>	The AHCCCS approved form "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" to obtain PA from the Contractor (25%)

**Documents Reviewed**

Copy of blank form "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements"  
Prior authorization criteria guideline for nutritional therapy  
Approvals and Denials for Nutritional Supplements (Summary Report)

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT

**Standard**  
**MCH 10 (Acute Only)**  
**The Contractor has developed and implemented policies and procedures to transition members who are aging out of Children’s Rehabilitative Services (CRS). [AMPM Chapter 500, Policy 520]**

**Findings: FULL COMPLIANCE**  
The Contractor has implemented a process for transitioning members with special health care needs who have been receiving services from CRS, but will lose eligibility, to its network providers (including specialty services). (100%)

**Documents Reviewed**  
Member Transition Policy 7000.40  
Desktop Procedure: Referral / tracking for CRS  
QM Evaluation CYE '08, care coordination

**Comments**  
None

**Recommendations**  
None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT

**Standard**

**MCH 11 (Acute Only)**

**The Contractor monitors providers for compliance with appropriate training and use of the PEDS tool. [AMPM Chapter 400, Policy 430]**

**Findings: NOT APPLICABLE INFORMATIONAL STANDARD FOR 2009**

The Contractor verifies provider training using the online AZAAP resource. (20%)

The Contractor has a process to notify PCPs when a NICU-discharged member is assigned to their panel. (20%)

The Contractor monitors provider use of the PEDS tool for EPSDT eligible members who were in the NICU following birth. (20%)

The Contractor has implemented specific interventions to improve provider receipt of PEDS training, and use of the PEDS tool. (20%)

The Contractor coordinates care/services with the PCP when needs are identified utilizing the PEDS tool. (20%)

**Documents Reviewed**

Provider Newsletter: Winter 2009 p. 10  
EPSDT/Dental Annual Plan Desk Top Procedure for PEDS  
QM Evaluation 2008 PEDS Assessment pp47-48

**Comments**

None

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
MATERNAL AND CHILD HEALTH AND EPSDT**

**Standard  
MCH 12**

**The Contractor has processes in place to implement and monitor the childhood obesity program using the AHCCCS Childhood Obesity Guidelines.**

**Findings: NOT APPLICABLE INFORMATIONAL STANDARD FOR 2009**

The Contractor provides outreach to members stressing healthy nutritional practices.

The Contractor does not educate and encourage providers to refer members to centers of excellence for childhood obesity.

The Contractor monitors members participating in the childhood obesity program.

**Documents Reviewed**

EPSDT/ Dental Annual Plan Desk top procedure for EPSDT Referrals member outreach  
Tracking outreach efforts log  
Childhood Obesity 8 Habits, physical activity pyramid exercise pyramid, food pyramid  
Parent letter for child who has been identified overweight, refer to Tucson Medical Center FitKids program

**Comments**

No documentation was provided of education to providers on referring members to centers of excellence for childhood obesity.

**Recommendations**

None



**Standard  
QM 1**

**The Contractor conducts a new member health risk assessment survey. [AMPM Chapter 900, Policy 920; 42CFR438.208]**

**Findings: FULL COMPLIANCE**

The Contractor makes a “best effort” attempt to conduct an initial assessment of each member’s health care needs. (50%)

The Contractor utilizes the information from the assessment to attempt to improve member’s health care needs. (50%)

**Documents Reviewed**

Quality Management Work Plan CYE 09  
Health Risk Assessment (HRA) – Policy 8300  
Desktop Procedure: QM Assessments

**Comments**

None

**Recommendations**

None



**Standard  
QM 2**

**The Contractor identifies specific health care needs through the new member health risk assessment survey.  
[AMPM Chapter 900, Policy 920; 42CFR438.208, 42CFR438.420]**

**Findings: FULL COMPLIANCE**

The Contractor assists members with specific health care needs, identified through the health risk assessment survey, to ensure their health care needs are met.

**Documents Reviewed**

Quality Management Work Plan CYE 09; page 37 – Health Status Assessment Survey  
Health Risk Assessment (HRA) – Policy 8300  
Desktop Procedure: QM Assessments

**Comments**

None

**Recommendations**

None



**Standard  
QM 3**

**The Contractor maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement its QM/QI Program. [AMPM Chapter 900, Policy 910; 42CFR428.242]**

**Findings: FULL COMPLIANCE**

The Contractor ensures that information data received from providers is accurate, timely, and complete. (34%)

The Contractor reviews reported data for accuracy, completeness, logic, and consistency. (33%)

The Contractor's review and evaluation processes are clearly documented. (33%)

**Documents Reviewed**

Healthcare Professionals – Policy number 8100.07

Information System Overview

Multidisciplinary team meeting 1/5/09

QM/UM Meeting Minutes: February 21, 2008

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
 CYE 2009  
 Mercy Care Plan  
 QUALITY MANAGEMENT

**Standard  
 QM 4**

The health information system data elements include at least the following information to guide the selection of and meet the data collection requirements for quality improvement requirements. [AMPM Chapter 900, Policy 910; 42CFR438.242]

**Findings: FULL COMPLIANCE**

The health information system includes at least the following elements:

<u>  </u> X	Member demographics (25%)
<u>  </u> X	Services provided to members (25%)
<u>  </u> X	Other information necessary for quality improvement (Grievances, utilization, appeals and disenrollment for other than loss of Medicaid eligibility) (50%)

**Documents Reviewed**

Desktop Procedure: Health Status Assessment Survey  
 QM/UM Meeting Minutes: February 21, 2008

**Comments**  
 None

**Recommendations**  
 None



**Standard  
QM 5**

**The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for member/system resolution. [AMPM Chapter 900, Policy 960; 42CFR438.402, 406, 408, and 416]**

**Findings: FULL COMPLIANCE**

The Contractor has been found to be 93% compliant with AMPM requirements after review of 30 quality-of-care files.

**Documents Reviewed**

30 QOC files

Peer Review – Policy number 8000.10

Acute Care Behavioral Health:

Coordination and QM Monitoring – Policy number 8000.25

Review of Health – Care Professionals

**Comments**

The review of at least seven of the quality of care cases lack documentation of referrals to licensing agencies. The Quality Management procedure indicates that only after three substantiated cases of poor outcomes are reported to licensing agencies.

**Recommendations**

None



**Standard  
QM 6**

**The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for system improvement. [AMPM Chapter 900, Policy 960; 42CFR438.240; 42CFR428.402, 406, 408, and 416]**

**Findings: FULL COMPLIANCE**

The Contractor ensures quality-of-care complaints received anywhere in the organization are referred to Quality Management for investigation and resolution. (20%)

The Contractor incorporates successful interventions into the QM program or assigns new interventions/approaches when necessary. (20%)

The Contractor monitors the success of interventions developed as a result of member complaint/abuse issues. (20%)

The Contractor analyzes and evaluates the data from this system to determine any trends related to the quality-of-care in the Contractor's service delivery system or provider network. (20%)

The Contractor utilizes trends referred to and reviewed by the QM Committee. (20%)

**Documents Reviewed**

Peer Review – Policy number 8000.10

Acute Care Behavioral Health:

Coordination and QM Monitoring – Policy number 8000.25

Review of Health – Care Professionals

**Comments**

None

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
QUALITY MANAGEMENT**

**Standard**

**QM 7 A (Acute Only)**

**The Contractor has a process in place for improving performance measure results. [AMPM Chapter 900, Policy 970; 42CFR438.240]**

**Findings: SUBSTANTIAL COMPLIANCE**

The Contractor is meeting the Minimum Performance Standard (MPS) for **ACUTE** Performance Measures at the following percentage:

<input type="checkbox"/>	≥90% (score 90 points)
<input checked="" type="checkbox"/>	Between 75 and 89% (score 75 points)
<input type="checkbox"/>	Between 50 and 74% (score 50 points)
<input type="checkbox"/>	≤49% (Score 0 points)

For all measures for which the Contractor has not met the MPS based on the most recent AHCCCS measurement the Contractor has:

<input checked="" type="checkbox"/>	Implemented corrective action plans approved by AHCCCS (if no, deduct 5 points)
<input checked="" type="checkbox"/>	Evaluated the effectiveness of all CAPs at least annually through the QM Program structure. (If no, deduct 5 points)
<input checked="" type="checkbox"/>	Implemented new or revised interventions to meet the MPS if evaluation demonstrates an ineffective CAP (no points given but 15 points deducted from Standard total if an ineffective CAP was not met with a new or revised intervention.)

**Documents Reviewed**

- AHCCCS-reported results of Performance Measures
- CYE 2008 Quality Management Evaluation and CYE 2009 QM/PI Work Plan
- Mercy Care Plan Corrective Action Plans
- CYE 2009 Quality Management/Utilization Management Committee Minutes



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
QUALITY MANAGEMENT**

CYE 2009 Prevention and Wellness Multidisciplinary Team Meeting Minutes

**Comments**

The CYE 2009 Acute-Care Contract includes 25 performance measures for which AHCCCS reported rates for the Contractor in 2008 (measures that include both Medicaid and KidsCare populations count as two measures). The Contractor met the AHCCCS MPS for 21 (84 percent) of these measures in the most recent measurement. It did not meet the MPS for Well Child Visits in the First 15 Months of Life, Children's and Adolescents' Access to Primary Care Providers (PCPs) from 12 to 24 Months, Children's and Adolescents' Access to PCPs from 12 - 19 Years, and Chlamydia Screening. In addition, two measures showed statistically significant declines in the last measurement — Timeliness of Prenatal Care (although the Contractor was still above the MPS) and Chlamydia Screening.

The Contractor submitted an evaluation of interventions in December 2008 with its CYE 2008 Quality Management Evaluation. On January 30, 2009, AHCCCS issued a Notice to Cure related to performance measures for which it is not meeting the AHCCCS MPS. The Contractor subsequently submitted new CAPs for all Acute-Care measures for which it is not meeting the MPS.

**Recommendations**

The Contractor must meet the AHCCCS MPS for all contractual performance measures and improve its rates for those that are currently below the AHCCCS MPS. MCP has submitted CAPs for performance measures through the Notice to Cure process, and is not required to submit a separate CAP for this standard.



**Standard**

**QM 8 A (Acute Only)**

The Contractor conducts PIPs to assess the quality and appropriateness of its service provision and to improve performance. [AMPM Chapter 900, Policy 980; 42CFR438.240]

**Findings: FULL COMPLIANCE**

For any AHCCCS-mandated ACUTE PIP for which AHCCCS has conducted a re-measurement, the Contractor has demonstrated or sustained improvement in each PIP indicator (100%)

OR

For each indicator for which the Contractor has not shown demonstrable or sustained improvement in the most recent measurement by AHCCCS, the Contractor has:

N/A	Evaluated the effectiveness of interventions implemented under each PIP at least annually through its QM Program structure. (50%)
N/A	Implemented new, revised, or enhanced interventions, based on its internal quality assessment and performance improvement process. (50%)

**Documents Reviewed**

- AHCCCS-reported results of Performance Improvement Projects
- CYE 2008 Quality Management Evaluation and CYE 2009 QM/PI Work Plan
- Mercy Care Plan PIP Re-measurement Reports
- CYE 2009 Quality Management/Utilization Management Committee Minutes
- CYE 2009 Prevention and Wellness Multidisciplinary Team Meeting Minutes

**Comments**

The Contractor completed the Acute-Care PIP on Provider Reporting to ASIS in CYE 2008, showing demonstrable and sustained improvement in the second re-measurement.

**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
QUALITY MANAGEMENT**



**Recommendations**  
None



**Standard QM 9**

**The Contractor ensures credentialing, re-credentialing, and provisional credentialing of the providers in their contracted provider network. [AMPM Chapter 900, Policy 950; 42CFR438.214]**

**Findings: FULL COMPLIANCE**

The Contractor identifies the Medical Director or designated physician as being responsible for oversight of the credentialing and re-credentialing and provisional credentialing decisions. (25%)

The Contractor identifies the role of the Credentialing Committee. (25%)

Performance monitoring data is included in the re-credentialing decision making process for primary care practitioners. This data set includes at a minimum (25% total):

<u>x</u>	Member concerns which include grievances (complaints) and appeals information. (4%)
<u>x</u>	Information from identified adverse events. (3%)
<u>x</u>	Utilization Management information. (3%)
<u>x</u>	Risk Management information. (3%)
<u>x</u>	Information on compliance with policies. (3%)
<u>x</u>	Physician profiling. (3%)
<u>x</u>	Performance Improvement and monitoring. (3%)
<u>x</u>	Contractor quality issues. (3%)

The Contractor's credentialing/recredentialing and provisional credentialing policies are reviewed and approved by the Contractor's executive management. (25%)

**Documents Reviewed**

- Coordination and QM Monitoring – Policy number 8000.25
- Review of Health – Care Professionals
- Office Medical Records – Policy number 8000.30



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
QUALITY MANAGEMENT**

Delegation of Responsibilities – Policy number 8000.60  
Credentialing Process for Healthcare Professionals – Policy number 8100.05  
Provisional Credentialing Process for Healthcare Professionals – Policy number 8100.07  
30 Re-credentialing files

**Comments**

None

**Recommendations**

None



**Standard**  
**QM 10**

**The Contractor ensures the credentialing and re-credentialing of providers in the contracted provider network. [AMPM Chapter 900, Policy 950; 42CFR438.214]**

**Findings: FULL COMPLIANCE**

57 out of 59 (97%) of the credentialing and re-credentialing files reviewed were compliant with the AMPM requirements.

**Documents Reviewed**

30 initial credentialing files  
29 re-credentialing files

**Comments**

None

**Recommendations**

None



**Standard  
QM 11**

**The Contractor's provisional credentialing process meets the AHCCCS required timelines. [AMPM Chapter 900, Policy 950; 42CFR438.214]**

**Findings: FULL COMPLIANCE**

27 of 28 (96%) of the provisional credentialing files (or all if less than 30) reviewed showed that the process had been completed within 14 calendar days from receipt of the completed application to the date signed by the Medical Director.

**Documents Reviewed**

Review of Health – Care Professionals  
Credentialing Process for Healthcare  
Professionals – Policy number 8100.05  
Provisional Credentialing Process for  
Healthcare Professionals – Policy number 8100.07

**Comments**

None

**Recommendations**

None



**AHCCCS OFR Standards**  
**CYE 2009**  
**Mercy Care Plan**  
**QUALITY MANAGEMENT**

**Standard**

**QM 12 A (Acute Only)**

**The Contractor monitors that PCPs maintain comprehensive records. [AMPM Chapter 900, Policy 940; Acute Contract Section D, Paragraph 21; 42CFR438.240]**

**Findings: PARTIAL COMPLIANCE**

The Contractor monitors their contracted Primary Care Physicians (PCP) to ensure that physicians:

—	Appropriately transition members being treated for ADHD, depression and anxiety to the RBHA to maintain continuity of care. (12%)
X	Possess legible medical records for each enrolled member who has been seen for medical appointments or procedures. (13%)
X	Receive medical/behavioral health records from other providers who have seen the enrolled member. (13%)
—	Update behavioral health providers when changes to medication or diagnoses occur. (13%)

The Contractor confirms that records are:

X	Kept up-to-date (17%)
X	Well organized (16%)
X	Comprehensive with sufficient detail to promote effective patient care and quality review (16%)

**Documents Reviewed**

Review of Healthcare Professional Medical Record – Policy Number 8000.30; pages 1 - 6  
 Peer Review – Policy number 8000.10  
 Acute Care Contract: Behavioral Health  
 Quality Management Department – Interpretation of PCP Medical Record Review Audit Tool  
 30 Medical Record Review Audit files

**Comments**

None



**Recommendations**

The Contractor must ensure contracted PCPs update the member's behavioral health provider when there are changes in the member's diagnoses or prescribed medication and appropriately transition members being treated for ADHD, depression and anxiety to the RBHA to maintain continuity of care.



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
QUALITY MANAGEMENT**

**Standard  
QM 13**

**The Contractor monitors that PCPs maintain comprehensive records that include at a minimum: identification information; demographic information; member initial and past medical and dental histories; and immunization records AMPM Chapter 900, Policy 940; and 42CFR438.240.**

**Findings: FULL COMPLIANCE**

The Contractor monitors PCP records for the following components:

<u>X</u>	Member identification information on each page of the record (i.e., name or AHCCCS ID). (20%)
<u>X</u>	Documentation of identifying demographics (i.e., name, address, telephone number, AHCCCS ID, gender, age, date of birth, marital status, next of kin, and if applicable, guardian or authorized representative). (20%)
<u>X</u>	Initial history of the member (i.e., family history, social history and preventive laboratory screening. The initial history for members under age 21 should also include prenatal care and birth history). (20%)
<u>X</u>	Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received. (20%)
<u>X</u>	Dental history if available, and current dental needs and/or services. (20%)

**Documents Reviewed**

Review of Healthcare Professional Medical Record – Policy Number 8000.30; pages 1 – 6  
 Coordination and QM Monitoring – Policy number 8000.25  
 30 Medical Record Review Audit files  
 Quality Management Department – Interpretation of PCP Medical Record Review Audit Tool

**Comments**

None

**Recommendations**

None



**Standard**

**QM 14 A (Acute Only)**

The Contractor monitors that PCPs maintain comprehensive records that include at a minimum: current problem listing; current medications; current and complete EPSDT forms; documentation of coordination of care; advance directives; and information releases AMPM Chapter 900, Policy 940; and 42CFR438.240.

**Findings: SUBSTANTIAL COMPLIANCE**

The Contractor monitors PCP records for the following components:

<u>X</u>	Current problem list/medications (15%)
<u>X</u>	Documentation, initialed by the member's PCP to signify review of diagnostic information (15%)
<u>X</u>	Reports from referrals, consultation and specialists, emergency/urgent care reports, hospital discharge summaries. (15%)
<u>X</u>	Behavioral health information about the member (including referrals and services provided) is kept in the medical record or a temporary file, if applicable. (15%)
<u>X</u>	Documentation related to the transmittal of diagnostic, treatment and disposition information to the PCP and other providers as appropriate. (15%)
<u>  </u>	Response to requests for information about members receiving behavioral health services from behavioral health providers is sent by the PCP within 10 days of receiving the request. (15%)
<u>X</u>	Documentation that the PCP reviews member behavioral health information received from the RBHA behavioral health provider who is also treating the member. (10%)

**Documents Reviewed**

- Office Medical Records – Policy number 8000.30
- Quality Management Department – Interpretation of PCP Medical Record Review Audit Tool
- Desktop Procedure: QM Oversight of PCP Response to RBHAs
- PCP Letter, Blank RBHA/Provider Letters
- Blank Behavioral Health Coordination Medical Record Report Form
- Provider Handbook
- 30 Medical Record Review Audit files

AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
QUALITY MANAGEMENT



**Comments**  
None

**Recommendations**

The Contractor must develop a process to ensure contracted PCPs respond to requests for information about members receiving behavioral health services from behavioral health providers is sent by the PCP within 10 days of receiving the request. The Contractor must document the status of the correction plan including re-evaluation to confirm the effectiveness of the plan.



**Standard  
QM 15**

**The Contractor monitors that providers document in the member's medical record whether or not the adult member has been provided information on advance directives and whether an advance directive has been executed. [AMPM Chapter 900, Policy 940; 42CFR438.6, 42CFR417.436]**

**Findings: FULL COMPLIANCE**

The Contractor ensures that providers document in the member's medical record notification of advance directives.

The Contractor ensures that providers document in the member's medical record that an advance directive has been executed.

**Documents Reviewed**

- Coordination and QM Monitoring – Policy number 8000.25
- Review of Health – Care Professionals
- Office Medical Records – Policy number 8000.30
- Quality Management Department
- Interpretation of PCP Medical Record Review
- 30 Medical Record Review Audit files

**Comments**

None

**Recommendations**

None



**Standard  
QM 16**

The Contractor ensures that there is appropriate supervision by a licensed professional documented in the member's record (does not include independent providers; e.g. Physicians Assistants under supervision of a DO or MD). [AMPM Chapter 900, Policy 940]

**Findings: FULL COMPLIANCE**

The Contractor ensures that there is appropriate supervision by a licensed professional documented in the member's record.

The Contractor monitors that all member medical record information protected by Federal and State law is kept confidential.

**Documents Reviewed**

Review of Health – Care Professionals  
Office Medical Records – Policy number 8000.30  
Quality Management Department  
Interpretation of PCP Medical Record Review  
30 Medical Record Review Audit files

**Comments**

None

**Recommendations**

None



**Standard**

**QM 17 (Acute Only)**

Primary Care Providers (PCP) are informed that they may medically manage behavioral health members for the treatment of anxiety, depression and Attention Deficit-Hyperactive Disorders (ADHD) and are informed about the coverage of medications to treat depression, anxiety and Attention Deficit-Hyperactive Disorders (ADHD) by the Contractor. [Contract Section D, Paragraph 12]

**Findings: FULL COMPLIANCE**

The Contractor has informed PCPs about their ability to medically manage behavioral health members for the treatment of depression, anxiety and ADHD.

The Contractor informs PCPs about the availability of medications to treat depression, anxiety, and ADHD.

**Documents Reviewed**

Desktop procedure for Assistance with Acute Care BH Referral Requests From PCPs, MCP and Members  
Desktop procedure for BH Corrective Action Plan Requests, Development and Monitoring  
Power Point Presentation  
Provider Handbook

**Comments**

None

**Recommendations**

None



**Standard**

**QM18 (Acute Only)**

The Contractor ensures that training and education is available to PCPs regarding behavioral health referral and consultation procedures for these members. [Contract Section D, Paragraph 12]

**Findings: FULL COMPLIANCE**

The Contractor ensures that training and education is available to PCPs regarding behavioral health referral procedures.

The Contractor ensures that training and education is available to PCPs regarding consultation procedures.

**Documents Reviewed**

Power Point Presentation

Provider Handbook

Training- Primary Care Physician Meeting

**Comments**

None

**Recommendations**

None



**Standard**

**QM 19 (Acute Only)**

The Contractor ensures that its quality management program incorporates the monitoring of the PCPs' medical management of behavioral health disorders. [Contract Section D, Paragraph 12]

**Findings: FULL COMPLIANCE**

The Contractor's quality management program incorporates monitoring of the PCP's medical management of behavioral health disorders.

**Documents Reviewed**

Policies and Desktop Procedures  
Auditing Tools  
Summaries of outcomes  
Behavioral Health Coordination Medical Record Report Form  
QM Meeting Minutes

**Comments**

None

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
QUALITY MANAGEMENT**

**Standard**

**QM 20 (Acute Only)**

The Contractor ensures the initiation and coordination of a referral when a behavioral health need has been identified and follows up to determine if the member received behavioral health services. [Contract Section D, Paragraphs 10 and 12]

**Findings: FULL COMPLIANCE**

The Contractor ensures the initiation and coordination of a referral when a behavioral health need has been identified. (50%)

The Contractor monitors whether members referred for behavioral health services have received services. (50%)

**Documents Reviewed**

Desktop Procedure for BHA Referrals of Acute Care Members Based on EPSDT Screening Form  
Health Risk Questionnaire or Enrollment Transition Information Form  
Parent/Guardian Letter  
Tracking Sheet and Progress Notes

**Comments**

None

**Recommendations**

None



**Standard**

**QM 21 (Acute Only)**

The Contractor incorporates industry best practices/evidence-based guidelines or AHCCCS endorsed "Tool Kits" for the treatment of anxiety, depression and ADHD. [Contract Section D, Paragraph 12]

**Findings: NOT RATED**

**FOR INFORMATION ONLY 2009**

**Documents Reviewed**

Desktop procedure for Acute Care Behavioral Health Medical Record Review  
ADHD Medical Record Review Form  
Blank Medical Record Review Form for Anxiety  
Blank Medical Record Review Form for Postpartum Depression  
Power Point Presentation  
Provider Handbook.

**Comments**

Although this standard was not scored for this review period, the Contractor did meet the requirements for this standard.

**Recommendations**

None



**Standard**

**QM 22 (Acute Only)**

**The Contractor collaborates with the Arizona State Hospital prior to member discharge. [Contract Section D, Paragraph 12]**

**Findings: FULL COMPLIANCE**

The Contractor coordinates with the Arizona State Hospital for members with co-morbidities prior to the member's discharge into the community. (50%)

The Contractor issues the same brand and model of glucometer test supplies that the member was trained to use while in the hospital. (50%)

**Documents Reviewed**

- Progress Notes
- E-mails
- Policies and Desktop Procedures
- Provider Handbook

**Comments**

None

**Recommendations**

None



**Standard**

**QM 23 (Acute Only)**

The Contractor provides ongoing medically necessary nursing services for members who, due to their mental health status, are incapable or unwilling to manage their medical condition when the member has a skilled medical need. [Contract Section D, Paragraph 12]

**Findings: FULL COMPLIANCE**

The Contractor provides ongoing medically necessary nursing services for members who have co-morbidities. (25%)

The Contractor has a process for evaluating medical necessity for members who have mental health conditions that render them incapable or unwilling to manage their medical condition. (20%)

The Contractor tracks who receives ongoing nursing services due to a mental health condition that renders them incapable or unwilling to manage their medical condition. (10%)

The Contractor refers members with co-morbidities for ongoing nursing services. (25%)

The Contractor coordinates care with the Regional Behavioral Health Authority for members who have a mental health condition that renders them incapable or unwilling to manage their medical condition. (20%)

**Documents Reviewed**

- Policies and Desktop Procedures
- Provider Handbook
- Progress Notes
- E-mails
- Evidence of Authorization
- Claims Processing Reports and QNEXT Printouts

**Comments**

None

**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
QUALITY MANAGEMENT**



**Recommendations**  
None



**Standard**

**QM 24 (Acute Only)**

**For members who have completed step therapy with medications for the treatment of anxiety, depression, and ADHD, the Contractor continues to provide medication at the dosage at which the member has been stabilized, unless there is a subsequent change in the member's medical condition. [Contract Section D, Paragraph 12]**

**Findings: NON COMPLIANCE**

The Contractor does not have a mechanism in place to identify members who have completed step therapy and are returning to the care of their PCPs for the treatment of depression, anxiety, or ADHD. (20%)

The Contractor does not monitor its PCPs to ensure that they prescribe medications in consistence with those prescribed by the RBHA providers when a member has completed step therapy. (20%)

The Contractor does not educate providers on the concept of step therapy, including that medication should not be changed unless there is a change in the member's medical condition. (20%)

When members transition from the RBHA to the PCP, the Contractor does not require PCPs to consult with, or obtain information from the RBHA providers for members who report having tried several medications/have participated in step therapy for the treatment of depression, anxiety, or ADHD prior to their current medication regime. (20%)

The Contractor does not authorize medications originally prescribed by a RBHA provider for members who have completed step therapy. (20%)

**Documents Reviewed**

- Policies and Procedures
- Provider Handbook
- Newsletter
- PCP letters

**Comments**



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
QUALITY MANAGEMENT**

The Contractor's documentation did not demonstrate that they educate providers on the concept of step therapy, or that they are in compliance with contract requirements.

**Recommendations**

The Contractor must have a mechanism in place to identify members who have completed step therapy and are returning to the care of their PCPs for the treatment of depression, anxiety, or ADHD.

The Contractor must monitor its PCPs to ensure that they prescribe medications in consistency with those prescribed by the RBHA providers when a member has completed step therapy.

The Contractor must require PCPs to consult with, or obtain information from the RBHA providers for members who report having tried several medications/have participated in step therapy for the treatment of depression, anxiety, or ADHD prior to their current medication regime.

The Contractor must authorize medications originally prescribed by a RBHA provider for members who have completed step therapy.



AHCCCS OFR Standards  
 CYE 2009  
 Mercy Care Plan  
 QUALITY MANAGEMENT

**Standard  
 QM 25**

**The Contractor ensures that HCBS services are monitored. (Attendant Care, Personal Care, Homemaker, and Habilitation services) [AMPM Chapter 900, Policy 920; B 4; 42 CFR 438.230]**

**Findings: FULL COMPLIANCE**

The Contractor ensures that HCBS services are monitored annually and includes supervision by agency, background checks, and three references:

X	Attendant Care Services
X	Personal Care Services
X	Homemaker Services
	Habilitation Services (if applicable)

**Documents Reviewed**

- Coordination and QM Monitoring – Policy number 8000.25
- Review of Health – Care Professionals
- Attendant Personal Care Audit Definition
- Attendant Personal Care Audit Tool
- HCBS Delegated Site Audit Definitions
- HCBS Delegated Site Audit Tool
- Attendant Care monitoring tools

**Comments**

The Contractor did not provide documentation of monitoring of habilitation providers. During the interview the Contractor noted that they are contracted with two habilitation providers.

**Recommendations**

None



**Standard  
DS 1**

**The Contractor has a mechanism for tracking and trending provider inquiries that includes timely acknowledgement and resolution and taking systemic action as appropriate. [Contract Section D, Paragraph 29]**

**Findings: SUBSTANTIAL COMPLIANCE**

The Contractor has policies and procedures for the acknowledgement and response to provider inquiries. (25%)

The Policies include all of the following (25%):

- 3 business day acknowledgement of the inquiry
- 30 business day resolution
- Taking systemic action as appropriate

The Contractor does show evidence of tracking provider inquiries for adherence to the Policy. (50%)

**Documents Reviewed**

- Provider Complaint Policy
- Provider Grievance Policy
- Desktop Procedure for Provider Complaints
- Desktop Procedure for Provider Grievances/Complaints
- Took Kit Provider Complaints
- Provider Services Network Development/Contracting Manual-Chapter 9-Call Tracking and Resolution Codes
- Provider Complaint Log – January 2009

**Comments**

The Provider Complaint Policy contains conflicting information with regard to provider issue resolution timeframes. The policy states that the timeframe should not exceed 60 days and also that resolution should not exceed 30 days. The Contractor's policy exceeds AHCCCS standards with regard to provider inquiry acknowledgment by stating that inquiries must be acknowledged within 48 hours. Although, the Contractor provided evidence of tracking provider inquiries many inquiries were resolved beyond the 30 business day timeframe.



**AHCCCS OFR Standards  
CYE 2009**

**Mercy Care Plan**

**DELIVERY SYSTEMS AND PROVIDER RELATIONS**

**Recommendations**

The Contractor must update its policy to reflect the correct timeframe for resolving provider inquiries. In addition, the Contractor must resolve all inquiries within the required timeframe of 30 business days.



**DELIVERY SYSTEMS AND PROVIDER RELATIONS**

**Standard**

**DS 2 (Acute Only)**

**The Contractor has appropriate mechanisms for the provision and monitoring of transportation for members with ongoing treatment needs. [Contract Section D, Paragraphs 11 and 33]**

**Findings: NON COMPLIANCE**

The Contractor does not have policies and procedures for the provision of transportation for members with ongoing treatment needs. (25%)

The Policies do not meet the requirements of Paragraphs 10, 11, and 33 of Contract YH09-0001. (75%)

**Documents Reviewed**

Policy MS 601: Transportation  
Member Services Manual-Chapter 15-Transportation  
MCP Narrative on Standard DS 2

**Comments**

None

**Recommendations**

The Contractor must update its policies and desktop procedures to include specific information on providing transportation for members with ongoing treatment needs. The reference to “blanket” transportation in the policy is not sufficient.



**AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
DELIVERY SYSTEMS AND PROVIDER RELATIONS**

**Standard**  
**DS 3 (Acute Only)**  
**The Contractor has implemented a quarterly performance audit tool to evaluate transportation wait times as described in paragraph 33 of the contract. [Contract Section D, Paragraph 33; ACOM Policy 417]**

**Findings: FULL COMPLIANCE**  
 The Contractor has policies and procedures for auditing transportation wait times. (40%)  
 The Contractor has completed quarterly audit tools. (60%)

**Documents Reviewed**  
 Transportation Survey Summaries February 2008-January 2009  
 Policy MS 601: Transportation  
 Member Services Training Manual

**Comments**  
 None

**Recommendations**  
 None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
DELIVERY SYSTEMS AND PROVIDER RELATIONS

**Standard**

**DS 4 (Acute Only)**

**The Contractor monitors appointment availability and wait times of contracted Primary Care, Specialist, Dental and Maternity providers as set forth in ACOM policy 417. [Contract Section D, Paragraph 33; ACOM Policy 417]**

**Findings: PARTIAL COMPLIANCE**

The Contractor has policies and procedures for monitoring appointment availability and wait times. (30%)

The Contractor has evaluated quarterly reports. (40%)

The Contractor has not taken corrective action when necessary based on the report results. (30%)

**Documents Reviewed**

Desktop Procedure: Provider Appointment Availability Review Process  
Appointment Availability Member Report: PCP, Specialist, Dentists  
Appointment Availability Provider Report: PCP, Specialist, Dentists  
Accessibility Survey Tool: PCP, Specialist, Dentist  
Policy & Procedure: 6100.08: Accessibility and Availability of Health Care Professionals  
Annual Accessibility Audit – Notice of Corrective Action Letter

**Comments**

The Contractor provided a template of a letter that is used to put a provider on corrective action for failure to comply with appointment availability and wait time standards but did not provide evidence of completed letters.

**Recommendations**

The Contractor must take corrective action when necessary based on the survey report results.



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
CLAIMS AND INFORMATION SYSTEMS

**Standard**  
**CIS 1**

The Contractor has processes to incorporate and update AHCCCS required system information for claims processing as specified in Contract.

**Findings: FULL COMPLIANCE**  
The Contractor applies CCI edits. (33%)

The Contractor applies Multiple Surgical Reductions appropriately. (33%)

The Contractor applies Global Day bundling logic appropriately. (34%)

**Documents Reviewed**

- 10 claims and remittance advices with CCI edits.
- 10 claims and remittance advices showing Multiple Surgical Reductions.
- 10 claims and remittance advices showing procedure bundling.

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
CLAIMS AND INFORMATION SYSTEMS

**Standard**  
CIS 2 (Acute Only)  
The Contractor has a protocol for accurately populating the Claims Dashboard. [Contract Section D, Paragraph 38; Claims Dashboard Reporting Guide]

**Findings: FULL COMPLIANCE**  
The Contractor has policies and procedures for the completion and submission of the Claims Dashboard. (50%)

The Contractor can reproduce the dashboard data upon request. (50%)

**Documents Reviewed**  
Dashboard policies  
Background reporting

**Comments**  
None

**Recommendations**  
None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
CLAIMS AND INFORMATION SYSTEMS

**Standard**  
CIS 3 (Acute Only)  
The Contractor accurately applies interest; quick-pay; and slow-pay payments. [Contract Section D, Paragraph 38]

**Findings: FULL COMPLIANCE**  
The Contractor shows evidence of accurate interest payment calculation. (25%)  
The Contractor shows evidence of quick-pay discount application. (25%)  
The Contractor shows evidence of slow-pay penalty application. (25%)  
The Contractor accurately pays interest on overturned Claim Disputes. (25%)

**Documents Reviewed**  
10 remittance advices showing interest payment  
10 remittance advices showing quick-pay application  
10 remittance advices showing slow-pay application  
10 overturned claim dispute files.

**Comments**  
None

**Recommendations**  
None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
CLAIMS AND INFORMATION SYSTEMS

<b>Standard</b> CIS 4 (Acute Only)	The Contractor has a methodology for the calculation of electronic claim receipt and payment percentages. [Contract Section D, Paragraph 38]
<b>Findings: SUBSTANTIAL COMPLIANCE</b>	The Contractor has a methodology for the calculation of electronic claim receipt and payment percentages. (33%)
	The Contractor has a valid methodology. (33%)
	The Contractor meets AHCCCS standards for electronic claim receipt. (17%)
	The Contractor does not meet AHCCCS standards for electronic payment. (17%)
<b>Documents Reviewed</b>	Dashboard policies/procedures Dashboard
<b>Comments</b>	None
<b>Recommendations</b>	The Contractor should continue efforts to promote electronic payment to electronic submitters as they are most likely to adopt.



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
CLAIMS AND INFORMATION SYSTEMS

**Standard**  
CIS 5 (Acute Only)  
The Contractor has appropriate policies and procedures in place for the reimbursement of services provided during the Prior Period Coverage period. [Contract Section D, Paragraph 38]

**Findings: FULL COMPLIANCE**  
The Contractor has policies addressing the reimbursement of claims received for services rendered during PPC. (75%)  
The Policies appropriately address reimbursement for Behavioral Health services rendered during PPC. (25%)

**Documents Reviewed**  
Prior Period Coverage Policies  
Claims Processing Manual – Behavioral Health Claims

**Comments**  
None

**Recommendations**  
None



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
CLAIMS AND INFORMATION SYSTEMS

**Standard**  
CIS 6

**The Contractor performs a periodic audit of contract loading accuracy. [Contract Section D, Paragraph 38 Acute]**

**Findings: FULL COMPLIANCE**

The Contractor has policies and procedures for the auditing of contract loading for accuracy of payment. (25%)

The Policies contain provisions for audit periodicity. (25%)

10 out of 10 (100%) contracts reviewed against Contractor system information (claims payment and provider file) demonstrated accurate loading of contracted rates. (50%)

**Documents Reviewed**

Policy for reconciliation of Contracts  
Contract files  
Remittance Advices

**Comments**

None

**Recommendations**

The Contractor should clarify in policy what periodicity will be for each line of business.



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
CLAIMS AND INFORMATION SYSTEMS

**Standard  
CIS 7**

**The Contractor integrates member and provider information provided by AHCCCS on a regular basis. [Contract Section D, Paragraph 38]**

**Findings: SUBSTANTIAL COMPLIANCE**

Policy requires the verification of member and provider files against AHCCCS provided information. (50%)

Reviewer is not able to verify appropriate eligibility denials. (25%)

Reviewer is able to verify provider registration/qualification denials. (25%)

**Documents Reviewed**

- 10 remittance advices showing denial for provider category of service.
- 5 remittance advices showing member not enrolled on DOS.
- 5 remittance advices showing member deceased.

**Comments**

2 of 5 eligibility denials were found to be incorrect based on enrollment files available on the date of processing suggesting that member enrollment files are not properly integrated.

**Recommendations**

The Contractor should develop processes for the validation of integrated member files against AHCCCS supplied data.



AHCCCS OFR Standards  
CYE 2009  
Mercy Care Plan  
CLAIMS AND INFORMATION SYSTEMS

**Standard**

**CIS 8 (Acute Only)**

The Contractor has a protocol for accurately populating Attachment A of the Grievance System Report and can reproduce reporting upon request. [Contract Section D, Paragraph 38; Grievance System Reporting Guide]

**Findings: FULL COMPLIANCE**

The Contractor has policies and procedures for the completion and submission of Attachment A of the Grievance System Report. (50%)

The Contractor can reproduce the Grievance System Report data upon request. (50%)

**Documents Reviewed**

Grievance System Report policies and procedures  
Background reporting

**Comments**

None

**Recommendations**

None



**AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE**

**Statistical Measures Methodology for Encounter Standards**

- A. Total possible points are assigned for each form type (A, C, D, I, L, and O) submitted by the peer group for all Contractors. For aged pending encounters, the total possible points are not subdivided for each form type.
- B. For the measurement period, a mean; one standard deviation; and two standard deviations are calculated. Only one tail of the standard deviation results in a reduction of possible points (e.g., for the aged pending encounters a higher ratio than the upper standard deviation will lose points whereas a lower ratio than the lower standard deviation will receive full points).
- C. For each form type, the Contractor's results will be scored as follows:

A measurement less than or equal to one standard deviation	100% of assigned points
A measurement greater than one standard deviation but less than or equal to two standard deviations	50% of assigned points
A measurement greater than two standard deviations	0% of assigned points

- D. Points are totaled and multiplied by the weight to determine the compliance score.
- E. If the Contractor's data is determined to be an outlier, AHCCCS reserves the right to exclude the data from the peer group.



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
ENC 1**

**The Contractor's Ratio of adjudicated encounters by month of service is within one standard deviation of the mean. [Contract Section D, Paragraph 65 Acute]**

**Findings: FULL COMPLIANCE**

For CYE08, a ratio of adjudicated encounters by month of service per paid member month is calculated and compared to the statistical measures described above from the peer group total mean (Weight 50%).

For March 2008 through February 2008, a ratio of adjudicated encounters by month of service per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2007 through February 2008 (Weight 50%).

**Documents Reviewed**

Administrative encounter and recipient data

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
ENC 2**

**The Contractor's ratio of encounters processed is within one standard deviation of the mean. [Contract Section D, Paragraph 65 Acute]**

**Findings: FULL COMPLIANCE**

For CYE08, a ratio of processed encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean (Weight 50%).

For March 2008 through February 2008, a ratio of processed encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2007 through February 2008 (Weight 50%).

**Documents Reviewed**

Administrative encounter and recipient data

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
ENC 3**

**The Contractor's ratio of new day encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 65 Acute]**

**Findings: FULL COMPLIANCE**

For CYE08, a ratio of new day encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean (Weight 50%).

For March 2008 through February 2008, a ratio of new day encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2007 through February 2008 (Weight 50%).

**Documents Reviewed**

Administrative encounter and recipient data

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
ENC 4**

**The Contractor's ratio of approved encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 65 Acute]**

**Findings: FULL COMPLIANCE**

For CYE08, a ratio of approved encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean (Weight 50%).

For March 2008 through February 2008, a ratio of approved encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2007 through February 2008 (Weight 50%).

**Documents Reviewed**

Administrative encounter and recipient data

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
ENC 5**

**The Contractor's ratio of total pending encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 65 Acute]**

**Findings: FULL COMPLIANCE**

For CYE08, a ratio of total pending encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean (Weight 50%).

For March 2008 through February 2008 a ratio of total pending encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2007 through February 2008 (Weight 50%).

**Documents Reviewed**

Administrative encounter and recipient data

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
ENC 6**

**For the most recent quarter, the Contractor's ratio of total pended encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 65 Acute]**

**Findings: FULL COMPLIANCE**

For the quarter ending CYE08 a ratio of total pended encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean (Weight 50%).

For the quarter ending February 2008 a ratio of total pended encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from the quarter ending February 2007 (Weight 50%).

**Documents Reviewed**

Administrative encounter and recipient data

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
ENC 7**

**The Contractor's ratio of aged pended (pended greater than 120 days) encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 65 Acute]**

**Findings: FULL COMPLIANCE**

For CYE08, a ratio of aged pended encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean (Weight 50%).

For March 2008 through February 2008, a ratio of aged pended encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2007 through February 2008 (Weight 50%).

**Documents Reviewed**

Administrative encounter and recipient data

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
ENC 8**

**For the most recent quarter, the Contractor's ratio of aged pended (pended greater than 120 days) encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 65 Acute]**

**Findings: FULL COMPLIANCE**

For the quarter ending February 2008 a ratio of aged pended encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean (Weight 50%).

For the quarter ending February 2008 a ratio of aged pended encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from the quarter ending February 2007 (Weight 50%).

**Documents Reviewed**

Administrative encounter and recipient data

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard**

**ENC 9 A (Acute Only)**

The Contractor's ratio of newly pending (pending less than 30 days) encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 65 Acute]

**Findings: FULL COMPLIANCE**

For CYE08, a ratio of newly pending encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean (Weight 50%).

For March 2008 through February 2008, a ratio of newly pending encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2007 through February 2008 (Weight 50%).

**Documents Reviewed**

Administrative encounter and recipient data

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
ENC 10**

**The Contractor's ratio of pended to approved encounters is within one standard deviation of the mean. [Contract Section D, Paragraph 65 Acute]**

**Findings: FULL COMPLIANCE**

For CYE08, a ratio of pended to approved encounters per paid member month is calculated and compared to the statistical measures described above from the peer group total mean (Weight 50%).

For March 2008 through February 2008 a ratio of pended to approved encounters per paid member month is calculated and compared to the statistical measures described above for this Contractor's mean from March 2007 through February 2008 (Weight 50%).

**Documents Reviewed**

Administrative encounter and recipient data

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard**  
**ENC 11**

**An AHCCCS-selected sample of paid claims is shown to be completely, accurately, and timely encountered.**  
**[Contract Section D, Paragraph 65 Acute]**

**Findings: FULL COMPLIANCE**

Acute - 128 of 139 (92.1%) of paid claims in the sample were successfully matched against complete, accurate, and timely encounters.

**Documents Reviewed**

Claims copies, remits and encounter data submitted by Contractor

**Comments**

None

**Recommendations**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard**

**ENC 12 (Acute Only)**

The Contractor shows evidence of using earmarked dollar amounts from the data validation results for provider education and training. [Contract Section D, Paragraph 65, Data Validation Technical Document, Page 16]

**Findings: FULL COMPLIANCE**

The Contractor has a system to track the provider education and training expenditures to ensure appropriate utilization of the earmarked sanction dollar amounts that records dollar amounts spent; agendas and/or training materials; attendee or distribution lists (75%).

The Contractor spent \$824,580 on provider education and training in the twelve months prior to the review (25%).

**Documents Reviewed**

Provider education records submitted by Contractor

**Comments:**

None

**Recommendations:**

None



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
RI 1**

**The Contractor has policies and desk level procedures for encountering transplants such that encounters balance to the total of the transplant stage invoice. [Contract Section D, Paragraph 57; Reinsurance Processing Manual]**

**Findings: FULL COMPLIANCE**

The Contractor has policies and procedures for processing transplant reinsurance cases that include balancing encounters with the transplant stage invoices.

**Documents Reviewed**

Desktop Procedure: Finance-Reinsurance-Catastrophic, Date 02/12/09, pages 1-2  
Desktop Procedure: Finance-Reinsurance-ACUTE, Date 09/10/08, pages 1-5  
Transplant Manual, pages 1-23

**Comments**

The documentation reviewed reflects processes for transplant stage balancing to the facility transplant stage invoice.

**Recommendations**

The Contractor should consider applying the transplant stage balancing processes as detailed in their procedures.



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
RI 2**

**The Contractor processes transplant related encounters reflecting the appropriate CN1/subcap code.  
[Reinsurance Processing Manual]**

**Findings: SUBSTANTIAL COMPLIANCE**

The Contractor submits transplant related encounters with the appropriate CN1/subcap code.

**Documents Reviewed**

Desktop Procedure: Finance-Reinsurance-Catastrophic, Date 02/12/09, pages 1-2  
Desktop Procedure: Finance-Reinsurance-ACUTE, Date 09/10/08, pages 1-5  
Transplant Manual, pages 1-23  
AHCCCS PMMIS Reinsurance cases for -  
Mercy Care Acute 010306, R260001371, R260001843 and R260011010

**Comments**

The random selected AHCCCS PMMIS transplant cases for the acute care plan reflect various CN1 codes mapped to subcap codes due to case creation notification issues. Four of the six reviewed are at issue, one case was compliant and one was non-compliant.

**Recommendations**

The Contractor should ensure the coordination between their medical management, encounters, and reinsurance finance units to produce an acceptable outcome for the contract requirement of transplant services as it pertains to CN1/subcap code.



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard  
RI 3**

**The Contractor has identified a process for advising AHCCCS of reinsurance overpayments against associated reinsurance encounters within 30 days of identification. This process includes open or closed contract years and open or closed reinsurance cases. [Contract Section D, Paragraph 57; Reinsurance Processing Manual]**

**Findings: NON COMPLIANCE**

The Contractor does not notify the AHCCCS Reinsurance unit of overpayments against associated reinsurance encounters.

The Contractor does not notify the AHCCCS Reinsurance unit of overpayments for closed reinsurance cases.

**Documents Reviewed**

Desktop Procedure: Finance-Reinsurance-Catastrophic, Date 02/12/09, pages 1-2  
Desktop Procedure: Finance-Reinsurance-ACUTE, Date 09/10/08, pages 1-5  
Transplant Manual, pages 1-23  
AHCCCS PMMIS Reinsurance Case R260004098  
Mercy Care Email with attached Spreadsheet 01/15/2009 MCP path referenced Overpayment-Aslamy m.xls  
AHCCCS PMMIS Reinsurance Case R260001133 RAC & R260001288 AUT  
Mercy Care Reinsurance Action Request with spreadsheet, titled "List of overpayments by AHCCCS, 01/30/09,  
List of encounters that need correction due to discount/penalty-list of overpayments

**Comments**

The documentation submitted did not include the appropriate information regarding notification to AHCCCS within 30 days of identification of reinsurance overpayments against associated reinsurance encounters.

**Recommendations**

The Contractor should update their Desktop Procedures to include the specific contract language for notification of any type of reinsurance overpayments within the contracted time frame. The Contractor should apply a report for monitoring the appropriateness of the reinsurance revenue received against paid claims data.



AHCCCS OFR Standards  
CYE 2009  
MERCY CARE PLAN  
ENCOUNTERS AND REINSURANCE

**Standard**  
**RI 4**

**The Contractor has policies and procedures for monitoring the appropriateness of the reinsurance revenue received against paid claims data.**

**Findings: NOT APPLICABLE**

**INFORMATIONAL STANDARD FOR 2009**

The Contractor has policies and procedures for monitoring the appropriateness of the reinsurance revenue received against paid claims data.

**Documents Reviewed**

Desktop Procedure: Finance-Reinsurance-Catastrophic, Date 02/12/09, pages 1-2  
Desktop Procedure: Finance-Reinsurance-ACUTE, Date 09/10/08, pages 1-5  
Transplant Manual, pages 1-23

**Comments**

The findings from this review do not show that the Contractor is applying their reports for the issues reviewed as detailed in their policies and procedures.

**Recommendations**

None

# Arizona Health Care Cost Containment System (AHCCCS)



AHCCCS

## 2008–2009 EXTERNAL QUALITY REVIEW ANNUAL REPORT *for* ACUTE CARE AND DES/CMDP CONTRACTORS

June 2010



1600 East Northern Avenue, Suite 100 ♦ Phoenix, AZ 85020

Phone 602.264.6382 ♦ Fax 602.241.0757

<b>1. Executive Summary</b> .....	<b>1-1</b>
Overview of the 2008–2009 External Review .....	1-3
Findings, Conclusions, and Recommendations About Timeliness, Access, and Quality of Care .....	1-4
Organizational Assessment and Structure Standards.....	1-4
Performance Measures .....	1-7
Performance Improvement Projects (PIPs).....	1-11
Overall Findings, Conclusions, and Recommendations .....	1-13
<b>2. Background</b> .....	<b>2-1</b>
History of the AHCCCS Medicaid Managed Care Program.....	2-1
AHCCCS Quality Strategy .....	2-2
Quality Strategy Objectives .....	2-2
Operational Performance Standards.....	2-3
Performance Measure Requirements and Targets .....	2-5
Performance Improvement Project Requirements and Targets .....	2-6
<b>3. Description of EQRO Activities</b> .....	<b>3-1</b>
Mandatory Activities.....	3-1
Optional Activities .....	3-1
Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives .....	3-1
<b>4. AHCCCS Quality Initiatives</b> .....	<b>4-1</b>
AHCCCS Statewide Quality Initiatives Across All Medicaid Managed Care Programs .....	4-1
AHCCCS Quality Initiatives Driving Improvement for the Acute Care and Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP) Contractors.....	4-6
<b>5. Contractor Best and Emerging Practices</b> .....	<b>5-1</b>
<b>6. Organizational Assessment and Structure Performance</b> .....	<b>6-1</b>
Conducting the Review .....	6-1
Objectives for Conducting the Review .....	6-1
Methodology for Conducting the Review.....	6-2
Contractor-Specific Results .....	6-5
Arizona Physicians IPA, Inc. (APIPA) .....	6-5
Bridgeway Health Solutions (BHS).....	6-10
Care1st Health Plan (Care1st) .....	6-15
Health Choice Arizona (HCA).....	6-19
Maricopa Health Plan (MHP).....	6-23
Mercy Care Plan (MCP) .....	6-27
Phoenix Health Plan (PHP).....	6-31
Pima Health Systems (PHS) .....	6-35
University Family Care (UFC) .....	6-39
Arizona Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP) .....	6-43
Comparative Results for Acute Care and DES/CMDP Contractors .....	6-47
Findings.....	6-47
Strengths .....	6-49

Opportunities for Improvement and Recommendations.....	6-49
Summary .....	6-50
<b>7. Performance Measure Performance .....</b>	<b>7-1</b>
Conducting the Review .....	7-1
Objectives for Conducting the Review .....	7-2
Methodology for Conducting the Review.....	7-2
Contractor-Specific Results .....	7-5
Arizona Physicians IPA, Inc. ....	7-6
Bridgeway Health Solutions .....	7-9
Care1st Health Plan .....	7-10
Health Choice Arizona.....	7-13
Maricopa Health Plan.....	7-16
Mercy Care Plan.....	7-19
Phoenix Health Plan.....	7-22
Pima Health Systems .....	7-25
University Family Care .....	7-27
Arizona Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP) .....	7-30
Comparative Results for Acute Care and DES/CMDP Contractors .....	7-32
Findings.....	7-32
Strengths.....	7-36
Opportunities for Improvement and Recommendations.....	7-36
Summary .....	7-37
<b>8. Performance Improvement Project Performance .....</b>	<b>8-1</b>
Conducting the Review .....	8-1
Objectives for Conducting the Review .....	8-2
Methodology for Conducting the Review.....	8-2
Contractor-Specific Results .....	8-4
Arizona Physicians IPA .....	8-5
Bridgeway Health Solutions .....	8-6
Care1st Health Plan .....	8-7
Health Choice Arizona.....	8-9
Maricopa Health Plan.....	8-11
Mercy Care Plan.....	8-13
Phoenix Health Plan, LLC .....	8-15
Pima Health System.....	8-17
University Family Care .....	8-19
Arizona Department of Economic Security/Comprehensive Medical and Dental Program.....	8-21
Comparative Results for Acute Care and DES/CMDP Contractors .....	8-22
Findings.....	8-22
Strengths.....	8-23
Opportunities for Improvement and Recommendations.....	8-23
Summary .....	8-23

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 EQRO may perform the mandatory and optional EQR-related activities.”

The Arizona Health Care Cost Containment System (AHCCCS) was the first statewide Medicaid managed care system in the nation. It is recognized as a leader in designing and administering effective service delivery models for Medicaid managed care programs. Based on its extensive experience and expertise in managing and overseeing its Medicaid managed care programs, AHCCCS elected to conduct the mandatory activities. The agency developed and has consistently followed valid, tested models and processes to:

- ◆ Prepare for conducting each of the activities.
- ◆ Determine MCO and PIHP (i.e., “Contractor” within the AHCCCS system) compliance with financial and operational performance standards.
- ◆ Collect Contractor encounter and other data and use the data to directly calculate and measure Contractor performance for the AHCCCS-selected performance measures and required PIPs.
- ◆ Conduct overall validation of encounter data according to industry standards.

To meet the requirements of 42 CFR 438.358(b), an external quality review organization (EQRO) must use information from the three mandatory activities for each MCO and PIHP to prepare an annual technical report that includes the EQRO’s:

- ◆ Analysis of the information.
- ◆ Conclusions drawn from the analysis of the quality and timeliness of, and access to, Medicaid managed care services provided to members by the state’s MCOs and PIHPs.
- ◆ Recommendations for improving service quality, timeliness, and access.

AHCCCS contracted with Health Services Advisory Group, Inc. (HSAG), to analyze the information AHCCCS obtained from conducting the mandatory activities and to prepare this 2008–2009 annual report. This is the sixth year that HSAG has prepared the annual report for AHCCCS. The report complies with requirements set forth at 42 CFR 438.364.

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

This Executive Summary includes an overview of HSAG's 2008–2009 external quality review and a high-level summary of the results. The results include a description of HSAG's findings with respect to performance by the AHCCCS Contractors in complying with federal and State standards, improving performance on AHCCCS-selected measures, and conducting valid and effective AHCCCS-required PIPs. A summary of HSAG's overall findings, conclusions, and recommendations across the three performance areas are also included in this section.

Additional sections of this 2008–2009 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 2008–2009 EQRO activities that HSAG conducted
- ◆ Section 4—An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care programs and those that are specific to the Acute Care Program (i.e., Acute Care Contractors and the Arizona Department of Economic Security/Comprehensive Medical and Dental Plan [DES/CMDP] Contractor)
- ◆ Section 5—An overview of the Contractors' best and emerging practices
- ◆ Section 6 (Organizational Assessment and Structure Performance), Section 7 (Performance Measure Performance), and Section 8 (Performance Improvement Project Performance)—A detailed description of each of the three mandatory activities that includes for each activity:
  - AHCCCS' objectives for conducting the required activity and HSAG's objectives for aggregating and analyzing the data and preparing this report of findings and recommendations.
  - AHCCCS' methodologies for conducting the activity and HSAG's methodologies for using the AHCCCS data to prepare this annual report, including the technical methods of data collection and analysis, a description of the data obtained, and how conclusions were drawn from the data.
  - Contractor-specific results and statewide comparative results across Contractors, as applicable (i.e., Section 7—Performance Measure Performance, and Section 8—Performance Improvement Project Performance), including an assessment of Contractor strengths and opportunities for improvement.
  - HSAG's recommendations for improving the quality and timeliness of, and access to, the care and services Contractors provide to members.

## Overview of the 2008–2009 External Review

During contract year ending (CYE) 2008–2009, AHCCCS contracted with 10 Contractors to provide services to members enrolled in the AHCCCS Acute Care Medicaid managed care program. The nine Contractors were: Arizona Physicians IPA, Inc.; Bridgeway Health Solutions; Care1st Health Plan Arizona, Inc.; Health Choice Arizona; Maricopa Health Plan; Mercy Care Plan; Phoenix Health Plan, LLC; Pima Health System; University Family Care; and DES/CMDP. As described previously, AHCCCS directly performed the following functions related to the three mandatory activities for CYE 2008–2009 for the Acute Care and DES/CMDP Contractors:

- ◆ Reviewed Contractors' performance and capabilities through Operational and Financial Reviews (OFRs) and a review of their AHCCCS-required contract deliverables.
- ◆ Collected Contractor encounter and other data and used the data to directly calculate, analyze, and report Contractor performance for the AHCCCS-selected performance measures.
- ◆ Collected Contractor encounter and other data and used the data to directly calculate, measure, and report Contractor performance for the AHCCCS-required PIPs.
- ◆ Conducted overall validation of Contractor encounter data according to industry standards.
- ◆ Compiled and provided to HSAG: (1) a comprehensive and detailed written description of the processes and methodologies it followed in conducting the three mandatory activities related to Contractor compliance with standards, performance measures, and PIPs and (2) Contractor-specific performance results AHCCCS obtained from conducting each of the activities.

On January 15, 2010, HSAG and AHCCCS met to discuss and clarify AHCCCS' expectations for the annual external quality review report of findings for the three mandatory activities that AHCCCS performed. AHCCCS provided to HSAG detailed written and electronic information about the processes AHCCCS followed in conducting the activities and the Contractors' performance results for each. HSAG reviewed AHCCCS' documentation and developed a summary tool to crosswalk the data related to the Contractors' performance for each of the activities. Following a preliminary review of the documentation, and to ensure that HSAG was using complete and accurate information in preparing this annual report, HSAG developed and provided to AHCCCS a list of questions or requests for clarification related to AHCCCS' documentation and data. AHCCCS responded promptly to HSAG's questions and requests for clarification. As needed throughout the preparation of this report, HSAG communicated with AHCCCS to clarify any remaining questions regarding the data and information.

HSAG provided monthly written status reports to AHCCCS that described HSAG's progress in completing each of the major work plan activities critical to preparing the annual report. HSAG provided a first draft of this annual quality review report to AHCCCS for its review and comment April 23, 2010.

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

The following section discusses Contractor performance regarding the three Medicaid managed care act-defined aspects of care (i.e., timeliness of care, access to care, and quality of care). The findings are presented within the context of the three activities AHCCCS conducted and for which it provided the results to HSAG for its analysis and preparation of this report: conducting a review of Contractor performance for organizational assessment and structure standards, calculating and reporting Contractor performance rates for State-selected measures, and calculating and reporting Contractor results for AHCCCS-mandated PIPs. Each section presents the overall outcomes of each activity across the Acute Care and the DES/CMDP Contractors.

### Organizational Assessment and Structure Standards

For CYE 2009, the third year of the three-year cycle of reviews, AHCCCS conducted an extensive review of the Acute Care and DES/CMDP Contractors' performance to assess their compliance with federal and State laws, rules and regulations, and the AHCCCS contract in the following nine performance categories:

- ◆ Member Information
- ◆ Medical Management
- ◆ Authorization and Grievance System
- ◆ Maternal and Child Health and EPSDT (Early and Periodic Screening, Diagnosis, and Treatment)
- ◆ Quality Management
- ◆ Delivery Systems and Provider Relations
- ◆ Claims and Information Systems
- ◆ Encounters
- ◆ Reinsurance

### Findings

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 was 90 percent to 100 percent compliant, substantial compliance was 75 percent to 89 percent compliant, partial compliance was 50 percent to 74 percent compliant, and noncompliance was 0 percent to 49 percent compliant. If a standard was not applicable to a Contractor, AHCCCS noted this using an *N/A* designation. When AHCCCS evaluates performance for a standard as less than fully compliant, it requires the Contractor to develop a corrective action plan (CAP), submit it to AHCCCS for review and approval, and implement the corrective actions.

Figure 1-1 shows the overall percentage of each Contractor's reviewed standards that AHCCCS found to be in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars. The left-most bar in the figure shows the proportions for compliance categories across the 10 Contractors.

**Figure 1-1—Categorized Levels of Compliance With Technical Standards for Acute Care and DES/CMDP Contractors<sup>1-1</sup>**

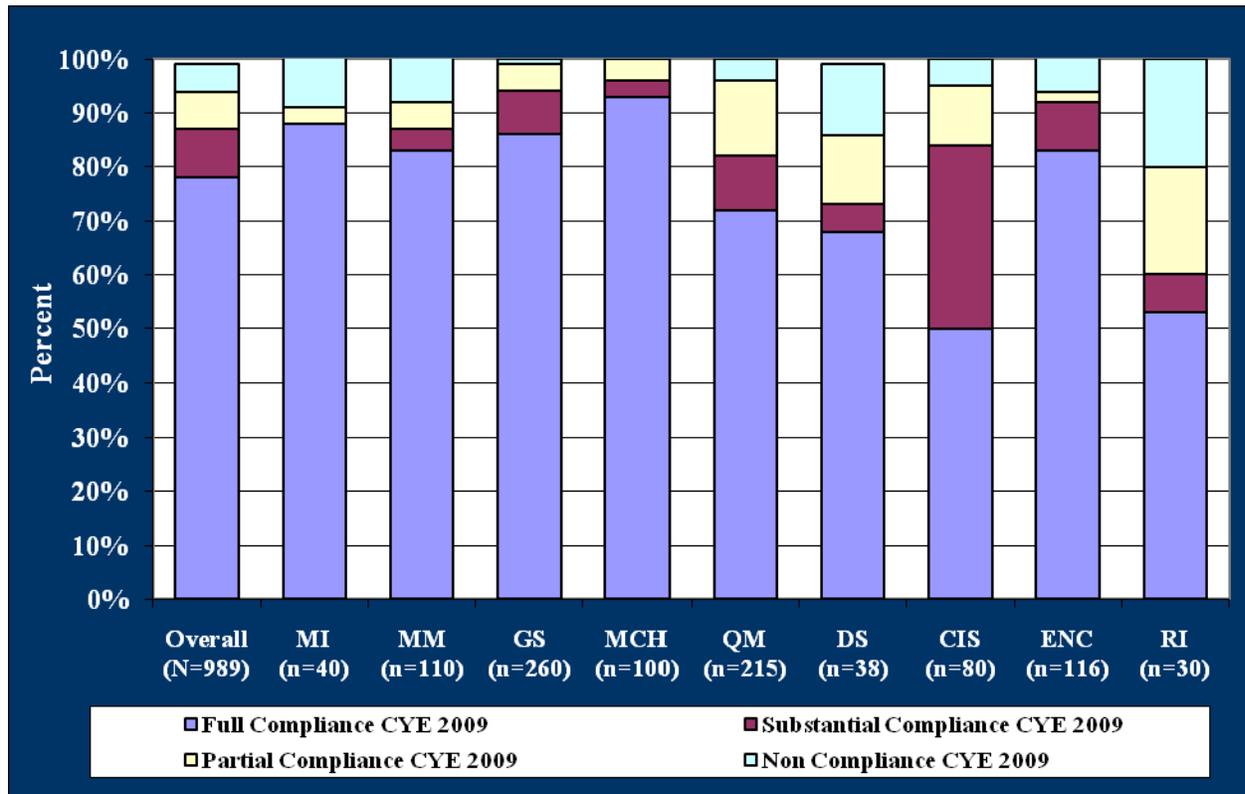


Figure 1-1 shows that the 10 Contractors were in full compliance for 78 percent of the 989 reviewed standards (left-most bar), with fairly wide variation in performance across all nine of the categories of standards. The Contractors’ strongest performance was for the standards associated with the Maternal and Child Health and EPSDT category, where AHCCCS scored 93 percent of the standards as fully compliant. Of the nine categories of standards, the Claims and Information Systems and the Reinsurance categories showed the lowest percentage of standards in full compliance (50 percent and 53 percent, respectively). All other categories scored above 70 percent compliant for their associated standards.

A comparison of the CAPs across compliance categories highlights areas for quality improvement activities across the Acute Care and DES/CMDP Contractors as a group. Table 1-1 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed in CYE 2009 for 10 Contractors.

<sup>1-1</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information	8	4%	40	20%
Medical Management	22	10%	110	20%
Authorization and Grievance System	35	15%	260	13%
Maternal and Child Health and EPSDT	9	4%	100	9%
Quality Management	63	28%	215	29%
Delivery Systems and Provider Relations	12	5%	38	32%
Claims and Information Systems	42	18%	80	53%
Encounters	20	9%	116	17%
Reinsurance	17	7%	30	57%
<b>Overall</b>	<b>228</b>	<b>100%</b>	<b>989</b>	<b>23%</b>

Table 1-1 shows that 23 percent of all reviewed OFR standards required a CAP for CYE 2009. Quality Management had the greatest number of CAPs (63) of all of the standards, which equaled 28 percent of the total CAPs. These results were followed by 42 CAPs within Claims and Information Systems. Together, these two categories represented 46 percent of all CAPs. All nine categories received at least eight CAPs. The largest percentage of CAPs relative to the number of standards in a category was in the Reinsurance category (57 percent), followed by the Claims and Information Systems category (53 percent).

### Conclusions

Results from the current assessment showed that Maternal and Child Health and EPSDT was a clear strength across the 10 Contractors. The category had only 4 percent of the total number of CAPS and had CAPs for only 9 percent of the assessed standards within the category. The Member Information category also had 4 percent of the total CAPs. These categories were relative strengths across all 10 Contractors.

With 57 percent of the standards within Reinsurance requiring a CAP, the category was assessed as a high-priority opportunity for improvement across the Contractors. Further, with 53 percent of its standards requiring a CAP, the Claims and Information Systems category was another systemwide opportunity for improvement.

### Recommendations

The intent of the OFR is to evaluate Contractors’ performance on and compliance with AHCCCS’ standards related to access, structure and operations, and measurement and improvement. Opportunities for improvement generated by the OFR and assigned CAPs identify areas within the structural operations of each Contractor that require significant attention and improvement. All of the Contractors received CAPs that could be resolved by ensuring that policies and protocols contain all AHCCCS-required elements and associated time frames (e.g., Notice of Action letters to members and service determination notices) and that Contractor staff monitors compliance with these requirements. Other CAPs generated from the CYE 2009 OFR identified opportunities to improve the timeliness, accuracy, and completeness of AHCCCS-required deliverables and reports

(e.g., encounter reporting and financial report deliverables). Deficiencies in coordination of care directly impacts access to care and the timeliness and quality of care the Contractors provide to members.

Based on AHCCCS' review of the Acute Care and DES/CMDP Contractor performance in CYE 2009 and the associated opportunities for improvement that were identified as a result of the OFR, HSAG recommends the following:

- ◆ Contractors should evaluate their current monitoring programs and activities. When deficiencies are noted, the Contractors should take steps to improve performance and/or compliance with contractual requirements.
- ◆ Contractors should develop and implement systems for monitoring the timeliness, accuracy, and completeness of all AHCCCS-required deliverables and reports. Additionally, Contractors should implement the recommendations, suggestions, and requirements identified by AHCCCS to bring policies and procedures, reports, and deliverables into compliance with AHCCCS requirements.
- ◆ Contractors should continually conduct internal reviews of operational systems to identify any instances of noncompliance with AHCCCS policies and standards. Specifically, Contractors should cross-reference existing policies and procedures with AHCCCS requirements and ensure, at a minimum, that they are in alignment with both the intent and content of AHCCCS standards.
- ◆ Contractors should review their claims and information systems and their reinsurance policies and bring them into compliance with the relevant AHCCCS standards.

### **Performance Measures**

AHCCCS collected data and calculated and reported Contractor performance for a set of AHCCCS-selected performance measures in both the previous and current reporting periods. As a result, the findings, conclusions, and recommendations are based on current Contractor performance and the change in performance over the two most recent reporting periods.

### **Findings**

Table 1-2 presents the performance measure rates for all Acute Care and DES/CMDP Contractors. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2009 minimum performance standard (MPS) and goal.

**Table 1-2—Performance Measurement Review for Acute Care and DES/CMDP Contractors**

Performance Measure	Performance for Oct. 1, 2006, to Sept. 30, 2007	Performance for Oct. 1, 2007, to Sept. 30, 2008	Relative Percentage Change	Significance Level <sup>^</sup> (p value)	CYE 2009 MPS	AHCCCS Goal
<i>Children's Access to PCPs (Total)</i>	76.7%	<b>80.8%</b>	<b>2.9%</b>	<b>p&lt;.001</b>	**	**
12–24 Months***	82.6%	<b>85.0%</b>	<b>7.2%</b>	<b>p&lt;.001</b>	93%	97%
25 Months–6 Years***	76.2%	<b>81.6%</b>	<b>4.2%</b>	<b>p&lt;.001</b>	83%	97%
7–11 Years***	75.2%	<b>78.4%</b>	<b>4.4%</b>	<b>p&lt;.001</b>	83%	97%
12–19 Years***	76.6%	<b>80.0%</b>	<b>5.4%</b>	<b>p&lt;.001</b>	81%	97%
<i>Adults' Access to Preventive/Ambulatory Health Services (Total)<sup>^</sup></i>	81.7%	<b>83.0%</b>	<b>1.6%</b>	<b>p&lt;.001</b>	**	**
20–44 Years <sup>^</sup>	79.9%	<b>81.0%</b>	<b>1.4%</b>	<b>p&lt;.001</b>	78%	96%
45–64 Years <sup>^</sup>	85.6%	<b>86.7%</b>	<b>1.2%</b>	<b>p&lt;.001</b>	85%	96%
<i>Well-Child Visits—First 15 Months***<sup>^</sup></i>	59.4%	59.5%	0.2%	p=.857	65%	90%
<i>Well-Child Visits—3, 4, 5, 6 Years***</i>	61.6%	<b>66.2%</b>	<b>7.5%</b>	<b>p&lt;.001</b>	64%	80%
<i>Adolescent Well-Care Visits***</i>	36.3%	<b>41.6%</b>	<b>14.5%</b>	<b>p&lt;.001</b>	41%	50%
<i>Annual Dental Visits—2–21 Years ***</i>	57.6%	<b>60.9%</b>	<b>5.8%</b>	<b>p&lt;.001</b>	55%	57%
<i>Breast Cancer Screening—52–69 Years<sup>^</sup></i>	51.8%	<b>62.3%</b>	<b>20.2%</b>	<b>p&lt;.001</b>	50%	70%
<i>Cervical Cancer Screening<sup>^</sup></i>	62.2%	<b>63.2%</b>	<b>1.7%</b>	<b>p&lt;.001</b>	65%	90%
<i>Chlamydia Screening—16–24 Years***<sup>^</sup></i>	38.7%	<b>39.9%</b>	<b>3.0%</b>	<b>p=.022</b>	51%	62%
<i>Timeliness of Prenatal Care***<sup>^</sup></i>	70.7%	<b>67.1%</b>	<b>-5.1%</b>	<b>p&lt;.001</b>	80%	90%
<i>EPSDT Participation</i>	71.2%	<b>76.0%</b>	<b>6.7%</b>	<b>p&lt;.001</b>	68%	80%
**During CYE 2007, the minimum performance standards and goals for the Children's Access to PCPs and Adults' Access to Preventive/Ambulatory Health Services measures were established for each age group instead of at the aggregate level, as in previous years.						
<sup>^</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the p value is ≤ .05. Rates in bold indicate statistical significance.						
***Because of a change in its contract, Pima Health System members were not included in the current measurement.						
<sup>^</sup> CMDP was not included in the current or previous measurements.						

Using the AHCCCS CYE 2009 MPS and goals as frames of reference, Table 1-2 shows that 16 of the 17 measures demonstrated improvement compared to the previous year. Fifteen of the measures that improved did so by a statistically significant amount. The measure, *Timeliness of Prenatal Care*, declined by a statistically significant amount. Seven of the 15 measures with an AHCCCS MPS exceeded the AHCCCS MPS. However, only one measure, *Annual Dental Visits*, exceeded the AHCCCS goal. Of the eight measures that did not meet the AHCCCS MPS, six measures showed statistically significant improvement, one demonstrated improvement, and one measure (*Timeliness of Prenatal Care*) declined.

Table 1-3 presents the Acute Care and DES/CMDP Contractors' required CAPs for the previous and the current review cycles for the 15 continuing measures with an AHCCCS MPS from both the previous and current reviews. The table shows each of the performance measures, the previous number of CAPs required, the CYE 2008 MPS, the current number of CAPs required, and the CYE 2009 MPS. Please note, the AHCCCS MPS increased from CYE 2008 to CYE 2009 for 11 measures, stayed the same for 3 measures, and decreased for 1 measure. Of the 11 measures with an

increased MPS, 4 measures (*Children’s Access to PCPs—12–24 Months, 25 Months–6 Years, and 7–11 Years* and *Well-Child Visits—3, 4, 5, 6 Years*) increased by at least 5 percentage points.

**Table 1-3—Performance Measures—Corrective Action Plans Required for Acute Care and DES/CMDP Contractors**

Performance Measure	CYE 2008		CYE 2009	
	Number of CAPs (10/1/2006–9/30/2007)	Minimum Performance Standard	Number of CAPs (10/1/2007–9/30/2008)	Minimum Performance Standard
<i>Children's Access to PCPs (Total)</i> <sup>A</sup>		n/a		
<i>12–24 Months</i>	8	85%	8	93%
<i>25 Months–6 Years</i>	7	78%	5	83%
<i>7–11 Years</i>	5	77%	7	83%
<i>12–19 Years</i>	6	79%	5*	81%
<i>Adults’ Access to Preventive/Ambulatory Health Services (Total)</i> <sup>B</sup>		n/a		
<i>20–44 Years</i>	4	78%	1	78%
<i>45–64 Years</i>	4	83%	3	85%
<i>Well-Child Visits—First 15 Months</i> <sup>A,B</sup>	7	70%	5	65%
<i>Well-Child Visits—3, 4, 5, 6 Years</i> <sup>A</sup>	3	56%	5	64%
<i>Adolescent Well-Care Visits</i> <sup>A</sup>	6	37%	3	41%
<i>Annual Dental Visits—2–21 Years</i> <sup>A</sup>	1	51%	0	55%
<i>Breast Cancer Screening—52–69 Years</i>	4	50%	0	50%
<i>Cervical Cancer Screening</i>	1	57%	7	65%
<i>Chlamydia Screening—16–25 Years</i>	4	43%	5	51%
<i>Timeliness of Prenatal Care</i>	3	70%	7	80%
<i>EPSDT Participation</i>	1	68%	0	68%
<b>Total Number of CAPs</b>	<b>64</b>		<b>56</b>	

<sup>A</sup> Pima Health System was not included in these measures.

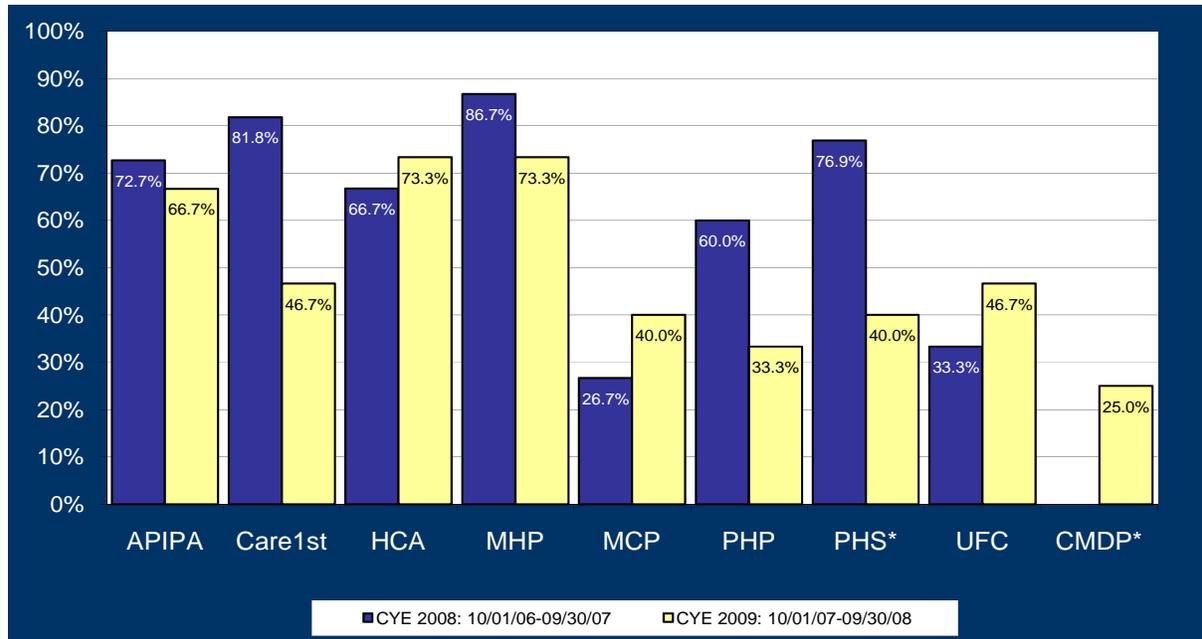
<sup>B</sup> DES/CMDP was not included in these measures.

\* One Contractor's rate (Mercy Care Plan) was 0.1 percentage point below the MPS

Overall, CAPs increased for *Children’s Access to PCPs—7–11 Years; Well-Child Visits—3, 4, 5, 6 Years; Cervical Cancer Screening; Chlamydia Screening; and Timeliness of Prenatal Care*. The CAPs remained the same for one measure (*Children’s Access to PCPs—12–24 Months*) and decreased for the remaining nine measures. The MPS increased for 11 measures, and the total number of CAPs decreased by 8, from 64 CAPs in CYE 2008 to 56 in CYE 2009. The number of CAPs for *Adolescent Well-Care Visits* and *Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years* decreased by at least half. There were no CAPs for *Annual Dental Visits—2–21 Years, Breast Cancer Screening—52–69, and EPSDT Participation* in CYE 2009. From CYE

2008 to CYE 2009, there was a decrease in the number of CAPs for nine measures and an increase in the number of CAPs for five measures.

**Figure 1-2—Corrective Action Plans Required for Acute Care and DES/CMDP Contractors**



\* The total number of measures reported by these plans was less than those for the other plans. In 2009, PHS collected only the following measures: *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* and *45–64 Years* and *EPSDT Participation*. CMDP did not collect the following measures in 2008 or 2009: *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* and *45–64 Years*, and *Well-Child Visits—First 15 Months of Life*.

Figure 1-2 shows the percentage of CAPs received by each of the Acute Care and DES/CMDP Contractors. The percentage of CAPs increased between CYE 2008 and CYE 2009 for the following four plans: HCA, MCP, UFC, and CMDP. The increase in CAPs could be attributed to the increase in the AHCCCS MPS for 11 measures. Five plans—APIPA, Care1st, MHP, PHP, and PHS—had a decrease in the percentage of CAPs from CYE 2008 to CYE 2009. It is important to note, however, that the total number of measures reported by PHS and CMDP during CYE 2008 and CYE 2009 was less than the total number of measures for the other plans.

## Conclusions

Based on the results of this review, the quality improvement effort implemented by the Contractors to increase rates has positively impacted the overall rates for the Acute Care and DES/CMDP Contractor performance measures. There were eight fewer CAPs in CYE 2009 than there were in CYE 2008 for measures evaluated during both years. The reduced number of CAPs for CYE 2009 demonstrates a positive trend for performance improvement because of the increased AHCCCS MPS for 11 of the measures in CYE 2009. The *Annual Dental Visits—2–21 Years*, *Breast Cancer Screening*, and *EPSDT Participation* measures demonstrated clear strengths among all Acute Care and DES/CMDP Contractors who reported rates for those measures. There were no CAPs required for these measures. *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* was

also a recognized strength because only one Contractor received a CAP for this measure. For *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years* and *Adolescent Well-Care Visits*, three Contractors received CAPs for these measures.

## Recommendations

There are a number of performance measures that require targeted strategies to improve performance, such as all of the *Children's Access to PCPs* measures, the *Well-Child Visits* measures, *Cervical Cancer Screening*, and *Timeliness of Prenatal Care*. Overall, HSAG recommends that the Contractors identify barriers that impact preventive service rates, such as those for the *Cervical Cancer Screening* and *Chlamydia Screening—16–24 Years* measures for female members. Since the rate for *Breast Cancer Screening* demonstrated statistically significant improvement (with a relative increase of 20.2 percent), the barriers that impact Chlamydia and cervical cancer screening rates may not be related to accessibility of services. Instead, the results may indicate that there is a need to increase education about the need for Chlamydia and cervical cancer screening.

HSAG also recommends that the Contractors identify barriers that impact access to care for children's services. The Contractors should determine if barriers are related to limited transportation to obtain care, limited availability of practitioner or clinic appointments, or misunderstanding by the member about what services to access and when. Access-related barriers could be overcome with increased transportation coordination and expanded office hours for practitioners or clinics. Member awareness barriers can be overcome with increased education on periodicity schedules for *Children's Access to PCPs* and *Well-Child Visits*.

HSAG further recommends that the Contractors work together to identify barriers that have reduced rates for *Timeliness of Prenatal Care*, which declined by a statistically significant amount. Targeted care coordination for expectant mothers could assist members with establishing a relationship with an obstetrician and potentially assist members with obtaining prenatal services according to the periodicity schedule recommended by the American College of Obstetricians and Gynecologists (ACOG).

Last, since the improvement strategies employed to increase the rates for *Annual Dental Visits—2–21 Years*, *Breast Cancer Screening*, and *EPSDT Participation* have been successful, HSAG recommends that the Contractors evaluate the interventions used to improve those measures. Lessons learned from quality improvement activities may be useful in improving the rates for other child and adult measures that did not meet the AHCCCS MPS.

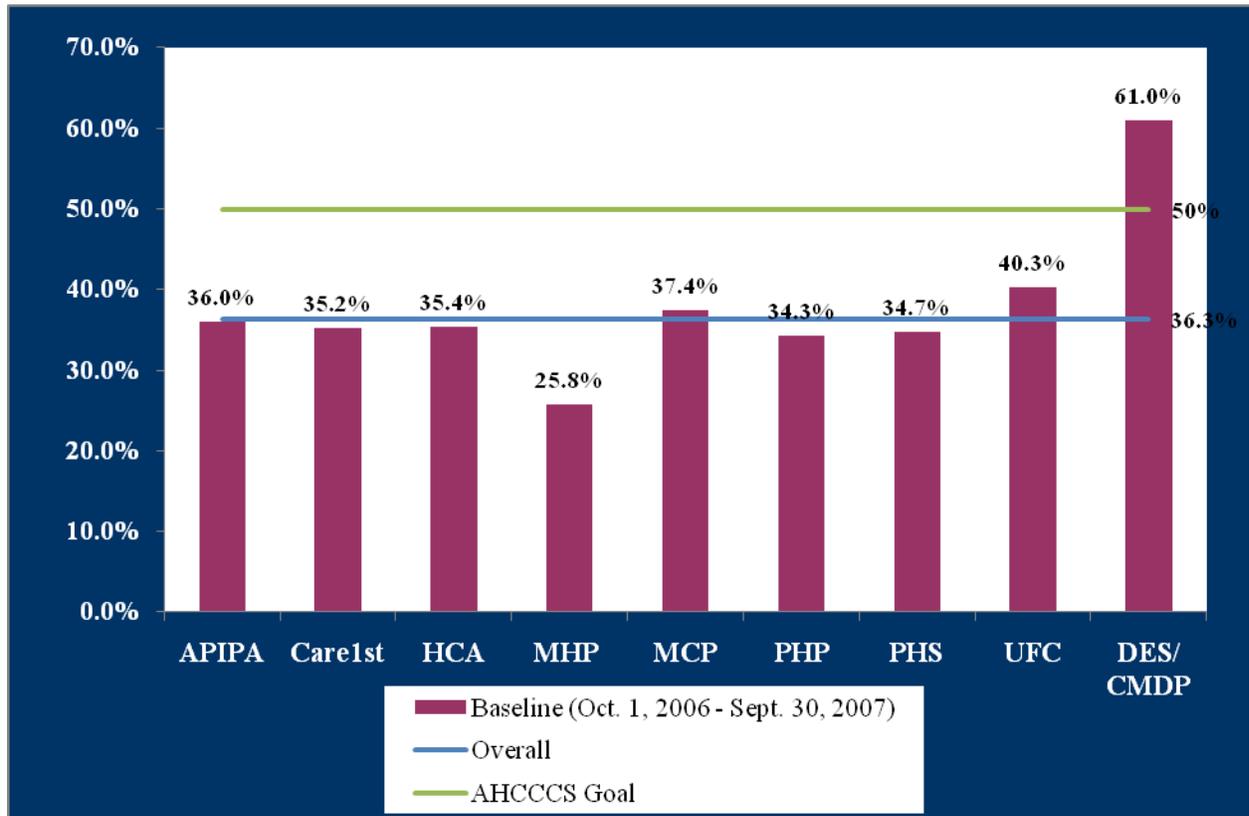
## Performance Improvement Projects (PIPs)

AHCCCS provided to HSAG the results it calculated for the Acute Care and DES/CMDP Contractors' AHCCCS-mandated PIPs. In CYE 2009, AHCCCS began the baseline measurement of a new PIP for the Acute Care Contractors and DES/CMDP: the *Adolescent Well-Care Visits* PIP. Bridgeway Health Solutions was not an AHCCCS Contractor at the time of the baseline measurement for the PIP. Therefore, the following results do not include results for Bridgeway Health Solutions.

**Findings**

Figure 1-3 presents a comparison of rates for the *Adolescent Well-Care Visits* PIP. The figure presents the baseline measurement rates for each of the Acute Care and DES/CMDP Contractors.

**Figure 1-3—Comparison of Adolescent Well-Care Rates for Acute Care and DES/CMDP Contractors<sup>1-2</sup>**



The overall average rate of adolescent well-care visits was 36.3 percent, which was 13.7 percentage points below the AHCCCS goal of 50 percent. Three of the Contractors—MCP, UFC, and DES/CMDP—had rates above the average rate of 36.3 percent. DES/CMDP had the highest rate among the Contractors and exceeded the AHCCCS goal of 50 percent by 11 percentage points. MHP had the lowest rate among the Contractors with 25.8 percent.

**Conclusions**

Only one Contractor, DES/CMDP, exceeded the AHCCCS adolescent well-care visit goal of 50 percent. The remaining Contractors’ adolescent well-care visit rates ranged from 25.8 percent for MHP to 40.3 percent for UFC.

<sup>1-2</sup> The Contractors’ names are abbreviated as follows: APIPA=Arizona Physicians IPA, Care1st=Care1st Health Plan, HCA=Health Choice Arizona, MHP=Maricopa Health Plan, MCP=Mercy Care Plan, PHP=Phoenix Health Plan, PHS=Pima Health Systems, UFC=University Family Care, and DES/CMDP=Arizona Department of Economic Security/Community Medical and Dental Program.

## Recommendations

Except for DES/CMDP, which had a rate that was above the AHCCCS goal, HSAG recommends that the Acute Care Contractors conduct causal/barrier analyses to identify obstacles that impact adolescent well-care visit rates. Through these analyses, the Contractors may identify if members have difficulty accessing services or if members require additional education on the types of services available and the importance of obtaining preventive health care visits. At the next remeasurement, the Contractors should determine if planned interventions were successful and enhance current interventions or develop new quality initiatives to increase the percentage of members with one or more adolescent well-care visits. Additionally, all Contractors should continue to track adolescent well-care rates by race and ethnicity to identify if any disparities exist. If it is determined that disparities exist in Contractor data, Contractors should develop quality improvement strategies that target disparate populations to increase adolescent preventive care visit rates.

## Overall Findings, Conclusions, and Recommendations

Acute Care and DES/CMDP Contractors are making progress toward improving the delivery of services and quality of care provided to their members. This conclusion is evidenced through the Contractors' performance results for the three activities AHCCCS conducted and HSAG analyzed and included in this report. Using a combination of review and assessment activities from the CYE 2009 OFR and measuring Contractor performance on AHCCCS-selected performance measures and PIPs to guide and facilitate improvement, it is clear that AHCCCS has implemented a comprehensive system to monitor and improve the quality and timeliness of, and access to, care the Contractors provide to Medicaid members.

With 87 percent of standards being in full or substantial compliance and 8 percent in noncompliance, the CYE 2009 Acute Care and DES/CMDP OFR found overall positive results. Most of the CAPs were related to monitoring, reporting, and communications processes. If the Contractors continue to improve, they should be able to achieve full or nearly full compliance in the near future. Nonetheless, both the Claims and Information Systems and the Reinsurance categories require relatively quick attention and a concerted effort to resolve the large percentage of CAPs across the Contractors.

Results of the review of performance measures showed that the Acute Care and DES/CMDP Contractors demonstrated improved rates in CYE 2009 compared to CYE 2008. The reduction in the number of CAPs by five for CYE 2009 demonstrated improved performance over the previous year because of the increased AHCCCS MPS for eight of the measures in CYE 2009. The highlight for all Contractors was the *Annual Dental Visits—2–21 Years* rate, which exceeded the AHCCCS MPS and the goal for all Acute Care and DES/CMDP Contractors that reported a rate for this measure. *Breast Cancer Screening* and *EPSDT Participation* demonstrated clear strengths among all Acute Care and DES/CMDP Contractors that reported rates for these measures because there were no CAPs required for these measures. There were a number of performance measures that required targeted strategies to improve performance, such as all of the *Children's Access to PCPs* measures, the *Well-Child Visits* measures, *Cervical Cancer Screening*, and *Timeliness of Prenatal Care*.

PIP results showed that only one Contractor, DES/CMDP, exceeded the AHCCCS adolescent well-care visit goal of 50 percent. The remaining Contractors' adolescent well-care visit rates did not meet the AHCCCS goal.

In general, this 2008–2009 Annual Report for Acute Care Contractors has shown improvement in the timeliness of, access to, and quality of care provided to Medicaid members. While several opportunities for improvement are highlighted throughout the report, the opportunities and the associated recommendations should not detract from the improvements and progress many Contractors demonstrated.

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.
- ◆ The operational performance standards AHCCCS used to evaluate Contractor performance in complying with CMS regulations and State contract requirements.
- ◆ The 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, the first statewide Medicaid managed care system in the nation, has operated under an 1115 Research and Demonstration Waiver since 1982, when it began its acute care program. The Arizona Long Term Care System (ALTCS) program was added in December 1988 for individuals with developmental disabilities, then expanded in January 1989 to include the elderly and physically disabled (EPD) populations. Coverage of comprehensive behavioral health services began in October 1990 for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Its last expansion gave all Medicaid-eligible individuals comprehensive behavioral health coverage. AHCCCS has operated throughout its 27-year history as a pioneer and recognized, respected leader in developing and managing innovative, quality, and cost-effective Medicaid managed care programs.

AHCCCS contracts with private and public managed care organizations (MCOs) and two prepaid inpatient health plans (PIHPs) to provide services to its members statewide. The two PIHPs are contracted to provide a defined and limited scope of services (i.e., one provides behavioral health services and the other provides children's rehabilitation services). Within the AHCCCS program, the MCOs and the PIHPs are called "Contractors."

As described in its 2011–2015 strategic plan:

- ◆ AHCCCS makes prospective capitation payments to contracted health plans responsible for the delivery of care to their members, creating a managed care system that:
  - Mainstreams recipients.
  - Allows recipients to select their providers.
  - Encourages quality care and preventative services.
- ◆ The majority of acute care program recipients are children and pregnant women who qualify for the federal Medicaid program (Title XIX). While most are enrolled with one of the AHCCCS-contracted health plans, American Indians and Alaska Natives in the acute care program may choose to receive their services through either the contracted health plans or the American Indian Health Program.

- ◆ AHCCCS also administers an emergency services-only program for individuals who, except for immigration statutes, would qualify for full AHCCCS benefits.

## AHCCCS Quality Strategy

The U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid 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 health care services offered to their members. The written strategy must describe the standards that the 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 its 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.

While AHCCCS has had a formal QAPI plan since 1994, it established and submitted its initial quality strategy to CMS in 2003. It has continued to update the strategy as needed and to submit revisions to CMS. AHCCCS' QAPI strategy was last revised in March 2009. 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 may also involve other internal and/or external collaborations/participants.

## Quality Strategy Objectives

AHCCCS' mission statement is: "Reaching across Arizona to provide comprehensive, quality health care to those in need." Consistent with this mission, AHCCCS states in its quality strategy that:

- ◆ AHCCCS develops the strategy through identifying specific goals and objectives.
- ◆ The quality strategy provides a framework for AHCCCS' overall goal of improving and/or maintaining members' health status as well as fostering the increased resilience and functional health status of members with chronic conditions.
- ◆ The overarching quality strategy objective is to design and implement "a coordinated, comprehensive, and proactive approach to drive quality throughout the AHCCCS system by utilizing creative initiatives, monitoring, assessment, and outcome-based performance

improvement . . . designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of services.”

The quality strategy objectives are one component of the agency’s five-year strategic plan. AHCCCS’ strategies for evidence-based outcomes and quality initiatives address its broad quality goals and objectives and include:

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

AHCCCS’ QAPI strategy describes detailed goals and objectives that address, in part:

- ◆ Enhancing performance measures, performance improvement, and best-practice activities as one approach to developing a statewide QAPI roadmap for driving improvement in member-centered outcomes.
- ◆ Building upon prevention efforts and health maintenance/management to improve members’ health status through targeted medical management.
- ◆ Developing collaborative strategies and initiatives with State agencies and other partners to improve access, health outcomes, and health education; manage vulnerable and at-risk members; and build professional and paraprofessional capacity in underserved areas.
- ◆ Enhancing customer service.
- ◆ Improving information retrieval and reporting capacity.

### **Operational Performance Standards**

The Assessment section of AHCCCS’ QAPI strategy describes the processes AHCCCS uses to assess the quality and appropriateness of care/services for members with routine and special health care needs. The assessment processes include conducting annual OFRs of Contractors and reviewing their deliverables required by contract, program-specific performance measures, and PIPs. AHCCCS conducts OFRs and reviews Contractor deliverables to meet the requirements of Medicaid managed care regulations (42 CFR 438.364). AHCCCS also conducts the reviews to determine the extent to which each Contractor complied with additional federal and State regulations as well as AHCCCS contract requirements and policies. As part of the OFRs, AHCCCS staff reviews Contractor progress in implementing recommendations made during prior OFRs and determines each Contractor’s compliance with its own policies and procedures.

At least every three years, AHCCCS reviews Contractor performance in complying with standards in all 14 performance areas to ensure Contractor compliance with federal Medicaid managed care requirements and AHCCCS contract standards. AHCCCS may review some areas more frequently—sometimes annually—if the requirements are new, there are Contractor compliance issues, or the requirements are in an area of special focus. AHCCCS issues a performance report to each Contractor that includes AHCCCS’ findings and the Contractor’s scores for each standard AHCCCS reviews in each performance area. The scores define the degree to which the Contractor’s

performance is in compliance with the requirements—i.e., full compliance (90 percent to 100 percent), substantial compliance (75 percent to 89 percent), partial compliance (50 percent to 74 percent), and noncompliance, (0 percent to 49 percent). If a standard is not applicable for a Contractor, AHCCCS notes this using an *NA* designation. AHCCCS also documents its recommendations to improve Contractor performance. For AHCCCS recommendations stating that the Contractor “must” or the Contractor “should,” AHCCCS requires Contractors to submit detailed corrective action plans (CAPs) to AHCCCS for its review and acceptance.

The performance categories AHCCCS evaluates are:

- ◆ Behavioral Health
- ◆ Case Management
- ◆ Claims and Information Systems
- ◆ Corporate Compliance
- ◆ Cultural Competency
- ◆ Delegated Agreements
- ◆ Delivery Systems and Provider Relations
- ◆ General Administration
- ◆ Authorization and Grievance System
- ◆ Maternal and Child Health and EPSDT
- ◆ Medical Management
- ◆ Quality Management
- ◆ Reinsurance
- ◆ Third-Party Liability

Examples of deliverables that Contractors are required to submit to AHCCCS for its review include the following:

- ◆ Annual Case Management Plan
- ◆ Annual Cultural Competency Evaluation
- ◆ Annual EPSDT Plan (including dental)
- ◆ Annual Medical Management Plan and Evaluation
- ◆ Annual Network Development and Management Plan
- ◆ Annual Quality Management Plan and Evaluation
- ◆ Quarterly EPSDT Progress reports
- ◆ Quarterly Quality Management reports

As described in detail in the 2006–2007 EQR annual report, for the 2006–2007 review period (that was the first year of a three-year cycle of performance reviews), AHCCCS conducted an extensive OFR of Contractor performance across 13 standards and, as applicable, required the Contractors to develop and implement CAPs for performance AHCCCS assessed as not fully compliant.

For the second year of the three-year cycle (2007–2008), as described in the 2007–2008 EQR annual report, AHCCCS conducted the following activities to evaluate Contractor performance for operational standards:

- ◆ Issued an RFP for Acute Care Contractors, conducted a complete review of all bidders as part of its evaluation process, and entered into new contracts with the successful bidders.
- ◆ Reviewed contractually-required Contractor deliverables throughout the year from all Acute Care and DES/CMDP Contractors to evaluate their compliance with the contract in the following areas:
  - Delegated agreements
  - Grievance system
  - Member handbook
  - Member information
  - Network development and management plans
  - QAPI program

As applicable, AHCCCS required revised deliverables until it approved them as complete and fully compliant with contract requirements.

For the third and last year of the three-year cycle, AHCCCS conducted a limited review that focused on the requirements that had not been reviewed in the previous two years. However, in some areas, items from previous reviews were repeated. As described in detail in Section 6 of this report—Organizational Assessment and Structure Performance—AHCCCS reviewed the following categories of requirements and the number of standards within each category:

- ◆ Member Information—4 standards
- ◆ Medical Management—11 standards
- ◆ Authorization and Grievance System—26 standards
- ◆ Maternal and Child Health and EPSDT—12 standards
- ◆ Clinical Quality Management—24 standards
- ◆ Delivery Systems and Provider Relations—4 standards
- ◆ Claims and Information Systems—8 standards
- ◆ Encounters—12 standards
- ◆ Reinsurance—4 standards

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

AHCCCS' quality strategy described the agency's processes to define, collect, and report Contractor performance data on AHCCCS-required measures. AHCCCS used the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®1-1</sup>) for most of its performance measures. Examples of measures for any given year could include breast and cervical cancer screening,

---

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

adolescent well-care visits, childhood immunizations, and timely initiation of services, including prenatal services. Each year, AHCCCS establishes an MPS and Goal for each measure. Contractors not meeting the MPS for any given measure are required to submit CAPs to AHCCCS that include the Contractors' planned interventions that will assist them in meeting the MPS.

For the measurement year ending September 30, 2008, AHCCCS collected and calculated the Acute Care and DES/CMDP Contractors' performance rates for the same six HEDIS measures used the previous year:

- ◆ *Children's Access to Primary Care Practitioners (12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years)*
- ◆ *Adults' Access to Preventive/Ambulatory Health Services (20–44 Years and 45–64 Years)<sup>1-2\*</sup>*
- ◆ *Well-Child Visits in the First 15 Months of Life\**
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- ◆ *Adolescent Well-Care Visits*
- ◆ *Annual Dental Visits—2–21 Years*

In addition to these measures, HSAG also collected and calculated rates for:

- ◆ *An EPSDT Participation measure based on CMS-prescribed methodology.*
- ◆ *The following additional HEDIS measures for the Acute Care Contractors only:*
  - *Cervical Cancer Screening*
  - *Chlamydia Screening*
  - *Timeliness of Prenatal Care*

### **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 that they select (e.g., increasing screening of blood lead levels for children and improving timeliness of prenatal care. However, AHCCCS also selects PIPs that the Contractors must conduct. The PIPs that the Acute Care and DES/CMDP Contractors must conduct during any given time period may or may not be the same as those that the Arizona Long Term Care System (ALTCS) program Elderly and Physically Disabled (EPD) Contractors and Department of Economic Security/Division of Developmental Disabilities (DES/DDD) Contractor must submit.

For the AHCCCS-mandated PIPs, AHCCCS and the Contractors measure performance for at least two years after Contractors report baseline rates and implement interventions to show not only improvement, but also sustained improvement, as required by the Medicaid managed care act. While AHCCCS does not establish minimum performance targets for Contractors, it does require

---

<sup>1-2</sup> Not required for DES/CMDP

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.

The AHCCCS-required PIP—with findings included in this EQR report—for the Acute Care and the DES/CMDP Contractors that was under way for the period covered by this EQR report was the *Adolescent Well-Care Visits PIP*.

### Mandatory Activities

As permitted by CMS and described in Section 1, Executive Summary, AHCCCS performed the functions associated with the three CMS-mandatory activities that must be performed for the State's Medicaid MCOs and PIHP Contractors:

- ◆ Conduct reviews to determine Contractor compliance with standards established by the State associated with the applicable federal and State regulations, statutes, rules, and contract requirements
- ◆ Validate Contractor performance measures
- ◆ Validate Contractor PIPs

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the activities for its Contractors and to prepare this CMS-required 2008–2009 external quality review annual report of findings and recommendations.

### Optional Activities

AHCCCS' EQRO contract with HSAG did not require HSAG to conduct any CMS-defined optional activities (e.g., validating encounter data, conducting focused studies of health care quality, and assessing information systems capabilities). The contract did not require HSAG to analyze and report results from these optional activities, including any conclusions by HSAG from activities conducted by AHCCCS.

### Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

In its current quality strategy, AHCCCS states that:

- ◆ The EQR reports include detailed information about the EQRO's independent assessment process, results, and recommendations.
- ◆ AHCCCS uses the information to assess the effectiveness of its current strategic goals and strategies and to provide a roadmap for potential changes and new goals and strategies.

AHCCCS also uses the EQR report findings and recommendations to:

- ◆ Support the goals of the national quality and cost transparency initiatives and AHCCCS' continued development and implementation of its statewide health information exchange (HIE) and electronic health record (EHR) central repository and a Web-based system to access and maintain the EHR repository. The applications are designed to make relevant and timely information available to Medicaid beneficiaries and providers in a user-friendly format. When

fully deployed, the HIE-EHR is expected to improve coordination of member care, enhance opportunities for self-management through personal health information and integrated wellness applications, improve quality-of-care oversight and transparency through timely performance information, and reduce both medical and administrative costs.

- ◆ Drive requirements contained in its RFP processes.
- ◆ Provide members, Contractors, and other stakeholders the opportunity to review and compare Contractor performance by publishing AHCCCS' EQR annual reports on its Web site. Such information can help newly enrolled AHCCCS members make informed enrollment choices.

### AHCCCS Statewide Quality Initiatives Across All Medicaid Managed Care Programs

AHCCCS has proven itself to be an innovative leader in identifying and aggressively, proactively pursuing opportunities to improve health care quality and outcomes, as seen in its mission, vision, QAPI strategy, and five-year strategic plan.

AHCCCS' mission statement is: "Reaching across Arizona to provide comprehensive, quality health care for those In need." In its QAPI strategy, the agency describes its vision as "shaping tomorrow's managed health care . . . from today's experience, quality, and innovation." That vision includes:

- ◆ Advocating for customer-focused health care.
- ◆ Leading the development of new quality-of-care initiatives and quality improvement strategies.
- ◆ Continuing its role as an innovator of health coverage and as a valued partner and collaborator in improving the health status of Arizonans.
- ◆ Expanding its role as a facilitator of collaborative health care initiatives that leverage public and private resources.
- ◆ Connecting uninsured and at-risk Arizonans to affordable health care coverage.
- ◆ Maintaining its role as a good steward of public and private health care finances.
- ◆ Increasing its role as a health information resource.
- ◆ Providing an optimal work environment for its employees.

Over time, AHCCCS administration has built its comprehensive quality structure by:

- ◆ Designing structures, programs, and initiatives that adhere to federal and State requirements.
- ◆ Continuously conducting environmental scans of applicable national standards and national and/or regional trends in such things as population growth and demographics, health status, health care costs, advances in technologies, etc.
- ◆ Collaborating with its public and private partners, members, Contractors, and other stakeholders.
- ◆ Building on its successes.

AHCCCS uses a participative and collaborative process to identify new clinical and nonclinical initiatives designed to improve quality of care, health outcomes, member satisfaction, and member well-being. AHCCCS ensures that the initiatives are aligned with its overall strategic goals and objectives related to quality and with its quality improvement processes.

In selecting and initiating new quality improvement initiatives, AHCCCS:

- ◆ Identifies priority areas for improvement.
- ◆ Establishes realistic outcome-based performance measures.
- ◆ Identifies, collects, and assesses relevant data.
- ◆ Considers incentives for excellence and imposes sanctions for poor performance.
- ◆ Shares best practices with and provides technical assistance to the Contractors.
- ◆ Includes relevant, associated requirements in its contracts.
- ◆ Regularly monitors and evaluates Contractor compliance and performance.
- ◆ Maintains an information system that supports initial and ongoing operations and review of AHCCCS' quality strategy.
- ◆ Conducts frequent evaluation of the initiatives' progress and results.

In addition, through its contracts with the Acute Care and DES/CMDP Contractors and the ALTCS EPD and DES/DDD Contractors, AHCCCS requires that each Contractor have an ongoing QAPI program for the services it furnishes to enrollees. The contracts specify QAPI requirements consistent with federal Medicaid managed care regulations, including those related to quality management and utilization/medical management activities, performance measure standards, and performance improvement project requirements. AHCCCS ensures that the Contractors have an ongoing QAPI program through, in part, reviewing their annual quality management, utilization management, maternal and child health, and behavioral health plans and evaluations that the Contractors must submit annually to AHCCCS for its review and approval.

AHCCCS implements quality initiatives that are specific to one of its Medicaid managed care programs, as well as quality initiatives that cross all or more than one of its programs and Contractors.

Examples of quality initiatives and results across its programs that AHCCCS had under way during the period covered by this report include the following:

- ◆ Recording statistically significant increases in quality performance measures despite a State budget crisis, resource limitations, membership increases, and staff reductions.
- ◆ Completing the groundwork necessary to move forward as a partner with other stakeholders in a statewide solution for HIE, addressing both technical and governance challenges and continuing the governor's e-Health Roadmap. Continuing to receive stakeholder input and foster partnerships with its sister agencies, contracted MCOs/programs (Contractors), providers, and the community to foster improved delivery of health services to Medicaid recipients and KidsCare members, including those with special needs; facilitate networking to address common issues and solve problems; and identify priority areas for quality improvement and the development of new initiatives.
- ◆ Continuing to expand electronic government service opportunities for both providers and members, including electronic claims attachments and continued development of Health-e Arizona and My AHCCCS.com.
- ◆ Receiving approval from State and federal partners to proceed with an RFP to upgrade its program integrity efforts through using more advanced data analytics.

- ◆ Continuing its participation in the Arizona Health Query. Together with other major Arizona health care providers, AHCCCS is a partner in a health data system that aggregates and analyzes essential, comprehensive health information for Arizona residents, tracking individuals across systems, over time.
- ◆ Continuing to enhance its data warehouse system to enable end users to quickly access AHCCCS data for a range of quality and medical management studies.
- ◆ Establishing strategic goals, including:
  - Implementing a medical management team structure to enhance the analysis and use of utilization data.
  - Collaborating with tribes and the Indian Health Service (IHS) area offices and engaging in dialogue with HIS facilities, tribal health programs operated under P.L. 93-538, and urban Indian health programs (I/T/U) to improve AHCCCS' knowledge and understanding of their quality assurance management and improvement processes.
  - Implementing efficiencies that streamline administrative processes for AHCCCS and Contractors.
  - Continuing to promote and ensure access to care.
  - Supporting transparency by reporting relevant information on the AHCCCS Web site.
  - Ensuring systemwide security and strict compliance with privacy regulations related to transfer of information.
- ◆ Participating in a Center for Health Care Strategies (CHCS) grant that focuses on developing the Medicaid pay-for-performance program and a related CHCS grant focused on return on investment, which was designed to evaluate the value of investing in pay for performance.
- ◆ Continuing its participation in regular meetings of the Arizona Coalition to identify and provide to Contractors quality improvement resources that can be used to support optimal health outcomes among members with asthma and other respiratory diseases.
- ◆ Continuing its collaboration with the Arizona Department of Health Services (ADHS) to ensure effective administration and oversight of the federal Vaccines for Children (VFC) program and working with AHCCCS Contractors to ensure that providers ADHS placed on probation provide necessary vaccinations to members.
- ◆ Continuing to work collaboratively with the ADHS Office of Environmental Health (OEH) and AHCCCS Contractors to increase member testing for lead and identification of members with elevated blood lead levels.
- ◆ Working with the ADHS Office of Nutrition on a statewide program responsive to the governor's call to action on childhood obesity. AHCCCS adopted the chronic care model for planning and developing a comprehensive approach to reduce or prevent childhood obesity.
- ◆ Collaborating with the Arizona Early Intervention Program (AzEIP), Arizona's Individuals with Disabilities Education Act (IDEA) Part C program, to facilitate early intervention services for children younger than 3 years of age who are enrolled with AHCCCS Contractors.
- ◆ Facilitating a collaborative work group focused on members who are seriously mentally ill and have medical complexities to allow the members to live in the community and not at a higher level of care.
- ◆ Participating in initiatives led by the Agency for Healthcare Research and Quality (AHRQ) and CHCS, which are exploring innovative ways to reward quality. AHCCCS is also working with

other states and employers in community purchasing groups and participating in the development of pay-for-performance programs that reward evidence-based care resulting in quality member outcomes. AHCCCS is also working with medical associations in the State to seek input in the development process.

- ◆ Providing leadership to the Arizona Health System Transformation Collaboration in working to implement innovative ways to reduce health disparities in certain populations by raising health literacy and competency in navigating the health care system, and by increasing members' ability to manage and participate in their care. Examples of initiatives include designing a valid health system competency instrument specifically for Medicaid members to determine their level of health literacy and system competency.
- ◆ Collaborating with the Arizona State Medical Association and American Academy of Pediatrics in developing and implementing innovative programs and provider training to enhance the quality and timeliness of, and access to, preventative health care services.
- ◆ In response to the Arizona Cancer Society's successful campaign and legislative advocacy, adding nicotine replacement therapies and tobacco cessation medications to the Contractor formularies and making these prescriptions available to Medicaid enrollees.
- ◆ Continuing its collaboration with and support of the ADHS' initiatives to publicize and promote public health smoking cessation programs.
- ◆ Developing and prioritizing recommendations for new AHCCCS-required Contractor PIPs based on data and research, such as performance measure and utilization trends; topics recommended by Contractors; and areas of high priority at the State and federal level.
- ◆ Updating the minimum standards for inclusion in CYE 2009 contracts for existing AHCCCS-required performance measures based on the most recent HEDIS Medicaid means reported by NCQA. AHCCCS is also strengthening some additional requirements for Contractor performance as one way to drive continued improvement in measurements of clinical quality.
- ◆ Continuing to require CAPs for those Contractors failing to meet AHCCCS' minimum performance standards for the AHCCCS-required measures.
- ◆ Continuing to provide information to Contractors on best practices and providing technical assistance across a broad array of topics addressing the delivery of high-quality, accessible, and timely care; administrative processes and requirements; and program operations.
- ◆ Continuing to:
  - Require Contractors to submit to AHCCCS for its approval and to implement AHCCCS-approved CAPs in response to AHCCCS-identified performance deficiencies.
  - Issue notices to cure (NTCs) and, in some cases, impose sanctions for those Contractors whose performance continues to fall below expectations regarding, for example, meeting the AHCCCS minimum performance standards for the AHCCCS-required measures, meeting encounter submission requirements, following member grievance guidelines, and following requirements related to notice-of-action correspondence sent to providers and members.

AHCCCS defines a CAP as a Contractor-developed measure to improve performance in a particular area of contractual responsibility and requires that Contractor CAPs identify the following:

- ◆ The root cause(s) of the deficiency
- ◆ The actions/tasks that the Contractor will take to facilitate an expedient return to compliance

- ◆ The time frame to finish the CAP

AHCCCS describes an NTC as a formal written notice to a Contractor regarding specific noncompliance that:

- ◆ Contains the specific timelines for the Contractor to meet performance standards and the possible penalties for continued noncompliance.
- ◆ May contain specific activities or reporting requirements that must be adhered to as the Contractor works toward compliance.

A Contractor's failure to achieve compliance as a result of an NTC may result in AHCCCS imposing a sanction. AHCCCS defines a sanction as a penalty assessed or applied for failure to demonstrate compliance in one or more areas of contractual responsibility, which may take the form of a monetary penalty, an enrollment cap, or other actions as AHCCCS deems appropriate.

AHCCCS publishes on its Web site a list, by Contractor, of the AHCCCS-required CAPs, the NTCs it issued, and the sanctions it imposed and the associated areas of Contractor performance that were unsatisfactory.

- ◆ Continuing its participation in the First Things First (FTF) Health Committee and providing input related to developing the State-level health care strategy, EPSDT requirements, care coordination among systems of care, early childhood development programs, developmental screenings, medical homes, and pay-for-performance programs.
- ◆ Coordinating the Baby Arizona project, focusing on streamlining the eligibility process to ensure Medicaid-eligible women have access to early prenatal care, and training/supporting provider participation in the program.
- ◆ Continuing its work with the AHCCCS-contracted community outreach partners in developing the Statewide KidsCare outreach, enrollment, and retention campaign, which includes working/partnering with schools and other State agencies and conducting presentations for community nonprofit organizations and local governments.
- ◆ Continuing its activities designed to ensure the agency's readiness to provide to the EQRO data associated with the KidsCare program and services for the EQRO to analyze, and to include its associated findings, conclusions, and recommendations in future EQR technical reports.

## AHCCCS Quality Initiatives Driving Improvement for the Acute Care and Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP) Contractors

Examples of AHCCCS' quality initiatives driving improvement for the Acute Care and DES/CMDP Contractors included the following:

- ◆ Calculating and reporting Contractor performance for the AHCCCS-required performance measures. AHCCCS also continued to analyze the historical trends in Contractor performance on the AHCCCS-required measures and to issue NTCs or letters of concern, advising Contractors of the sanctions AHCCCS would impose if their performance did not meet AHCCCS' minimum performance standards. AHCCCS required the Contractors to develop CAPs to bring their performance up to AHCCCS' minimum standards. If CAPs were already in place, AHCCCS required the Contractors to evaluate each CAP activity to determine its effectiveness. In addition, Contractors had to notify AHCCCS of whether they were going to continue activities or implement new interventions to improve their performance. AHCCCS identified additional, key outcome-based performance measures to include in the new Acute Care Contractor contracts, which went into effect October 1, 2008.
- ◆ Providing technical assistance to Contractors to help them improve their ability to effectively monitor their performance from internal data and reinforced strategies to improve performance measure rates.
- ◆ Identifying and including in the CYE 2009 Acute Care Contractor contracts several new or strengthened provisions to enhance the quality of medical services provided to members across a broad range of improvement goals, including:
  - Encouraging Contractors to assign EPSDT-aged members to providers who are trained and use AHCCCS-approved developmental tools.
  - Requiring Contractors to ensure that members with ongoing medical needs—such as dialysis, radiation therapy, and chemotherapy—have coordinated, reliable, and medically necessary transportation to ensure that they arrive on time for regularly scheduled appointments and are picked up upon completion of appointments.
  - Ensuring that Contractors and their PCPs implement evidence-based guidelines for the treatment of anxiety, depression, and attention-deficit hyperactivity disorder (ADHD).
- ◆ Continuing monthly audits of the Contractors' notice-of-action correspondence to members and providers. The audit included reviewing the timeliness of decisions and notices, reviewing the language and format of the letter, and conducting reviews to ensure that the Contractors were not arbitrarily denying or reducing a service due to a member's diagnosis, illness, or condition. The review was also to ensure that services were being provided in an amount, duration, and scope to achieve the purpose for which the services were furnished. AHCCCS also reviewed the documentation supporting that the Contractors were consulting with the requesting provider when appropriate, the Contractors were consistent in applying the review criteria for authorization, and qualified health care professionals were making the decisions.

- ◆ Calculating and reporting Contractor performance for AHCCCS-required PIPs. AHCCCS required the Contractors to submit reports that included an analysis of the data and barriers to care/services, as well as new or revised interventions proposed by the Contractors, if necessary.
- ◆ Continuing its facilitation of a work group between ADHS, the Arizona Partnership for Immunizations, the Pinal County Health Department, and the two Acute Care Contractors that served Pinal County to improve rates of childhood immunizations in that county, where rates were among the lowest in the State.

## 5. Contractor Best and Emerging Practices

Best practices can be achieved by striving to incorporate evidence-based guidelines into operational structures, policies, and procedures. One method that AHCCCS has used to achieve best practices among Acute Care and DES/CMDP Contractors is to ensure that its contract provisions are at least as stringent as the standards contained in Subpart D of the federal Medicaid managed care act. The standards address the following areas:

- ◆ Access to care (the availability and adequate capacity of services, coordination and continuity of care, and coverage and authorization of services)
- ◆ Structure and operations (provider selection, confidentiality, and grievance system)
- ◆ Quality measurement and improvement provisions (practice guidelines, quality assessment, performance improvement, and health information systems)

Of particular note is the sharing of best practices among AHCCCS and its Contractors. AHCCCS provides opportunities and forums for regularly sharing best practices with, and providing technical assistance to, its Acute Care and DES/CMDP Contractors. In addition, Contractors are encouraged to share evidence-based best practices with each other and their providers. An example of this is the sharing of successful quality improvement strategies and interventions during AHCCCS Contractor quality management meetings. AHCCCS' use of these meetings as a forum for addressing performance improvement opportunities and initiatives is in itself a best practice.

AHCCCS' policies reward quality of care, member safety, and member satisfaction outcomes; support evidence-based best practices in disease management and preventive health; provide feedback on quality and outcomes to Contractors and providers; and provide for strategic, periodic monitoring of a wide variety of processes and outcomes. As part of its five-year goals, AHCCCS has adopted the following tenets:

- ◆ Enhance current performance measures, PIPs, and best-practice activities by creating a comprehensive quality-of-care assessment and improvement plan across AHCCCS Medicaid programs that serves as a road map for driving improvement of member-centered outcomes
- ◆ Continue using nationally recognized protocols, standards of care, and benchmarks
- ◆ Continue using a system of rewards for providers, in collaboration with Contractors, based on clinical best practices and outcomes
- ◆ Develop collaborative strategies and initiatives with State agencies and external partners, including the following:
  - Strategic partnerships to improve access to health care services and affordable health care coverage
  - Collaboration with Contractors and providers on best practices in disease prevention and health maintenance

Both AHCCCS and HSAG had the opportunity to identify noteworthy practices by Contractors that were in place during the period covered by this report. AHCCCS identified Contractor best practices through formal Contractor reviews and the review of Contractor deliverables, as well as

through its ongoing interactions and communications with the Contractors. AHCCCS identified the following best practices related to quality management, medical/utilization management, and maternal and child health (MCH) based on the annual QAPI and MCH plans and evaluations the Contractors submitted to AHCCCS. The following list should not be considered an all-inclusive list, but serves to highlight some approaches that AHCCCS generally considered Contractor best practices.

**Arizona Physicians IPA, Inc. (APIPA)**—The Contractor developed a process to monitor member outreach to facilitate member appointments by using a scorecard for all performance measures. The scorecard ranks the need for outreach into three priorities: Priority 1 measures—not meeting 12-month outcomes; Priority 2 measures—meeting 12-month outcomes, but not at 9-month mark; and Priority 3 measures—meeting minimum by 9-month mark. Members identified in Priority 1 measures receive live, automated telephone calls. Members receiving live calls also receive assistance with scheduling appointments. Care opportunities are now identified at the practice level and targeted through medical home support coordinators for members identified in Priority 2 measures.

APIPA also has a no-show policy and procedure to reduce missed appointments by members and to ensure timely and effective delivery of care. On an ongoing basis, APIPA educates all members on the importance of being active participants in their own health care and keeping all scheduled appointments. When members miss appointments, APIPA conducts outreach to these members to identify the root cause of a member’s missed appointment and to track individual patterns (repeated no-show behavior) and/or patterns for individual provider offices or vendor practices (such as transportation), which may indicate a need for changes in how the practice schedules or treats members. APIPA logs and tracks all provider- and vendor-reported incidents of missed appointments by members and follows up with appropriate interventions based on the frequency of no-show behavior of the individual member.

**Care1st**—Care1st EPSDT outreach coordinators mail a roster to dentists identifying members in their surrounding ZIP codes who have not had a dental visit during the previous six months. The dental roster is mailed quarterly to dentists who request to receive such a list, which may be requested at any time throughout the year. Dentists may also request to be removed from the mailing list. Dental providers are encouraged to reach out to members to schedule appointments with these members. This strategy is used in conjunction with member outreach by Care1st EPSDT staff to encourage members/families to have annual dental visits.

**Health Choice Arizona (HCA)**—HCA distributes a “Healthy Families” tool kit to provider offices containing tips and general information. The Healthy Families binder covers the EPSDT program, childhood/adolescent immunizations, nutrition and physical activity, children with special needs (developmental/behavioral/AzEIP/autism/children’s rehabilitation services [CRS]), medical home strategies, best practice strategies and interventions, adult preventive health, and adult and children’s behavioral health services. In January 2009, the binder material also became available on the HCA provider Web site.

HCA also partnered with Assured Imaging to have its mobile mammogram unit in areas of need so that underserved populations (based on claims reports) have better access to mammogram services. High-volume, rural providers are notified as to when the mobile unit will be in their area.

Personalized reminder cards are sent to those members who have scheduled a mammogram through the mobile mammogram unit. Women who take advantage of the mobile service are given a gift card and a summary flyer of all well care that the member should receive.

**Mercy Care Plan (MCP)**—To reduce inappropriate utilization of services through hospital emergency departments (EDs), the Contractor's Medical Case Management Department receives a list of members who used an ED three or more times in a three-month period. Case managers attempt to contact members via telephone and educate them about appropriate use of services through their PCP or an urgent care center instead of going to the ED.

The Medical Case Management Department also receives a report from member services on members who fail to keep provider appointments on three or more separate occasions during a six-month period, and case managers attempt to contact the members by telephone to identify and assist them in overcoming barriers to keeping appointments.

Contractor staff members also make outreach calls to members who recently delivered, encouraging them to have their postpartum visit. During these calls, staff asks members about any symptoms of postpartum depression. If a member acknowledges symptoms, she is referred to case management.

**Phoenix Health Plan (PHP)**—PHP's Asthma Disease Management Program includes educating members on appropriate medications for managing their disease. It also includes provider education about appropriate use of asthma medications, using asthma action plans on all medical charts of members with the disease and scheduling office visits quarterly to assess the need for step-up or step-down therapy. The Contractor tracks the asthma performance measure rate under the AHCCCS-mandated PIP and identifies and recognizes top-performing providers.

Through its review of the documentation AHCCCS provided to HSAG to use in preparing this report (including the Contractor's QAPI program documents and PIP and performance measure results), HSAG also identified Contractor practices that could be considered promising or best practices. Examples of these practices are described below.

**Enhanced Member Outreach**—Many Contractors reported using newsletters, reminder postcards, and other member materials as part of their outreach program. Some Contractors also employed the use of televox outreach phone calls and one-to-one member phone calls to remind members of upcoming appointments and the need to obtain preventive screenings. For expectant mothers, some of the Contractors reported the use of high-risk care management services targeted to high-risk mothers, pregnancy welcome kits, and prenatal visit reminder postcards.

**Continuity of Care Planning**—Some of the Contractors have targeted family members such as new mothers during follow-up visits to assist in coordinating services for newborn children and children who require preventive screenings. Some of the Contractors have reported improvement in children's performance measure rates after targeting parents to increase rates for a different type of service, such as for prenatal care or preventive care for adults.

**Enhanced Transportation Coordination**—Many Contractors are applying strategies to overcome access-related barriers by coordinating transportation to and from appointments for members who

need assistance with transportation. Transportation assistance is provided by Contractors in the form of bus passes and service vehicles to shuttle members to and from appointments.

**Enhanced Provider Outreach**—Contractors are strengthening provider outreach through Web outreach and education. Contractors also use provider newsletters that contain specific information regarding a type of service related to one of the performance measures or PIPs.

**Pay for Performance**—Some of the Contractors reported the use of targeted pay-for-performance strategies to increase rates for specific services such as prenatal care or adolescent well-care visits. Some of the pay-for-performance initiatives have included payment to providers, movie passes to adolescents, and department store gift cards to parents who have taken their children to providers for well-child screenings or other preventive care services.

**Increased Tracking of Provider Performance**—Some Contractors have implemented enhanced tracking mechanisms to track performance on specific measures for high-volume practitioners. The reports generated from these tracking mechanisms enable the Contractor to identify lower-performing providers and implement targeted provider outreach and face-to-face meetings between a practitioner's office staff and the Contractor's provider relations staff.

## 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 has extensive experience preparing for, conducting, and reporting findings from its reviews of Contractors' performance in complying with federal and State requirements. As permitted by 42 CFR 438.258(a), AHCCCS elected to conduct the functions associated with the Medicaid managed care act 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 2008–2009 annual report.

### Conducting the Review

In CYE 2006–2007, AHCCCS initiated a new, three-year cycle of OFRs and evaluated Contractor performance in 13 areas. For CYE 2008–2009, the third year of the three-year cycle of reviews, AHCCCS conducted an extensive review of the Acute Care and DES/CMDP Contractors' performance to assess their compliance with federal and State laws, rules and regulations, and the AHCCCS contract in the following nine performance categories:

- ◆ Member Information
- ◆ Medical Management
- ◆ Authorization and Grievance System
- ◆ Maternal and Child Health and EPSDT
- ◆ Quality Management
- ◆ Delivery Systems and Provider Relations
- ◆ Claims and Information Systems
- ◆ Encounters
- ◆ Reinsurance

### Objectives for Conducting the Review

AHCCCS' objectives for conducting the CYE 2009 OFR were to:

- ◆ Determine if the Contractors satisfactorily met AHCCCS' requirements as specified in their contract, AHCCCS policies, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR).

- ◆ Increase AHCCCS' knowledge of the Contractors' operational and financial procedures.
- ◆ Provide technical assistance and identify areas where Contractors can improve and areas of noteworthy performance and accomplishments.
- ◆ Review the Contractors' progress in implementing recommendations AHCCCS made during prior OFRs.
- ◆ Determine if the Contractors complied with their own policies and evaluated the effectiveness of those policies and procedures.
- ◆ Perform Contractor oversight as required by CMS in accordance with AHCCCS' 1115 waiver.
- ◆ Provide information to HSAG as AHCCCS' EQRO for its use in preparing this report as described in 42 CFR 438.364.

HSAG designed a summary tool to:

- ◆ Organize and represent the information AHCCCS presented in the nine Acute Care and DES/CMDP individual Contractor CYE 2009 OFR reports that documented each Contractor's performance in complying with the operational and financial standards.
- ◆ Facilitate a comparison of the Contractors' performance.

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

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

### **Methodology for Conducting the Review**

AHCCCS followed a CMS-approved process to conduct the OFRs that was also consistent with CMS' protocol for EQROs that conduct the reviews—i.e., the February 11, 2003, Final Protocol (Version 1.0), *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR, Parts 400, 430, et al.

The CYE 2009 OFR conducted by AHCCCS was an extensive review of Contractor performance in meeting standards. AHCCCS provided the Contractors with: (1) a detailed description of the contract requirements and expectations for each of the standards that AHCCCS would review and (2) a list of documents and information that was to be available to AHCCCS for its review during the OFR on-site review process.

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

- ◆ Desk review activities that AHCCCS conducted prior to its on-site review to minimize the time needed on-site and to begin its assessment of the Contractors' performance by reviewing documents Contractors were required to submit to AHCCCS.
- ◆ On-site review activities that included AHCCCS reviewing additional Contractor documentation and conducting interviews with key Contractor administrative and program staff. Reviews generally required three to five days, depending on the extent of the review and the location of the Contractor.
- ◆ Activities AHCCCS conducted following the on-site review, including:
  - Documenting and compiling the results of its reviews, preparing the draft reports of findings, and issuing the draft reports to the Contractors for their review and comment. In the reports, each standard and substandard was individually listed with the applicable performance designation based on AHCCCS' review findings and assessment of the degree to which the Contractor was in compliance with the standards. Full compliance was 90 percent to 100 percent compliant, substantial compliance was 75 percent to 89 percent compliant, partial compliance was 50 percent to 74 percent compliant, and noncompliance was 0 percent to 49 percent compliant. If a standard was not applicable to a Contractor, AHCCCS noted this using an N/A designation. The reports sent to the Contractors also included, when applicable, any AHCCCS recommendations, which were stated as:
    - 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 daily operation of the Contractor.
    - The Contractor should consider....*This statement is a suggestion by the review team to improve the operations of the Contractor but is not directly related to contract compliance.
  - Reviewing and responding to any Contractor challenges to AHCCCS' draft report findings and, as applicable based on its review of the challenges, revising the draft reports.
  - Issuing the final Contractor reports describing the findings, scores, and, as applicable, required Contractor CAPs for each standard AHCCCS reviewed.

AHCCCS' review team members included employees of the Reinsurance, Operations, Finance, Data Analysis and Research, Medical Management, and Clinical Quality Management units of the Division of Health Care Management (DHCM); the Office of Program Integrity; the Office of Administrative Legal Services; and the Third Party Liability unit of the Division of Business and Finance.

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

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

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

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

Following a preliminary review of AHCCCS' documentation of its OFR findings, and to ensure that HSAG was using complete and accurate information in preparing the annual report, HSAG developed and provided to AHCCCS a list of questions or requests for clarification related to AHCCCS' documentation and data. AHCCCS responded promptly to HSAG's questions and requests for clarification. As needed throughout the preparation of this report, HSAG communicated with AHCCCS to clarify any remaining questions regarding the accuracy and completeness of the data and information that HSAG would use to prepare this 2008–2009 annual report.

Using the verified results AHCCCS obtained from conducting the OFRs, HSAG organized and aggregated the performance data and the required CAPs for each Contractor and across the Contractors. HSAG then analyzed the data by performance area (e.g., Quality Management, Delivery Systems and Provider Relations) and by each of the individual standards within an area.

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

## Contractor-Specific Results

AHCCCS conducted a more extensive OFR for the nine Acute Care Contractors and DES/CMDP in CYE 2009 than in the CYE 2007 review. AHCCCS reviewed the Contractors' performance on approximately 100 compliance standards. The percentage of these standards with performance in full compliance with requirements ranged from 66 to 90 percent across the Contractors. Separate results for each of the Contractors are presented next.

### **Arizona Physicians IPA, Inc. (APIPA)**

APIPA has contracted with AHCCCS since 1982. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed APIPA's staff at work.

### **Findings**

Figure 6-1 presents the overall compliance results (i.e., the far-left bar) and the results for each of nine categories of OFR 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 APIPA<sup>6-1</sup>

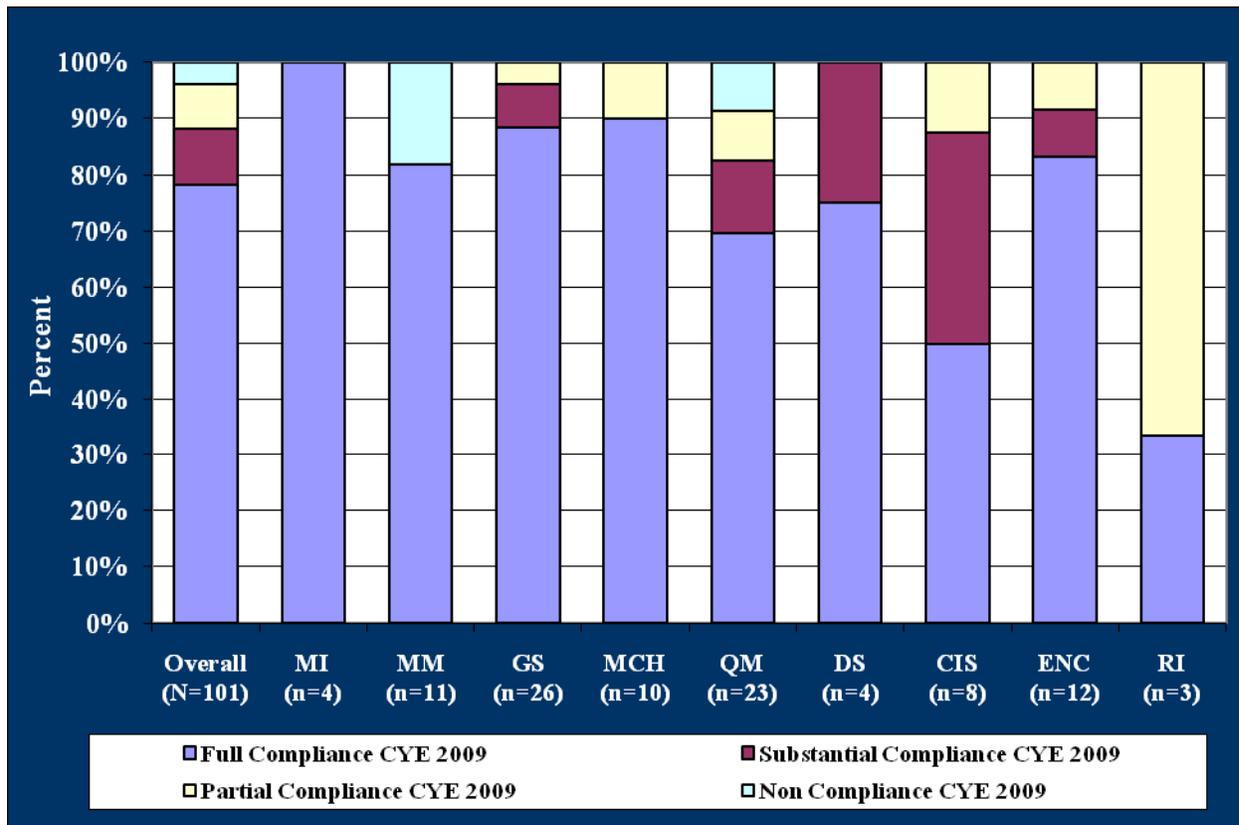


Figure 6-1 shows that APIPA was in full compliance for 78 percent of the 101 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the Member Information category, for which 100 percent of the standards reviewed were in full compliance. Of the nine categories of standards, Reinsurance showed the lowest percentage of standards in full compliance (33 percent) and the highest percentage in partial compliance (67 percent). Medical Management had the highest percentage of standards in noncompliance (18 percent), which demonstrated the greatest opportunity for improvement. Nine percent of the 23 standards reviewed for Quality Management also demonstrated opportunities for improvement where these standards were not compliant with AHCCCS standards.

### CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard. Table 6-1 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2009.

<sup>6-1</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information*	1	5%	4	25%
Medical Management	2	9%	11	18%
Authorization and Grievance System	2	9%	26	8%
Maternal and Child Health and EPSDT	1	5%	10	10%
Quality Management	7	32%	23	30%
Delivery Systems and Provider Relations	1	5%	4	25%
Claims and Information Systems	4	18%	8	50%
Encounters	2	9%	12	17%
Reinsurance	2	9%	3	67%
<b>Overall</b>	<b>22</b>	<b>100%</b>	<b>101</b>	<b>22%</b>

\* Fully compliant standards can be scored as requiring a CAP.

Table 6-1 shows that 22 percent of the standards reviewed required a CAP for CYE 2009. The largest number of required CAPs (seven) was in the Quality Management category, which represented 30 percent of all of the standards for that category and 32 percent of all CAPs received. The category with the smallest percentage of CAPs for the total standards was Authorization and Grievance System, where only two CAPs were required for 26 standards. All of the categories of standards received at least one CAP. The Quality Management category and the Claims and Information Systems category accounted for almost half of the total CAPs (11 of 22). The largest percentage of CAPs relative to the number of standards in a category was in Reinsurance (67 percent), Claims and Information Systems (50 percent), and Quality Management (30 percent).

### Strengths

Member Information, Maternal and Child Health and EPSDT, and Delivery Systems and Provider Relations all had one CAP each, and each category represented 5 percent of the standards. Authorization and Grievance System had two CAPs, which represented 8 percent of the standards for that category. Comparative results from the previous review showed that APIPA improved its score for 17 of the standards reviewed.

### Opportunities for Improvement and Recommendations

The findings for APIPA demonstrate widespread opportunities for improvement. There was at least one CAP in every category reviewed. Most notably, 67 percent of the standards for Reinsurance required a CAP, 50 percent of the standards reviewed for Claims and Information Systems required a CAP, and 30 percent of the Quality Management standards required a CAP. Quality Management had the largest number of CAPs among all of the categories. Comparative results from the previous review showed that APIPA declined in performance for seven of the standards reviewed.

In the final report generated from APIPA’s OFR, AHCCCS included a list of recommendations at both the standard and category levels. HSAG’s review of these recommendations highlights the following findings:

- ◆ **Member Information:** APIPA should include Medicare Part D information in one of the remaining newsletters scheduled for distribution in CYE 2009.
- ◆ **Medical Management:** The Contractor must develop a policy and process for review of new technology based on authorization requests that may be time dependent. In addition, APIPA must document its oversight of outcomes, evaluation, and revision of its disease management programs.
- ◆ **Authorization and Grievance System:** The Contractor should develop a process for expedited requests that do not meet criteria and include notification of the requesting provider. Additionally, APIPA must obtain written consent from the member to open and adjudicate an appeal.
- ◆ **Maternal and Child Health and EPSDT:** APIPA should implement and document activities aimed at improving timely access to services identified on the EPSDT Tracking form.
- ◆ **Quality Management:** APIPA must acknowledge, explain, follow up on, resolve, refer and report quality-of-care concerns as outlined in the AHCCCS Medical Policy Manual (AMPM) (Policy 960). Regarding performance improvement activities related to performance measures, the Contractor must meet the AHCCCS MPS for all contractual performance measures and improve its rates for those that are currently below the AHCCCS MPS. The Contractor should implement a process to document the success of interventions, the review and evaluation of interventions, and the implementation of new interventions/approaches as needed into the quality management program. APIPA must also document performance monitoring of all providers during the recredentialing process as described in the AMPM, Chapter 900, Section 950, and ensure that primary source verification is performed for initial credentialing and recredentialing of individual providers. Regarding behavioral health, APIPA must provide ongoing medically necessary nursing services for members who have comorbidities in addition to their behavioral health condition. The Contractor must track members who receive ongoing nursing services due to a mental health condition that renders them incapable or unwilling to manage their medical condition. For medication monitoring, APIPA must monitor its PCPs to ensure that prescribed medications are consistent with those prescribed by the Regional Behavioral Health Authority (RBHA) providers when a member has completed step therapy. The Contractor must educate providers on the concept of step therapy, including that medication should not be changed unless there is a change in the member's medical condition. The Contractor must authorize medications originally prescribed by a RBHA provider for members who have completed step therapy.
- ◆ **Delivery Systems and Provider Relations:** APIPA must maintain approved policies and procedures for the acknowledgment of and response to provider inquiries.
- ◆ **Claims and Information Systems:** APIPA should update grievance system processes to reimburse overturned claim disputes based on the date of receipt of the original claim. The Contractor should continue efforts to increase electronic payments to providers and it must also address issues with provider and member demographic information in its claims payment system. Last, APIPA must revise policy to clarify that all behavioral health (BH) services encountered during the prior period are the responsibility of the Acute Contractor.
- ◆ **Encounters:** APIPA must evaluate and correct any paid claims that are incomplete or inaccurately encountered. The Contractor must document provider education and training that would result in complete, accurate, and timely encounter submission; and the documented expenditures must be at least the amount required according to the latest data validation study results.

- ◆ **Reinsurance:** APIPA must update its policies and procedures to include a process to ensure that the encountered information reflects appropriate codes and a process for the identification and notification of Reinsurance overpayments as per contract.

### Summary

The results of the APIPA OFR demonstrated that APIPA was in full compliance for 78 percent of the 101 standards reviewed and improved its score for 17 of the standards reviewed in the previous review. The Contractor's strongest performance was in the Member Information category, for which 100 percent of the standards reviewed were in full compliance. Nonetheless, APIPA had opportunities for improvement in each of the nine categories reviewed. Three categories—Reinsurance, Claims and Information Systems, and Quality Management—demonstrated considerable opportunities for improvement.

**Bridgeway Health Solutions (BHS)**

BHS has contracted with AHCCCS since 2009. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed staff at work.

**Findings**

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

**Figure 6-2—Categorized Levels of Compliance With Technical Standards for BHS<sup>6-2</sup>**

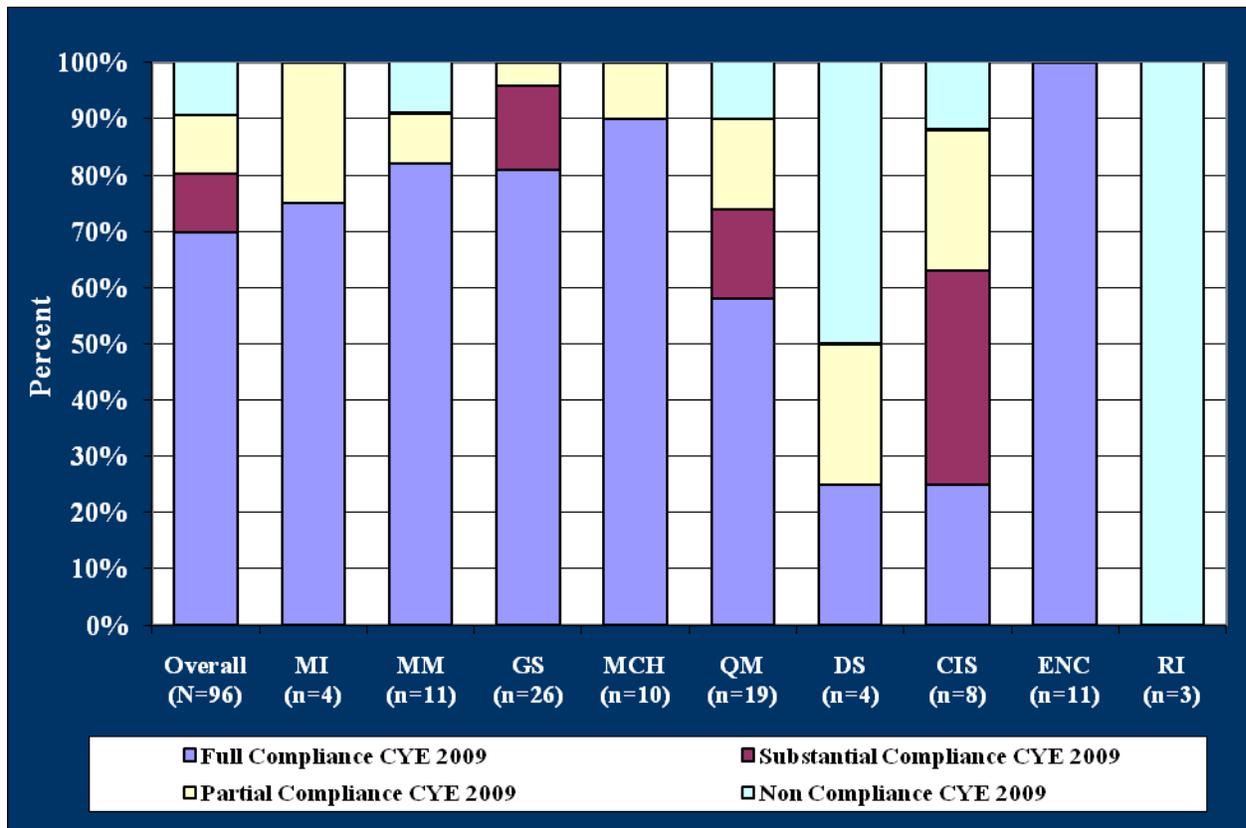


Figure 6-2 shows that BHS was in full compliance for 70 percent of the 96 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the Encounters category, for which 100 percent of the standards reviewed were in full compliance. Of the nine categories of standards, four of the categories had 10 percent or more of its standards scored as not compliant. Reinsurance had

<sup>6-2</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

the highest percentage of standards in noncompliance (100 percent) which demonstrated the greatest opportunity for improvement. Delivery Systems and Provider Relations also highlighted opportunities for improvement, with only 25 percent of its standards scored as fully compliant and the remaining 75 percent of the standards scored as partially or noncompliant.

### CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard. Table 6-2 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2009.

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information	1	3%	4	25%
Medical Management	2	7%	11	18%
Authorization and Grievance System	4	14%	26	15%
Maternal and Child Health and EPSDT	1	3%	10	10%
Quality Management	9	31%	19	47%
Delivery Systems and Provider Relations	3	10%	4	75%
Claims and Information Systems	6	21%	8	75%
Encounters	0	0%	11	0%
Reinsurance	3	10%	3	100%
<b>Overall</b>	<b>29</b>	<b>100%</b>	<b>96</b>	<b>30%</b>

Table 6-2 shows that 30 percent of the standards reviewed required a CAP for CYE 2009. The largest number of required CAPs (nine) was in the Quality Management category, which represented 47 percent of all of the standards for that category. One of the categories, Encounters, did not have any CAPs and was a recognized strength for the Contractor. Eight of the nine categories of standards received at least one CAP each. The Quality Management category and the Claims and Information Systems category accounted for more than half of the total CAPs (15 of 29). The largest percentage of CAPs relative to the number of standards in a category was in Reinsurance (100 percent), Claims and Information Systems (75 percent), and Delivery Systems and Provider Relations (75 percent).

### Strengths

Encounters had no CAPs and Member Information and Maternal and Child Health and EPSDT had one CAP each. Medical Management had two CAPs, which represented 18 percent of the standards for that category. BHS was not a contractor at the time of the previous review; therefore, comparative results from the previous review were not available.

## Opportunities for Improvement and Recommendations

The findings for BHS demonstrate widespread opportunities for improvement. There was at least one CAP in eight of the nine categories reviewed. Most notably, 100 percent of the standards for Reinsurance required a CAP, 75 percent of the standards reviewed for Claims and Information Systems required a CAP, and 75 percent of the Delivery Systems and Provider Relations standards required a CAP. Quality Management had the largest number of CAPs (9 of 29 CAPs) among all of the categories.

In the final report generated from BHS's OFR, AHCCCS included a list of recommendations at both the standard and category levels. HSAG's review of these recommendations highlights the following findings:

- ◆ **Member Information:** BHS must produce and distribute one member newsletter on a quarterly basis and the newsletters must contain information on the required topics.
- ◆ **Medical Management:** BHS must include in its meeting minutes the person responsible for any planned interventions when trends are identified. The Contractor must report to the Medical Management Committee analysis and/or interventions regarding previous meeting recommendations and the changes based on the recommendations. BHS must also evaluate the most effective and efficient use of facilities and services consistent with member needs and professionally recognized standards of care and demonstrate a process by which practice guidelines are disseminated to members or potential members upon request.
- ◆ **Authorization and Grievance System:** BHS must monitor and report the timeliness of all prior-authorization decisions at the Medical Management Committee quarterly meeting and act upon any areas requiring improvement. BHS should include the information that is being requested or is needed to make the service decision in the Notice of Extension letter. The Contractor must include in its policies and procedures that the hospital or facility is notified when the Contractor denies a continued inpatient stay, and it must obtain written consent from the member on all appeals filed by a provider.
- ◆ **Maternal and Child Health and EPSDT:** BHS must implement a process to coordinate with AzEIP using the AHCCCS/AzEIP procedure.
- ◆ **Quality Management:** BHS must maintain documentation of reporting to and communication with appropriate regulatory agencies. BHS's quality management research process should maintain documentation of all research processes (log of events and conversations). The level of substantiation, severity, and interventions should be clearly documented when multiple allegations are addressed in the same case file. The Contractor should include the following when determining recredentialing of individual providers: utilization management information, risk management information, information on compliance with policies, physician profiling, and performance improvement and monitoring. The Contractor must ensure that training and education is available to PCPs regarding behavioral health referral and consultation processes. With regard to behavioral health, BHS must:
  - Consistently monitor to ensure that members who have been referred for behavioral health services have received services.
  - Educate its PCPs on the process for step therapy related to behavioral health medications through the use of trainings and provider outreach materials.

- Monitor its PCPs to ensure prescribing of the same medication and dosages with which the member was stabilized by the RBHA, and to ensure that these medications are not changed unless there is a change in the member's medical condition.
- Develop a process for evaluating medical necessity for members who have mental health conditions that render them incapable or unwilling to manage their medical condition. The Contractor must develop a mechanism to track members who receive ongoing nursing services. The Contractor must coordinate care with the RBHA for all members who have a mental health condition that renders them incapable or unwilling to manage their medical condition.
- ◆ When BHS begins medical record review of providers caring for acute members the Contractor should include a review of:
  - Appropriate transitions by providers of members being treated for ADHD, depression, and anxiety to the RBHA to maintain continuity of care, and updates to behavioral health providers when changes to medication or diagnoses occur.
  - Documentation related to the transmittal of diagnostic, treatment, and disposition information to the PCP and other providers as appropriate and documentation that the PCP reviews member behavioral health information received from the RBHA behavioral health provider who is also treating the member.
- ◆ **Delivery Systems and Provider Relations:** BHS must develop policies and/or procedures for the acknowledgment of and response to provider inquiries that include all the required information. The Contractor must also develop appropriate mechanisms for the provision and monitoring of transportation for members with ongoing treatment needs. Last, BHS must implement a quarterly performance audit tool to evaluate transportation wait times.
- ◆ **Claims and Information Systems:** BHS must apply bundling logic appropriately and review policies for interest application against contractual requirements for inpatient and professional claim handling. The Contractor must increase electronic claim receipt and payment participation among its network providers. BHS should also update policies to make clear that behavioral health services rendered during a prior period of coverage are the responsibility of the Contractor. Last, BHS should implement a focused audit for the periodic validation of contract terms loaded in the system against the original signed documents and ensure that claims are edited against the provider Category of Service table extracts provided by AHCCCS.
- ◆ **Reinsurance:** BHS must add processes to its policy and procedures for encountering transplants such that the encounters balance to the total of the transplant stage invoice. The Contractor must revise policies and procedures for processing transplant-related encounters to reflect the appropriate CNI/subcap code and include the specific contract language for notification of any type of reinsurance overpayments within the contracted time frame. BHS should also apply a report for monitoring the appropriateness of the reinsurance revenue received against paid claims data.

## Summary

The results of the BHS OFR demonstrated that the Contractor was in full compliance for 70 percent of the 96 standards reviewed. The Contractor's strongest performance was in the Encounters category, for which 100 percent of the standards reviewed were in full compliance. Still, BHS had opportunities for improvement where it received at least one CAP in eight of the nine categories

reviewed. Three categories—Reinsurance, Claims and Information Systems, and Delivery Systems and Provider Relations—demonstrated considerable opportunities for improvement.

**Care1st Health Plan (Care1st)**

Care1st has contracted with AHCCCS since 2003. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed staff at work.

**Findings**

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

**Figure 6-3—Categorized Levels of Compliance With Technical Standards for Care1st<sup>6-3</sup>**

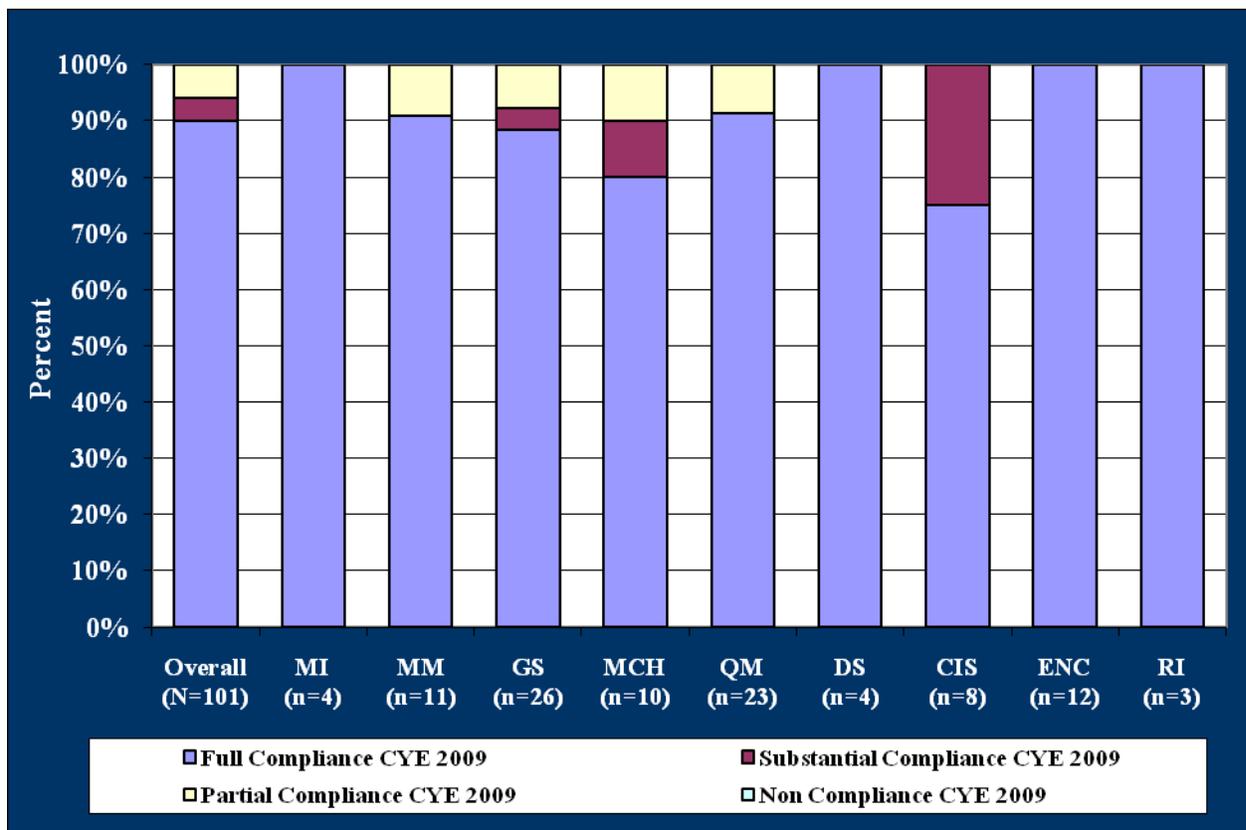


Figure 6-3 shows that Care1st was in full compliance for 90 percent of the 101 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the following categories: Member Information, Delivery Systems and Provider Relations, Encounters, and Reinsurance, all of which had 100 percent of the standards reviewed in full compliance for all categories. Of the nine

<sup>6-3</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

categories of standards, none of the categories contained standards that were scored as not compliant. Medical Management, Authorization and Grievance System, Maternal and Child Health and EPSDT, and Quality Management contained standards scored as partially compliant.

### CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard. Table 6-3 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2009.

**Table 6-3—Corrective Action Plans By Category for Care1st**

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information	0	0%	4	0%
Medical Management	1	8%	11	9%
Authorization and Grievance System	3	23%	26	12%
Maternal and Child Health and EPSDT	2	15%	10	20%
Quality Management	3	23%	23	13%
Delivery Systems and Provider Relations	0	0%	4	0%
Claims and Information Systems	2	15%	8	25%
Encounters	0	0%	12	0%
Reinsurance*	2	15%	3	67%
<b>Overall</b>	<b>13</b>	<b>100%</b>	<b>101</b>	<b>13%</b>

\* Fully compliant standards can be scored as requiring a CAP.

Table 6-3 shows that 13 percent of the standards reviewed required a CAP for CYE 2009. The largest number of required CAPs (three) was in the Authorization and Grievance System and Quality Management categories. Three of the categories—Member Information, Delivery Systems and Provider Relations, and Encounters—did not have any CAPs and were considered recognized strengths for the Contractor. Six of the nine categories of standards received at least one CAP each. The largest percentage of CAPs relative to the number of standards in a category was in Reinsurance (67 percent, but still scored as fully compliant), Claims and Information Systems (25 percent), and Maternal and Child Health and EPSDT (20 percent).

### Strengths

Care1st was in full compliance for 90 percent of the 101 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the following categories: Member Information, Delivery Systems and Provider Relations, Encounters, and Reinsurance in which 100 percent of the standards reviewed were in full compliance for all categories. Three of the categories, Member Information, Delivery Systems and Provider Relations, and Encounters did not have any CAPs required.

## Opportunities for Improvement and Recommendations

The findings for Care1st demonstrate few opportunities for improvement. There was at least one CAP in six of the nine categories reviewed. Most notably, 67 percent of the standards for Reinsurance required a CAP, although the standards were scored as fully compliant. Authorization and Grievance System and Quality Management had the highest number of CAPs (each with 3 of the 13 CAPs) among all of the categories.

In the final report generated from Care1st's OFR, AHCCCS included a list of recommendations at both the standard and category levels. HSAG's review of these recommendations highlights the following findings:

- ◆ **Medical Management:** Care1st must document changes made in the disease management process based on recommendations of the medical management meetings and demonstrate that evaluation and revisions are made based on results of quarterly reviews.
- ◆ **Authorization and Grievance System:** Care1st must clearly document the rationale for the adverse decision and this must be reflected in the Notice of Action Letter sent to the member. The Contractor must describe the service requested and the purpose of the service and clearly document a member-specific reason for the decision. Last, Care1st must make expedited decisions within the three-day time frame, and if an extension is taken, the Contractor must make a decision by the end date on the extension. The Contractor must get an order from the provider when changing an expedited request to a standard time frame.
- ◆ **Maternal and Child Health and EPSDT:** Care1st should ensure provider compliance with completing and documenting all screenings and services required during the age-appropriate EPSDT visit. The Contractor should develop and implement a process to document all activities and/or interventions used to ensure members receive timely and appropriate treatment.
- ◆ **Quality Management:** Care1st must include the level of substantiation in documentation of the quality-of-care cases. The Contractor must ensure that interventions and resolutions appropriate to the issues are implemented for each quality-of-care case. The quality-of-care policy must include the determination of substantiation and which cases are referred to peer review. With regard to performance measures, Care1st must meet the AHCCCS MPS for all contractual performance measures and improve its rates for those that are currently below the AHCCCS MPS. The Contractor should develop separate policies for the Peer Review Committee and Credentialing Committee. The committees may contain the same practitioner membership and meet consecutively as long as the peer review section of the meeting is held in executive session.
- ◆ **Claims and Information Systems:** Care1st must meet AHCCCS standards for electronic payment. The Contractor must also revise policies to state that behavioral health services rendered during prior-period coverage (PPC) are the Contractor's responsibility without limitation unless medical necessity is not established by the medical record.
- ◆ **Reinsurance:** Care1st should revise its policies to include the transplant language from the contract and reference to the CN1 code for transplant encounters.

## Summary

The results of Care1st's OFR demonstrated that the Contractor was in full compliance for 90 percent of the 101 standards reviewed. The Contractor's strongest performance was in the following categories: Member Information, Delivery Systems and Provider Relations, Encounters, and Reinsurance, all of which had 100 percent of the standards reviewed in full compliance. Care1st's results demonstrated few opportunities for improvement as the Contractor received only 13 CAPs for the 101 standards reviewed.

**Health Choice Arizona (HCA)**

HCA has contracted with AHCCCS since 1990. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed staff at work.

**Findings**

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

**Figure 6-4—Categorized Levels of Compliance With Technical Standards for HCA<sup>6-4</sup>**

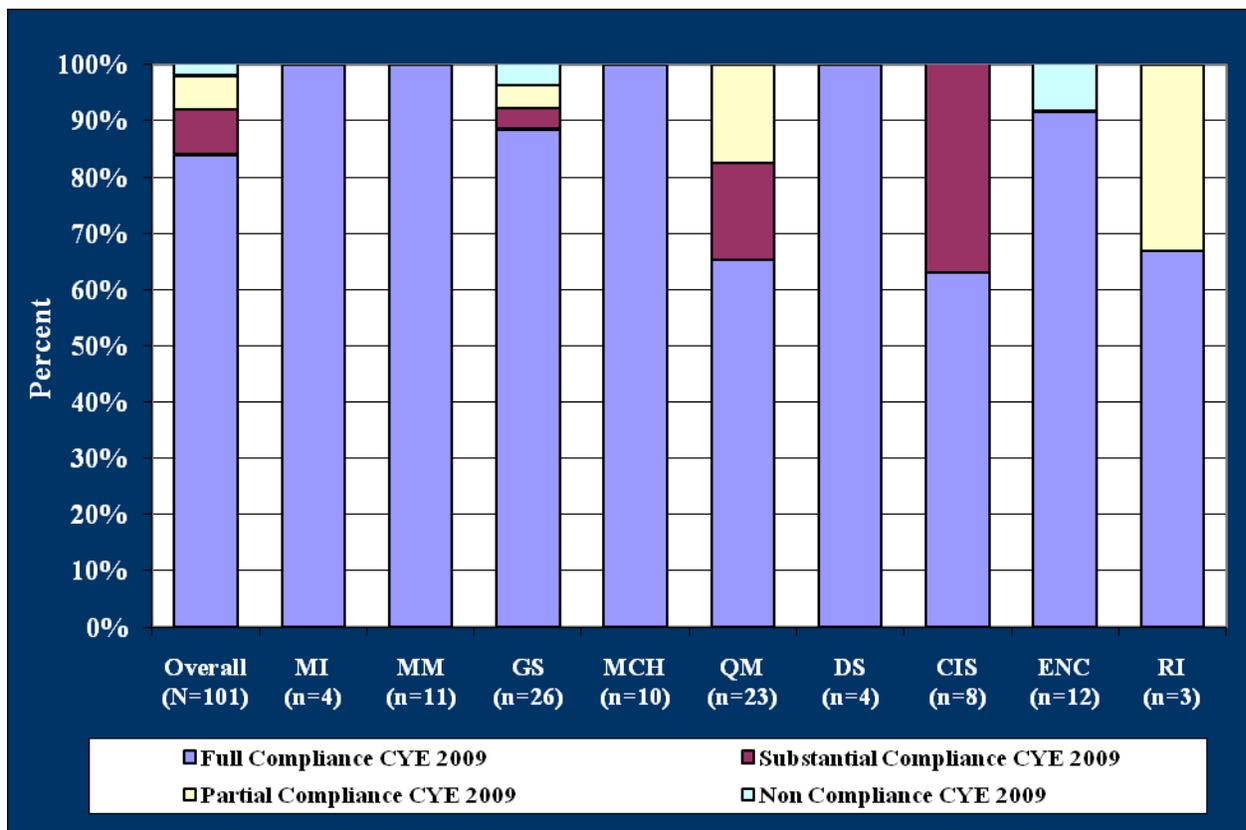


Figure 6-4 shows that HCA was in full compliance for 84 percent of the 101 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the following categories: Member Information, Medical Management, Maternal and Child Health and EPSDT, and Delivery Systems and Provider Relations, all of which had 100 percent of the standards reviewed in full compliance

<sup>6-4</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

for all categories. Of the nine categories of standards, two of the categories (Encounters and Authorization and Grievance System) contained standards that were scored as not compliant. Claims and Information Systems had the lowest percentage of fully compliant standards (63 percent). The highest percentage of noncompliant standards was in the Encounters category, which had 8 percent of the standards scored as noncompliant.

### CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard. Table 6-4 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2009.

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information*	1	5%	4	25%
Medical Management	0	0%	11	0%
Authorization and Grievance System	5	26%	26	19%
Maternal and Child Health and EPSDT	0	0%	10	0%
Quality Management	8	42%	23	35%
Delivery Systems and Provider Relations	0	0%	4	0%
Claims and Information Systems	3	16%	8	38%
Encounters	1	5%	12	8%
Reinsurance	1	5%	3	33%
<b>Overall</b>	<b>19</b>	<b>100%</b>	<b>101</b>	<b>19%</b>

\* Fully compliant standards can be scored as requiring a CAP.

Table 6-4 shows that 19 percent of the standards reviewed required a CAP for CYE 2009. The largest number of required CAPs (eight) was in the Quality Management category. Three of the categories—Medical Management, Maternal and Child Health and EPSDT, and Delivery Systems and Provider Relations—did not have any CAPs and were considered recognized strengths for the Contractor. Six of the nine categories of standards received at least one CAP each. The largest percentage of CAPs relative to the number of standards in a category was in Claims and Information Systems (38 percent), Quality Management (35 percent), and Reinsurance (33 percent).

### Strengths

HCA was in full compliance for 84 percent of the 101 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the following categories: Member Information, Medical Management, Maternal and Child Health and EPSDT, and Delivery Systems and Provider Relations, all of which had 100 percent of the standards reviewed in full compliance for all categories. Three of the categories—Medical Management, Maternal and Child Health and EPSDT, and Delivery Systems and Provider Relations—did not have any CAPs.

## Opportunities for Improvement and Recommendations

The findings for HCA demonstrated some opportunities for improvement. There was at least one CAP in six of the nine categories reviewed. Most notably, 38 percent of the standards for Claims and Information Systems required a CAP. Quality Management had the highest number of CAPs (8 of 19 CAPs) among all of the categories.

In the final report generated from HCA's OFR, AHCCCS included a list of recommendations at both the standard and category levels. HSAG's review of these recommendations highlights the following findings:

- ◆ **Member Information:** HCA should include information on cultural competency, other than translation information, in one of the remaining CYE 2009 member newsletters.
- ◆ **Authorization and Grievance System:** HCA must include a statement in the Notice of Extension letter that a decision will be made as expeditiously as the member's condition requires and no later than the date the extension is set to expire. The Contractor must have a policy or process that informs the member that all service authorization decisions not reached within the stated time frames are considered denied on the date the review period expires. When a Notice of Extension is issued, the decision is also denied on the date the review period expires and shall never exceed 28 days from the date of the initial request. In addition, HCA must ensure that appeals are reviewed by individuals who were not previously involved in authorization decisions and that those individuals meet the requirements of a health care professional with appropriate clinical expertise. The Contractor must also change the language in the provider manual to state that emergency care and hospitalization do not require approval through the prior-authorization department.
- ◆ **Quality Management:** HCA must meet the AHCCCS MPS for all contractual performance measures and improve its rates for those that are currently below the AHCCCS MPS. HCA should review all policies annually, and the policy for recredentialing should include performance monitoring, utilization management information, information on compliance with policies, physician profiling, and performance improvement monitoring when making re-credentialing decisions. The Contractor must ensure that training and education is available to PCPs regarding consultation procedures. The training and education must consist of at least two mechanisms (e.g., provider handbook, provider newsletters, fax blasts, one-to-one interaction, etc.). HCA must monitor PCPs to ensure that they prescribe medications consistent with those prescribed by the RBHA when a member has completed step therapy or that documentation exists in the member's chart indicating that prescribing the same medication is not in the member's best interest. Regarding delegated entities, HCA must implement the following:
  - The delegated entity's review tool must clearly indicate whether or not dental history is included in the medical record when appropriate. In addition, the Contractor must ensure that the delegated entity's medical record review policy and documents include all of the AHCCCS requirements for medical record review.
  - The delegated entity's tool and revised instruction document must include the transmittal of diagnostic, treatment, and disposition information to the PCP and other providers as appropriate.
  - The delegated entity's medical record review tool must include whether or not an advanced directive was executed.

- The Contractor must ensure that the delegated medical record review entity monitors the provider for compliance with both physician initials on every entry and appropriate supervision by a licensed professional documented in the member's record.
- ◆ **Claims and Information Systems:** HCA should concentrate efforts on promotion of electronic file transfer (EFT) payment methods to larger provider groups and high-volume submitters. The Contractor must revise prior-period coverage policies to incorporate the correct language regarding behavioral health services. Last, HCA should add a periodic random sample audit of contract files to ensure that all changes made to contracts are effectuated.
- ◆ **Encounters:** HCA must develop a system to track provider education and training expenditures to ensure appropriate use of earmarked sanction dollar amounts and maintain agendas, training materials, attendee lists, or distribution lists.
- ◆ **Reinsurance:** HCA should update its policies and procedures to include contract requirements.

## Summary

The results of HCA's OFR demonstrated that the Contractor was in full compliance for 84 percent of the 101 standards reviewed. The Contractor's strongest performance was in the following categories: Member Information, Medical Management, Maternal and Child Health and EPSDT, and Delivery Systems and Provider Relations, all of which had 100 percent of the standards reviewed in full compliance. HCA's results demonstrated some opportunities for improvement where the Contractor received 19 CAPs for the 101 standards reviewed.

**Maricopa Health Plan (MHP)**

MHP has contracted with AHCCCS since 1982. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed staff at work.

**Findings**

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

**Figure 6-5—Categorized Levels of Compliance With Technical Standards for MHP<sup>6-5</sup>**

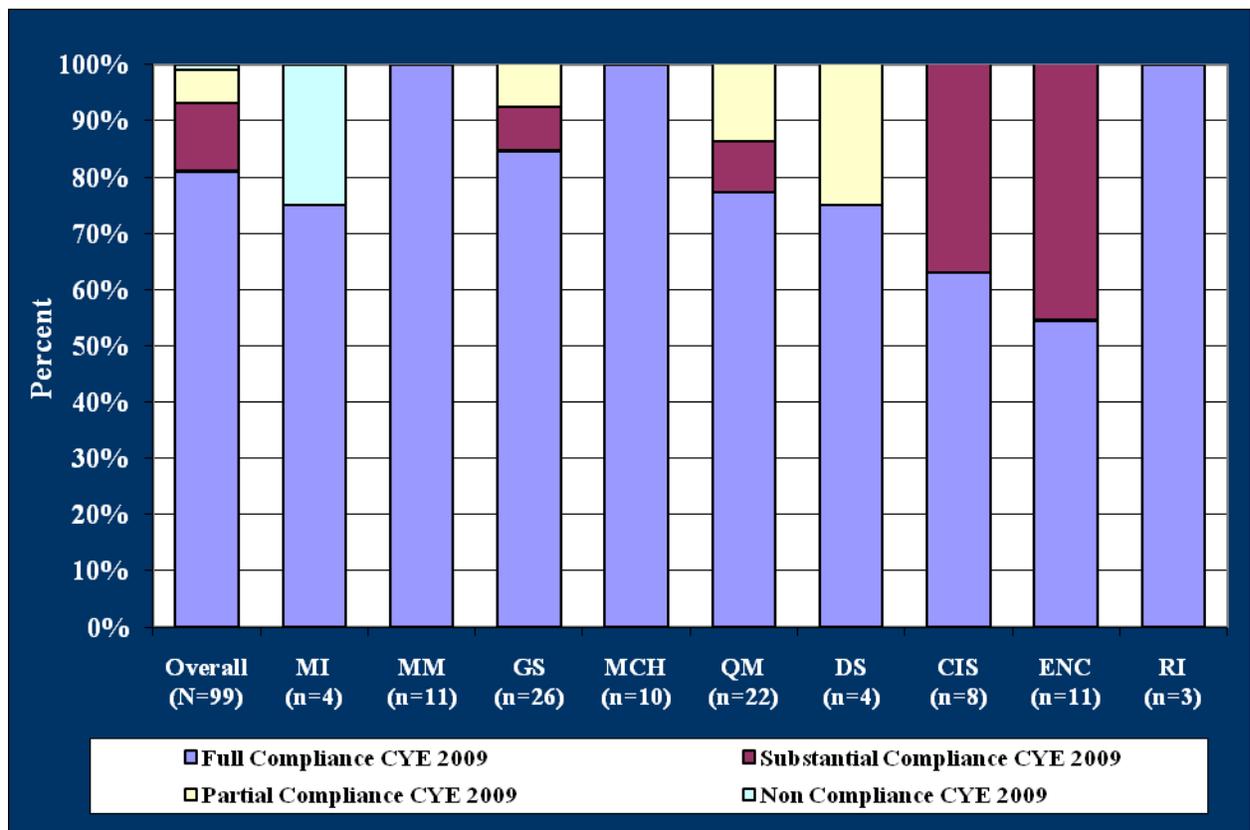


Figure 6-5 shows that MHP was in full compliance for 81 percent of the 99 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the following categories: Medical Management, Maternal and Child Health and EPSDT, and Reinsurance, all of which had 100 percent of the standards reviewed in full compliance for all categories. Of the nine categories of

<sup>6-5</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

standards, only one category (Member Information) contained standards that were scored as noncompliant. Encounters had the lowest percentage of fully compliant standards (55 percent), but the remaining 45 percent of the standards for that category were scored as substantially compliant.

### CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard. Table 6-5 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2009.

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information	1	4%	4	25%
Medical Management*	2	9%	11	18%
Authorization and Grievance System	4	17%	26	15%
Maternal and Child Health and EPSDT*	1	4%	10	10%
Quality Management	5	22%	22	23%
Delivery Systems and Provider Relations	1	4%	4	25%
Claims and Information Systems	4	17%	8	50%
Encounters	5	22%	11	45%
Reinsurance	0	0%	3	0%
<b>Overall</b>	<b>23</b>	<b>100%</b>	<b>99</b>	<b>23%</b>

\* Fully compliant standards can still be scored as requiring a CAP.

Table 6-5 shows that 23 percent of the standards reviewed required a CAP for CYE 2009. The largest number of required CAPs (five) was in the Quality Management and Encounters categories. Only one category, Reinsurance, did not have any CAPs and was considered a recognized strength for the Contractor. Eight of the nine categories of standards received at least one CAP each. The largest percentage of CAPs relative to the number of standards in a category was in Claims and Information Systems (50 percent), Encounters (45 percent), Delivery Systems and Provider Relations (25 percent), and Member Information (25 percent).

### Strengths

MHP was in full compliance for 81 percent of the 99 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the following categories: Medical Management, Maternal and Child Health and EPSDT, and Reinsurance, all of which had 100 percent of the standards reviewed in full compliance for all categories. Member Information, Maternal and Child Health and EPSDT, and Delivery Systems and Provider Relations had only one CAP each. Reinsurance did not have any CAPs.

## Opportunities for Improvement and Recommendations

The findings for MHP demonstrated some opportunities for improvement. There was at least one CAP in eight of the nine categories reviewed. Most notably, 50 percent of the standards for Claims and Information Systems required a CAP. Quality Management and Encounters had the largest number of CAPs (5 of 23 CAPs) among all of the categories.

In the final report generated from MHP's OFR, AHCCCS included a list of recommendations at both the standard and category levels. HSAG's review of these recommendations highlights the following findings:

- ◆ **Member Information:** MHP should implement use of the Provider Look Up and Mapping Desk Top Procedure that is dated June 9, 2009. The Contractor should include information on mapping services in its desk reference and/or training materials.
- ◆ **Medical Management:** MHP should demonstrate in its interrater reliability testing that criteria for transplant authorization is applied in a consistent manner when evaluating requests for transplant services. Additionally, MHP must have a methodology to identify providers willing to provide medical home services and make reasonable efforts to offer access to members for these providers.
- ◆ **Authorization and Grievance System:** MHP must make prior-authorization decisions within 14 days for a standard request and within 3 days for an urgent (expedited) request and notify the appropriate parties (the requesting provider and member) of the outcome of the decision. The Contractor must report the timeliness of all prior-authorization decisions to the Medical Management Committee and act upon any areas requiring improvement. In addition, MHP must issue a Notice of Extension letter to the member that contains (1) the reason for the extension when either the member requests an extension to the service authorization review period or the Contractor requires additional information to make a decision and (2) a statement that the decision will be made as expeditiously as the member's condition requires and no later than the date that the extension is set to expire. Last, the Contractor must obtain written consent from the member to open and adjudicate an appeal.
- ◆ **Maternal and Child Health and EPSDT:** MHP should correct the desktop procedure to ensure that referrals are not made to the Women, Infants, and Children (WIC) program for nutritional therapy.
- ◆ **Quality Management:** MHP should formalize a process for data validation using Managed Care.com and develop a process to ensure the data used are validated. MHP must also develop processes to increase the incidence of reporting to regulatory agencies, hospital quality management departments, and accrediting agencies when issues are substantiated. Regarding performance measures, MHP must meet the AHCCCS MPS for all contractual performance measures and improve its rates for those that are currently below the AHCCCS MPS. Last, MHP must educate providers on the concept of step therapy, including that medication should not be changed unless there is a change in the member's medical condition.
- ◆ **Delivery Systems and Provider Relations:** MHP must update its provider inquiry tracking logs to reflect when calls are acknowledged and resolved.
- ◆ **Claims and Information Systems:** MHP must revise its explanation of benefits (EOB) description for multiple surgery reductions to include the necessary information and improve the percentage of claims reimbursed through EFT. Regarding policies, MHP should develop policies

and desktops specific to the processing of behavioral health services and ensure that policies reflect appropriate differences between BH services provided during PPC and the full enrollment period. Last, MHP must ensure that provider demographic information, including assigned categories of service, is validated against AHCCCS information on a regular basis.

- ◆ **Encounters:** MHP must evaluate and correct its ratios for the following: adjudicated encounters by month, aged pended encounters, and newly pended encounters to ensure that ratios are within the allowable AHCCCS limits.

## Summary

The results of the MHP's OFR demonstrated that the Contractor was in full compliance for 81 percent of the 99 standards reviewed. The Contractor's strongest performance was in the following categories: Medical Management, Maternal and Child Health and EPSDT, and Reinsurance, all of which had 100 percent of the standards reviewed in full compliance for all categories. MHP's results demonstrated opportunities for improvement where the Contractor received 23 CAPs for the 99 standards reviewed.

**Mercy Care Plan (MCP)**

MCP has contracted with AHCCCS since 1983. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed staff at work.

**Findings**

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

**Figure 6-6—Categorized Levels of Compliance With Technical Standards for MCP<sup>6-6</sup>**

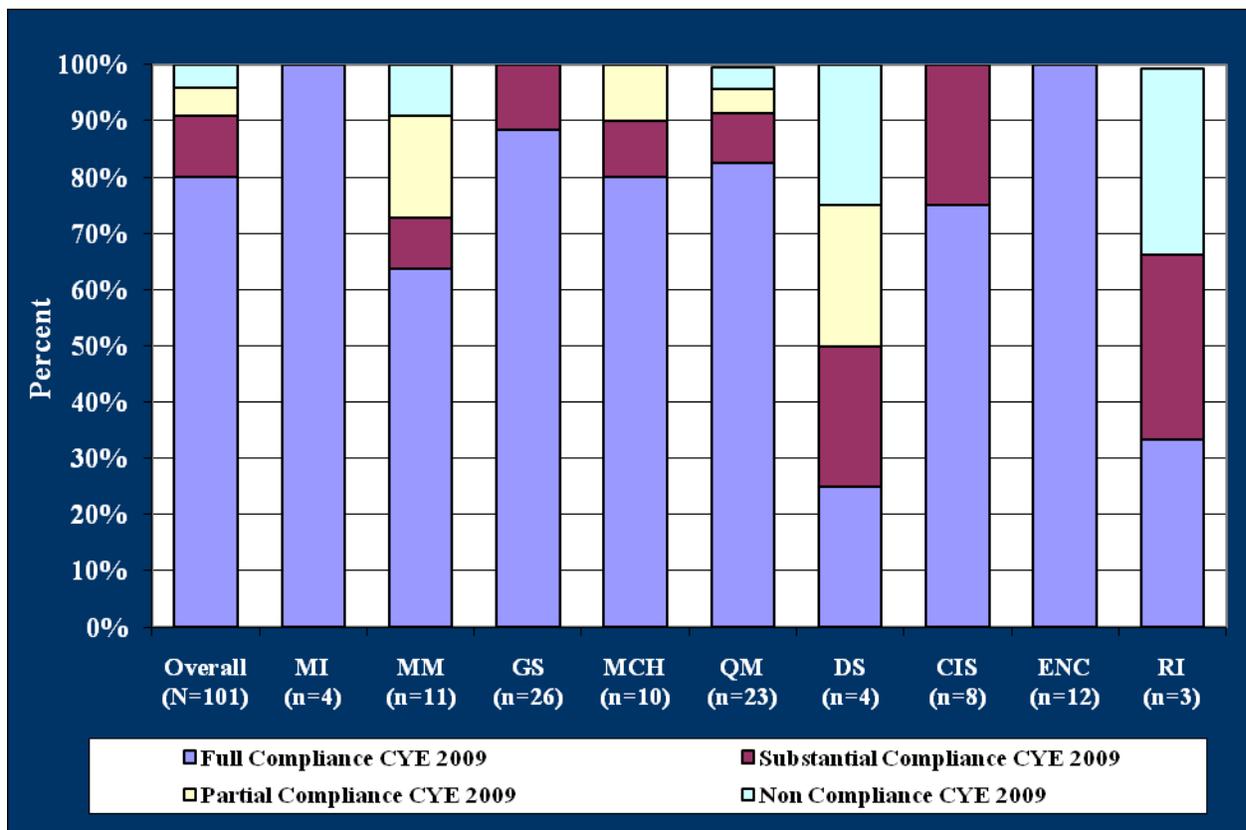


Figure 6-6 shows that MCP was in full compliance for 80 percent of the 101 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the Member Information and Encounters categories, both of which had 100 percent of the standards reviewed in full compliance. Of the nine categories of standards, three of the categories had 9 percent or more of its standards scored as not

<sup>6-6</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

compliant. Reinsurance had the highest percentage of standards in noncompliance (33 percent), which demonstrated the greatest opportunity for improvement. Delivery Systems and Provider Relations was also highlighted as an opportunity for improvement, with only 25 percent of its standards scored as fully compliant and the remaining 75 percent of the standards scored as substantially, partially, or noncompliant.

### CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard. Table 6-6 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2009.

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information	0	0%	4	0%
Medical Management	4	20%	11	36%
Authorization and Grievance System	3	15%	26	12%
Maternal and Child Health and EPSDT	2	10%	10	20%
Quality Management	4	20%	23	17%
Delivery Systems and Provider Relations	3	15%	4	75%
Claims and Information Systems	2	10%	8	25%
Encounters	0	0%	12	0%
Reinsurance	2	10%	3	67%
<b>Overall</b>	<b>20</b>	<b>100%</b>	<b>101</b>	<b>20%</b>

Table 6-6 shows that 20 percent of the 101 standards reviewed required a CAP for CYE 2009. The largest number of required CAPs (four) was found in both the Medical Management and Quality Management categories. Two categories (Member Information and Encounters) did not have any CAPs. Seven of the nine categories of standards received at least two CAPs each. The largest percentage of CAPs relative to the number of standards in a category was in Delivery Systems and Provider Relations (75 percent), Reinsurance (67 percent), and Medical Management (36 percent).

### Strengths

MCP was in full compliance for 80 percent of the 101 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the Member Information and Encounters categories, both of which had 100 percent of the standards reviewed in full compliance. Neither category received a CAP.

## Opportunities for Improvement and Recommendations

The findings for MCP demonstrated some opportunities for improvement. There were at least two CAPs in seven of the nine categories reviewed. Most notably, 75 percent of the standards for Delivery Systems and Provider Relations required a CAP. Medical Management and Quality Management had the highest number of CAPs (4 CAPs each) among all of the categories.

In the final report generated from MCP's OFR, AHCCCS included a list of recommendations at both the standard and category levels. HSAG's review of these recommendations highlights the following findings:

- ◆ **Medical Management:** MCP must document any actions/interventions and/or any changes made as a result of the actions or interventions based on data reviewed and reported through the Medical Management Committee. In addition, MCP must evaluate the Practice Guidelines annually through a multidisciplinary process to determine if the guidelines remain applicable and represent the best and most current practice standards. The Contractor must also report the interventions and any changes made to those interventions based on the outcomes or evaluation of those interventions. This must be documented in the meeting minutes. Last, MCP must develop the methodology to identify providers willing to provide medical home services and make reasonable efforts to offer access for members to these providers.
- ◆ **Authorization and Grievance System:** MCP must make the standardized authorization criteria available to members upon request. The Contractor should include in policy and procedure that the requesting provider is notified for an order change when an "expedited" authorization request does not meet the criteria for expedited authorization in order to determine why the provider has requested an expedited review. Additionally, MCP must include in its Notice of Extension letter a statement that the decision will be made as expeditiously as the member's condition requires and no later than the date that the extension is set to expire and the date the request will expire if the additional information is not received.
- ◆ **Maternal and Child Health and EPSDT:** MCP must ensure that all PCPs delivering care to EPSDT-aged members use the age-appropriate EPSDT tracking forms during each EPSDT visit and implement processes to ensure that providers not using the EPSDT tracking forms are compliant with using the forms. MCP should also have a process to coordinate with WIC and the member's guardian when issues related to WIC services are identified.
- ◆ **Quality Management:** For its performance measures, MCP must meet the AHCCCS MPS for all contractual performance measures and improve its rates for those that are currently below the AHCCCS MPS. In addition, MCP must ensure that contracted PCPs update the member's behavioral health provider when there are changes in the member's diagnoses or prescribed medication, and appropriately transition members being treated for ADHD, depression, and anxiety to the RBHA to maintain continuity of care. MCP must develop a process to ensure that responses by contracted PCPs to requests for information about members receiving behavioral health services from behavioral health providers are sent within 10 days of receiving the request. The Contractor must document the status of the correction plan including reevaluation to confirm the effectiveness of the plan. Last, MCP must have a mechanism in place to identify members who have completed step therapy and are returning to the care of their PCPs for the treatment of depression, anxiety, or ADHD. The Contractor must monitor its PCPs to ensure that they

prescribe medications consistent with those prescribed by the RBHA providers when a member has completed step therapy.

- ◆ **Delivery Systems and Provider Relations:** MCP must update its policy to reflect the correct time frame for resolving provider inquiries. In addition, the Contractor must resolve all inquiries within the required time frame of 30 business days. In addition, MCP must update its policies and desktop procedures to include specific information on providing transportation for members with ongoing treatment needs.
- ◆ **Claims and Information Systems:** MCP should clarify in policy what the periodicity will be for each line of business. Additionally, MCP should develop processes for the validation of integrated member files against AHCCCS-supplied data.
- ◆ **Reinsurance:** MCP should ensure coordination between its medical management, encounters, and reinsurance finance units to produce an acceptable outcome for the contract requirement of transplant services. In addition, MCP should update its desktop procedures to include the specific contract language for notification of any type of reinsurance overpayments within the contracted time frame. The Contractor should apply a report for monitoring the appropriateness of the reinsurance revenue received against paid claims data.

## Summary

The results of the MCP's OFR demonstrated that the Contractor was in full compliance for 80 percent of the 101 standards reviewed. The Contractor's strongest performance was in the Member Information and Encounters categories, both of which had 100 percent of the standards reviewed in full compliance for all categories. Neither category received a CAP. MCP's results demonstrated opportunities for improvement where the Contractor received 20 CAPs for the 101 standards reviewed.

**Phoenix Health Plan (PHP)**

PHP has contracted with AHCCCS since 1983. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed staff at work.

**Findings**

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

**Figure 6-7—Categorized Levels of Compliance With Technical Standards for PHP<sup>6-7</sup>**

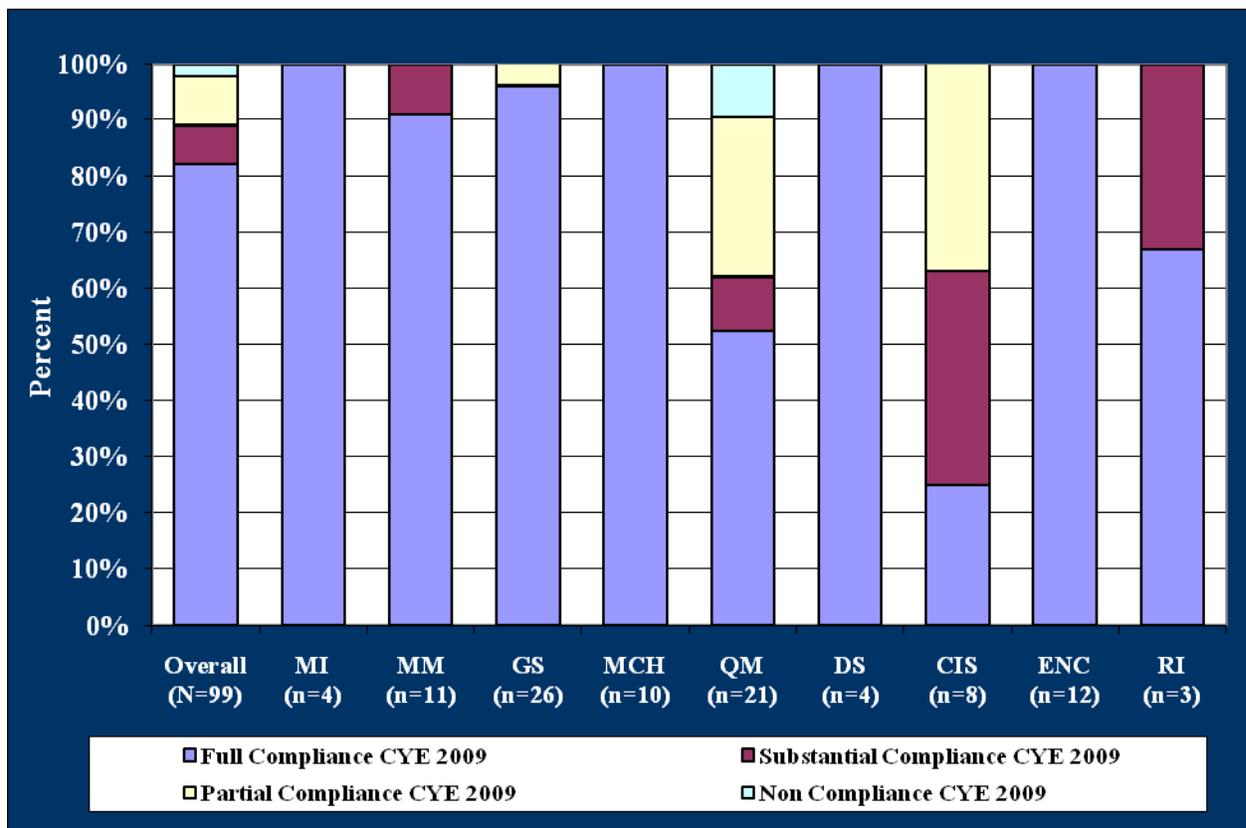


Figure 6-7 shows that PHP was in full compliance for 82 percent of the 99 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the Member Information, Maternal and Child Health and EPSDT, Delivery Systems and Provider Relations, and Encounters categories, all of which had 100 percent of the standards reviewed in full compliance. At least 90 percent of all

<sup>6-7</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

standards reviewed for Member Information, Medical Management, Authorization and Grievance System, Maternal and Child Health and EPSDT, Delivery Systems and Provider Relations, and Encounters were in full compliance. Only 25 percent of the standards for Claims and Information Systems were scored as in full compliance. Of the nine categories of standards, only one category had any standards scored as not compliant. Quality Management had the highest percentage of standards in noncompliance (10 percent), which demonstrated the greatest opportunity for improvement.

**CAPs**

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard. Table 6-7 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2009.

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information	0	0%	4	0%
Medical Management	1	5%	11	9%
Authorization and Grievance System	2	11%	26	8%
Maternal and Child Health and EPSDT	0	0%	10	0%
Quality Management	9	47%	21	43%
Delivery Systems and Provider Relations	0	0%	4	0%
Claims and Information Systems	6	32%	8	75%
Encounters	0	0%	12	0%
Reinsurance	1	5%	3	33%
<b>Overall</b>	<b>19</b>	<b>100%</b>	<b>99</b>	<b>19%</b>

Table 6-7 shows that 19 percent of the 99 standards reviewed required a CAP for CYE 2009. The largest number of required CAPs (nine) was in the Quality Management category. Four categories (Member Information, Maternal and Child Health and EPSDT, Delivery Systems and Provider Relations, and Encounters) did not have any CAPs. Five of the nine categories of standards received at least one CAP each. The largest percentage of CAPs relative to the number of standards in a category was in Claims and Information Systems (75 percent), Quality Management (43 percent), and Reinsurance (33 percent).

**Strengths**

PHP was in full compliance for 82 percent of the 99 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the following categories: Member Information, Maternal and Child Health and EPSDT, Delivery Systems and Provider Relations, and Encounters, wherein none of the standards required a CAP. At least 90 percent of all standards reviewed for Member Information, Medical Management, Authorization and Grievance System, Maternal and Child

Health and EPSDT, Delivery Systems and Provider Relations, and Encounters were in full compliance.

### Opportunities for Improvement and Recommendations

The findings for PHP demonstrated some opportunities for improvement. There was at least one CAP in five of the nine categories reviewed. Most notably, 75 percent of the standards for Claims and Information Systems required a CAP. Quality Management represented another significant opportunity for improvement, with the highest number of CAPs (9 of 19) among all of the categories. The two categories, Quality Management and Claims and Information Systems, had 79 percent of all CAPs (15 of 19 CAPs).

In the final report generated from PHP's OFR, AHCCCS included a list of recommendations at both the standard and category levels. HSAG's review of these recommendations highlights the following findings:

- ◆ **Medical Management:** PHP must amend its policy to include all staff in interrater reliability testing to ensure consistent application of criteria.
- ◆ **Authorization and Grievance System:** PHP should include a statement in the Notice of Extension Letter/Notice of Action Process policy that decisions shall never exceed 28 days from the date of the initial request. In addition, PHP should amend its grievance policy to address grievances that exceeds 45 days.
- ◆ **Quality Management:** PHP should refer cases to the hospital Quality Management or other applicable agencies such as ADHS or AHCCCS as appropriate. Regarding performance measures, PHP must meet the AHCCCS MPS for all contractual performance measures and improve its rates for those that are currently below the AHCCCS MPS. The Contractor should submit a plan for achieving statistically improvement in its rate for the five-antigen immunization series (4:3:1:3:3), specifically focusing on improving the rate among Medicaid-eligible children, for the next measurement period of this PIP. For credentialing, PHP should revise the application update form for recredentialing to include attestation to lack of current illegal drug use. For ongoing PCP monitoring, PHP must: use the current Medical Record Review Audit tool, include monitoring provider compliance with notifying members of and documenting advance directives in the member's medical record, and ensure that provider compliance with appropriate supervision by a licensed professional is documented in the member's record. Additionally, PHP must monitor PCPs to ensure that members being treated for ADHD, depression, and anxiety are appropriately transitioned to the RBHA to maintain continuity of care and ensure that training and education is available to PCPs regarding the behavioral health referral procedures. For behavioral health, PHP must: ensure the initiation and coordination of a referral when a behavioral health need has been identified, monitor whether members referred for behavioral health services have received services, and monitor its PCPs to ensure that they prescribe medications consistent with those prescribed by the RBHA providers when a member has completed step therapy.
- ◆ **Claims and Information Systems:** PHP must revise the provider claim dispute process to ensure that all overturned disputes receive interest payment when applicable. The Contractor should increase efforts to promote EFT payment to large provider groups to meet the contractual standards. PHP must revise prior-period coverage policies to reflect that all medically necessary

behavioral health services are the responsibility of the Contractor during the PPC period. Additionally, PHP must develop a mechanism for memorializing the agreed-upon rate schedules in contract files. The Contractor must ensure that provider-type and category-of-service tables are appropriately integrated into claims payment systems. Last, PHP should document the process for data gathering and completion of the Grievance System Report in a policy or desktop reference.

- ◆ **Reinsurance:** PHP must revise the provider claim dispute process to ensure that all overturned disputes receive interest payment when applicable and increase efforts to promote EFT payment to large provider groups to meet contractual standards. Additionally, PHP must revise prior-period coverage policies to reflect that all medically necessary behavioral health services are the responsibility of the Contractor during the PPC period and develop a mechanism for memorializing the agreed-upon rate schedules in contract files. PHP must ensure that provider-type and category-of-service tables are appropriately integrated into claims payment systems. Last, PHP should document the process for data gathering and completion of the Grievance System Report in a policy or desktop reference.

## Summary

The results of the PHP's OFR demonstrated that the Contractor was in full compliance for 82 percent of the 99 standards reviewed. The Contractor's demonstrated strength in the following categories: Member Information, Maternal and Child Health and EPSDT, Delivery Systems and Provider Relations, and Encounters, wherein none of the standards required a CAP. PHP's results demonstrated opportunities for improvement where the Contractor received 19 CAPs for the 99 standards reviewed.

**Pima Health Systems (PHS)**

PHS has contracted with AHCCCS since 1983. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed staff at work.

**Findings**

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

**Figure 6-8—Categorized Levels of Compliance With Technical Standards for PHS<sup>6-8</sup>**

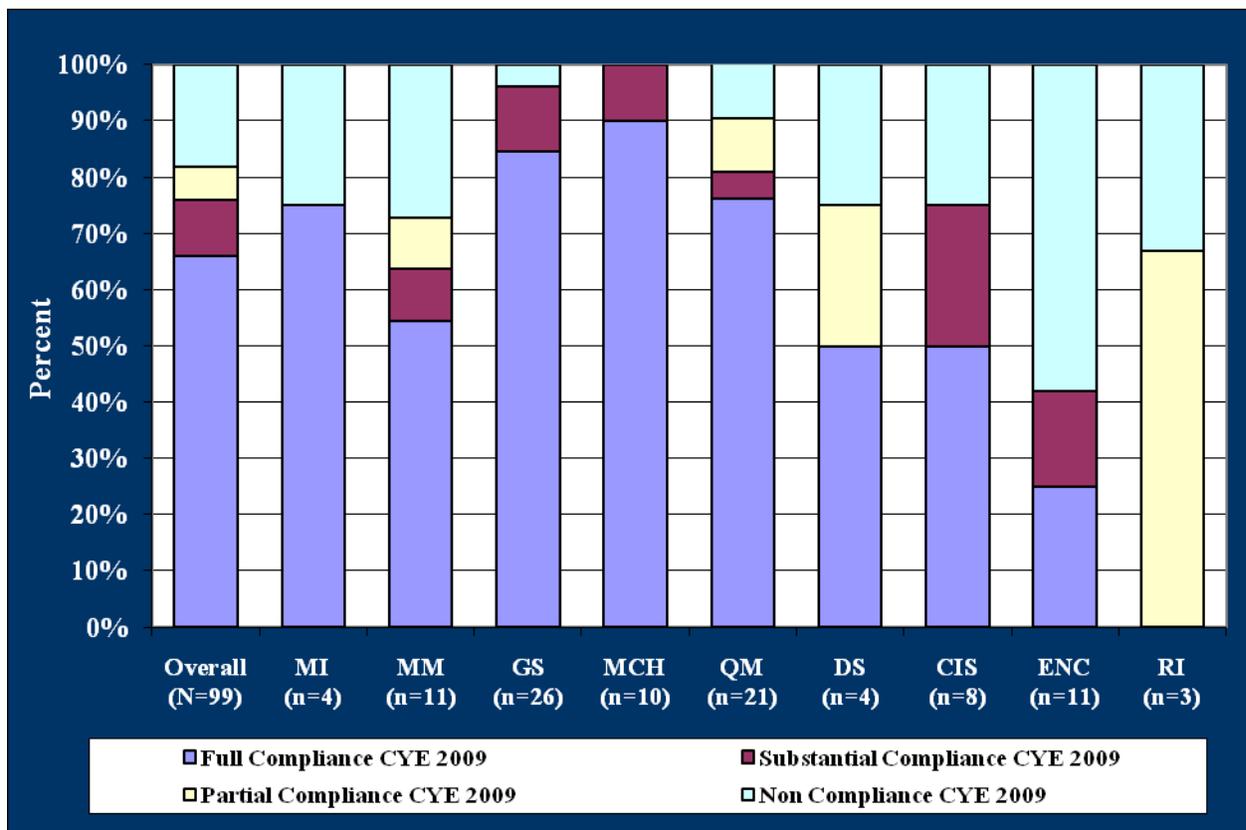


Figure 6-8 shows that PHS was in full compliance for 66 percent of the 99 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the Authorization and Grievance System and Maternal and Child Health and EPSDT categories, which had 85 percent and 90 percent of the standards reviewed in full compliance, respectively. At least 25 percent of the standards for

<sup>6-8</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

Member Information, Medical Management, Delivery Systems and Provider Relations, Claims and Information Systems, Encounters, and Reinsurance were noncompliant. Encounters had the largest percentage of standards in noncompliance (58 percent), which demonstrated the greatest opportunity for improvement.

### CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard. Table 6-8 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2009.

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information	2	6%	4	50%
Medical Management	5	15%	11	45%
Authorization and Grievance System	2	6%	26	8%
Maternal and Child Health and EPSDT	1	3%	10	10%
Quality Management	6	18%	21	29%
Delivery Systems and Provider Relations	2	6%	4	50%
Claims and Information Systems	4	12%	8	50%
Encounters	9	26%	12	75%
Reinsurance	3	9%	3	100%
<b>Overall</b>	<b>34</b>	<b>100%</b>	<b>99</b>	<b>34%</b>

Table 6-8 shows that 34 percent of the 99 standards reviewed required a CAP for CYE 2009, which was the largest number of CAPs among the Acute Care and DES/CMDP Contractors. The largest number of required CAPs (nine) was in the Encounters category. All of the categories required at least one CAP. The largest percentage of CAPs relative to the number of standards in a category was in Reinsurance (100 percent), Encounters (75 percent), Delivery Systems and Provider Relations (50 percent), Claims and Information Systems (50 percent), and Member Information (50 percent).

### Strengths

PHS was in full compliance for 66 percent of the 99 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the Authorization and Grievance System and the Maternal and Child Health and EPSDT categories, with 8 percent and 10 percent of the standards requiring a CAP, respectively. Ninety percent of the standards reviewed for Maternal and Child Health and EPSDT were in full compliance.

## Opportunities for Improvement and Recommendations

The findings for PHS demonstrated widespread opportunities for improvement. There was at least one CAP in all nine categories reviewed. Most notably, 100 percent of the standards for Reinsurance required a CAP. Encounters had the largest number of CAPs (9 of 34 CAPs) among all of the categories.

In the final report generated from PHS' OFR, AHCCCS included a list of recommendations at both the standard and category levels. HSAG's review of these recommendations highlights the following findings:

- ◆ **Member Information:** PHS must include information for Medicare Part D members in its Summer 2009 member newsletter. Additionally, the Contractor should develop policies and procedures and desk reference materials on mapping services.
- ◆ **Medical Management:** PHS must document the follow-up on previous meeting recommendations, analysis of interventions, and any changes made based on the recommendations. The minutes should also reflect the owner of the process and update the action column as indicated. Also, the Contractor should develop a process for provider profiling to include authorization timeliness and its impact on member care. The data should be reported on a quarterly basis to the Medical Management/Utilization Management Committee. Additionally, PHS must amend the Prior Authorization and/or the Medical Assessment Technology Process Standard and Procedure to reflect the review of new technology based on requests that may be time-dependent. Moreover, PHS must develop a process for documentation of interventions, evaluation, revision, and outcomes regarding its Disease Management Program. Last, the Contractor must develop a policy describing utilization management structured compensation.
- ◆ **Authorization and Grievance System:** PHS must revise its Standard and Procedures for Prior Authorization to include that all service authorization decisions that are not reached within the stated time frames are considered denied. Further, PHS must amend its Notice of Decisions to indicate the applicable statute, rule, applicable contractual provisions, policy, or procedure.
- ◆ **Maternal and Child Health and EPSDT:** PHS should implement interventions to ensure that providers are using and submitting the most current AHCCCS-approved EPSDT tracking forms to document all services performed during an EPSDT visit. Electronic medical records used in place of an AHCCCS EPSDT form must include all the components found on the most current AHCCCS-approved EPSDT tracking forms.
- ◆ **Quality Management:** PHS must add a specific category to the Quality Assessment Report Worksheet and specify the quality-of-care level of substantiation. PHS must implement the AHCCCS temporary/provisional credentialing process and approve temporary, provisional credentialing within 14 days from receipt of the deemed completed application, until the date the decision is signed by the medical director for professionals associated with federally qualified health centers. Moreover, PHS should revise the medical record review tool to include monitoring to ensure that behavioral health providers are updated by PCPs when changes to medications or diagnoses occur. Also, PHS should revise the medical record review tool to include notification/education of members regarding advance directives. PHS must also educate PCPs regarding consultation procedures. Training must consist of the provider handbook and at least one other mechanism (e.g., newsletters, fax blasts, one-to-one interaction, etc.). Last, PHS

must develop a mechanism to identify members who have completed step therapy and are returning to the care of their PCPs for the treatment of depression, anxiety, or ADHD.

- ◆ **Delivery Systems and Provider Relations:** PHS must revise its policy and procedure to include the 3-business-day standard for acknowledgment of a provider inquiry and the 30-business-day standard for resolution. Also, the Contractor should not limit its definition of chronic treatment to dialysis, chemotherapy/radiation and physical therapy. The definition should be changed to “including but not limited to these types of treatment.” Further, PHS should develop a policy for auditing transportation wait times that reflects current practices.
- ◆ **Claims and Information Systems:** PHS should revise system calculations for interest payment based on Arizona Revised Statutes and Arizona Administrative Code. The Contractor should increase efforts to promote electronic submission and payment methods and should develop a method to identify the manner in which a claim was paid. Further, PHS must revise policies to correctly state that all medically necessary behavioral health services provided to an enrollee during prior-period coverage are the responsibility of the acute health plan without limitation. Additionally, PHS should review pricing in the claims payment system to ensure that rate schedules are correctly applied and that if a discount or contractual variance is being applied it is reflected within the claim payment system.
- ◆ **Encounters:** PHS must evaluate and correct the problem with its ratio of adjudicated encounters. Also, the Contractor must evaluate and correct the problem with its ratio of total pended encounters. PHS must evaluate and correct the problem with its ratio of total pended encounters for the quarter. Further, the Contractor must evaluate and correct the problem with its ratio of newly pending and aged pended encounters, with its pended to approved encounters, and with its claims that are not encountered appropriately. Last, PHS must track education and training expenditures to ensure appropriate use of earmarked sanction dollar amounts.
- ◆ **Reinsurance:** PHS must update its policies and procedures to the October 1, 2008, contract requirements. Also, the Contractor should update its policies and procedures to include narrative related to the CN1/Subcap code. Further, PHS should update its policies and procedures to include the notification process and 30-day requirement as specified in contract.

## Summary

The results of PHS’ OFR demonstrated that the Contractor was in full compliance for 66 percent of the 99 standards reviewed. The Contractor demonstrated strength in the Authorization and Grievance System and the Maternal and Child Health and EPSDT categories, wherein 8 percent and 10 percent of the category’s standards required a CAP, respectively. Nonetheless, PHS’ results demonstrated widespread opportunities for improvement where the Contractor received 34 CAPs for the 99 standards reviewed.

**University Family Care (UFC)**

UFC serves eligible, enrolled members in Geographical Service Area (GSA) 10 (Pima County) and has contracted with AHCCCS since October 1, 1997. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed staff at work.

**Findings**

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

**Figure 6-9—Categorized Levels of Compliance With Technical Standards for UFC<sup>6-9</sup>**

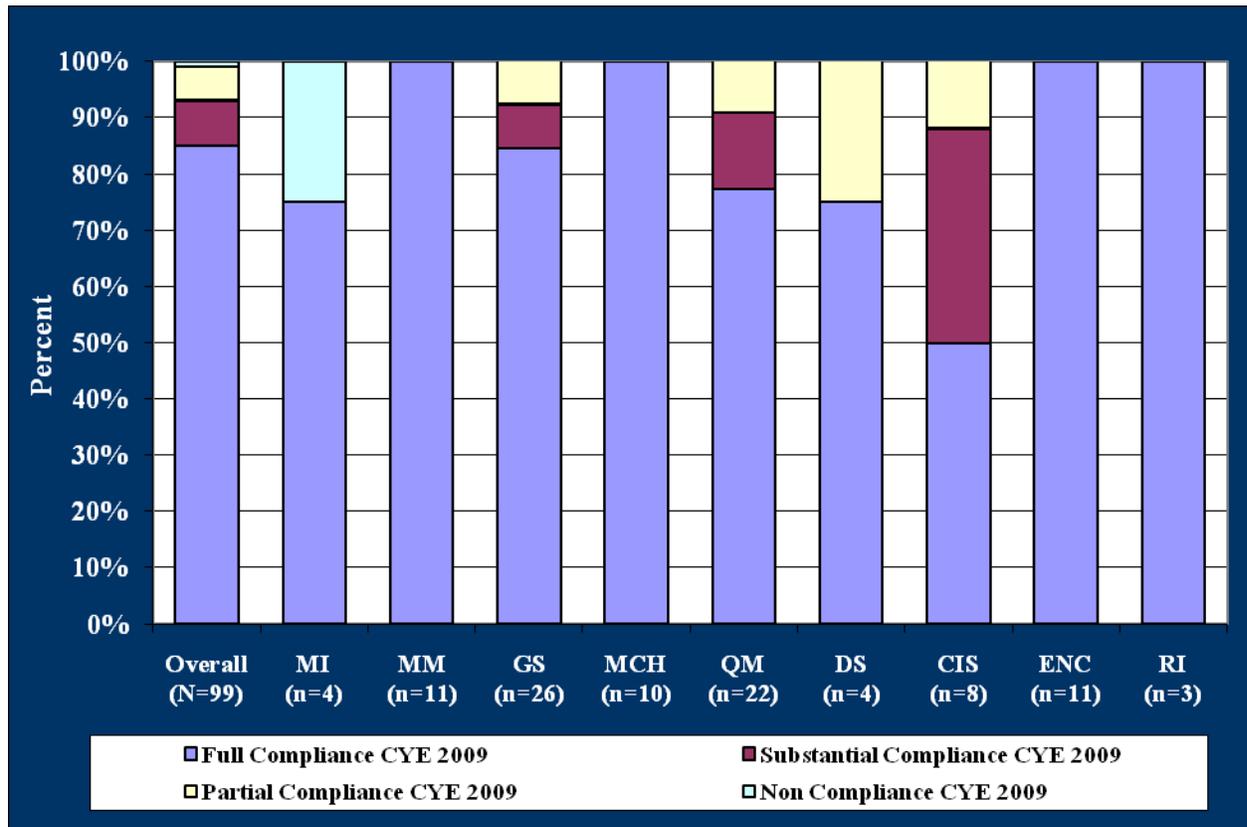


Figure 6-9 shows that UFC was in full compliance for 85 percent of the 99 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the Medical Management, Maternal and Child Health and EPSDT, Encounters, and Reinsurance categories, all of which had 100 percent of

<sup>6-9</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

the standards in full compliance. Twenty-five percent of the standards for Member Information were noncompliant, the only standards assessed this year as noncompliant for the Contractor. The Claims and Information Systems showed the lowest percentage of standards in full compliance (50 percent).

**CAPs**

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard. Table 6-9 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2009.

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information	1	6%	4	25%
Medical Management*	1	6%	11	9%
Authorization and Grievance System	4	22%	26	15%
Maternal and Child Health and EPSDT*	1	6%	10	10%
Quality Management	5	28%	22	23%
Delivery Systems and Provider Relations	1	6%	4	25%
Claims and Information Systems	5	28%	8	63%
Encounters	-	0%	11	0%
Reinsurance	-	0%	3	0%
<b>Overall</b>	<b>18</b>	<b>100%</b>	<b>99</b>	<b>18%</b>

\* Fully compliant standards can still be scored as requiring a CAP.

Table 6-9 shows that 18 percent of the 99 standards reviewed required a CAP for CYE 2009. The largest number of required CAPs (five) was in the Quality Management and the Claims and Information Systems categories. Seven of the nine categories required at least one CAP. The largest percentage of CAPs relative to the number of standards in a category was in Claims and Information Systems (63 percent).

**Strengths**

UFC was in full compliance for 85 percent of the 99 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the Encounters and Reinsurance categories, for which no CAPs were received.

**Opportunities for Improvement and Recommendations**

The findings for UFC demonstrated relatively limited opportunities for improvement. There was at least one CAP in seven of the nine categories reviewed. Most notably, 63 percent of the standards

for Claims and Information Systems required a CAP. The Quality Management and the Claims and Information Systems categories had the highest number of CAPs (five CAPs each).

In the final report generated from UFC's OFR, AHCCCS included a list of recommendations at both the standard and category levels. HSAG's review of these recommendations highlights the following findings:

- ◆ **Member Information:** UFC should implement use of the Provider Look Up and Mapping Desk Top Procedure dated June 9, 2009. UFC should include information on mapping services in its desk reference and/or training materials.
- ◆ **Medical Management:** UFC should demonstrate in its interrater reliability testing that criteria for transplant authorization are applied in a consistent manner when evaluating requests for transplant services.
- ◆ **Authorization and Grievance System:** UFC must make prior-authorization decisions within 14 days for a standard request and within 3 days for an urgent (expedited) request and notify the appropriate parties (the requesting provider and member) of the outcome of the decision. The Contractor must report the timeliness of all prior-authorization decisions at the medical management quarterly meeting and act upon any areas requiring improvement. Additionally, UFC must issue a Notice of Extension letter to the member that contains the reason for the extension when either the member requests an extension to the service authorization review period or the Contractor requires additional information to make a decision. The Notice of Extension letter must include a statement that the decision will be made as expeditiously as the member's condition requires and no later than the date that the extension is set to expire. UFC must indicate that the written decision is a Notice of Decision and must refer to matters as claim disputes. Last, the Contractor must obtain written consent from the member to open and adjudicate an appeal.
- ◆ **Maternal and Child Health and EPSDT:** UFC should correct the desktop procedure to ensure that referrals are not made to WIC for nutritional therapy.
- ◆ **Quality Management:** UFC should formalize a process for data validation using Managed Care.com and should develop a process to ensure the data used are validated. Also, UFC must develop processes to increase the incidence of reporting to regulatory agencies, hospital quality management departments, and accrediting agencies when issues are substantiated. Issues involving a potential hospital medication error, readmission for the same diagnosis, or complications should be referred to the hospital Quality Management Department for internal investigation. UFC should clearly describe the indicators/levels of substantiation used to determine if a quality-of-care case should be referred to the Peer Review Committee. UFC must meet the AHCCCS MPS for all contractual performance measures and improve its rates for those that are currently below the AHCCCS MPS. UFC must ensure that providers document when members are notified of advance directives. Last, the Contractor must educate providers on the concept of step therapy, explaining that medication should not be changed unless there is a change in the member's medical condition.
- ◆ **Delivery Systems and Provider Relations:** UFC must update its provider inquiry tracking logs to reflect when calls are acknowledged and resolved.
- ◆ **Claims and Information Systems:** UFC must revise its EOB description for multiple surgery reductions to include the necessary information. Plus, the Contractor should develop a strategy

for improving electronic claim submission and payment statistics. Additionally, UFC should develop policies and desktops specific to processing behavioral health services and ensure that policies reflect appropriate differences between BH services provided during PPC and the full enrollment period. Further, UFC should perform regular random-sample audits to match system loading to hard copy contracts and update its policies to reflect this practice. Moreover, the Contractor must ensure that provider demographic information, including assigned categories of service, is validated against AHCCCS information on a regular basis.

## Summary

The results of UFC's OFR demonstrated that the Contractor was in full compliance for 85 percent of the 99 standards reviewed. The Contractor demonstrated strength in the Medical Management, Maternal and Child Health and EPSDT, Encounters, and Reinsurance categories, wherein none of the standards required a CAP. Nonetheless, UFC's results demonstrated opportunities for improvement where the Contractor received 18 CAPs for the 99 standards reviewed.

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

DES/CMDP serves eligible, enrolled members in all GSAs and has contracted with AHCCCS since 2003. During the OFR, the AHCCCS review team performed a document review, conducted interviews with appropriate Contractor personnel, and observed staff at work.

**Findings**

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

**Figure 6-10—Categorized Levels of Compliance With Technical Standards for DES/CMDP<sup>6-10</sup>**

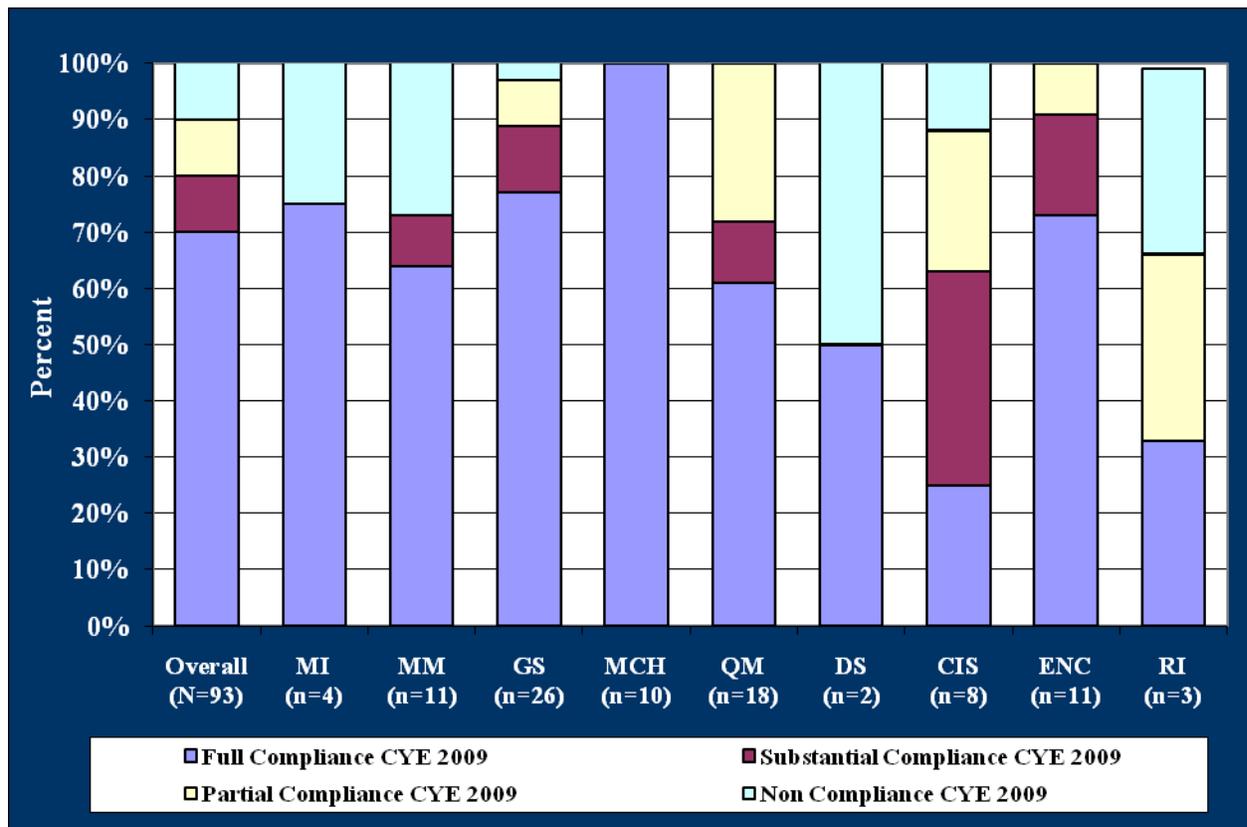


Figure 6-10 shows that DES/CMDP was in full compliance for 70 percent of the 93 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the Maternal and Child Health and EPSDT category, in which 100 percent of the standards were in full compliance. Fifty

<sup>6-10</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

percent of the standards for Delivery Systems and Provider Relations were noncompliant. Only 25 percent of the standards within Claims and Information Systems were scored as fully compliant, followed by the Reinsurance category, with 33 percent of standards scored as fully compliant.

### CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. The same is true for any standards that receive a recommendation from AHCCCS in which the Contractor “should” or “must” implement a required action to address a deficit within the standard. Table 6-10 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2009.

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information	1	3%	4	25%
Medical Management	4	13%	11	36%
Authorization and Grievance System	6	19%	26	23%
Maternal and Child Health and EPSDT	0	0%	10	0%
Quality Management	7	23%	18	39%
Delivery Systems and Provider Relations	1	3%	2	50%
Claims and Information Systems	6	19%	8	75%
Encounters	3	10%	11	27%
Reinsurance	3	10%	3	100%
<b>Overall</b>	<b>31</b>	<b>100%</b>	<b>93</b>	<b>33%</b>

Table 6-10 shows that 33 percent of the 93 standards reviewed required a CAP for CYE 2009. The largest number of required CAPs (seven) was in the Quality Management category. Eight of the nine categories required at least one CAP. The largest percentage of CAPs relative to the number of standards in a category was in Reinsurance (100 percent), followed by Claims and Information Systems (75 percent). No CAPs were received for Maternal and Child Health and EPSDT.

### Strengths

DES/CMDP was in full compliance for 70 percent of the 93 standards reviewed in CYE 2009. The Contractor’s strongest performance was in the Maternal and Child Health and EPSDT category, which received no CAPs.

### Opportunities for Improvement and Recommendations

The findings for DES/CMDP demonstrated widespread opportunities for improvement. There was at least one CAP in eight of the nine categories reviewed. Most notably, 100 percent of the standards for Reinsurance required a CAP. The Quality Management category had the largest number of CAPs (7), followed by Authorization and Grievance System and Claims and Information Systems, which had 6 CAPs each.

In the final report generated from DES/CMDP's OFR, AHCCCS included a list of recommendations at both the standard and category levels. HSAG's review of these recommendations highlights the following findings:

- ◆ **Member Information:** DES/CMDP should update its policies and training materials to include information on the use of mapping services to determine appropriate service locations.
- ◆ **Medical Management:** DES/CMDP must document measureable outcomes, planned interventions, and revisions of its disease management program. Additionally, the Contractor must develop a policy or policy language to state that decision makers are not incentivized to deny, limit, or discontinue medically necessary services to any enrollee. DES/CMDP must develop a policy and procedure for monitoring nursing facility stays to ensure they are for enrolled members. Last, DES/CMDP should develop policies and procedures for step therapy management of members receiving behavioral health medications and demonstrate implementation of the AHCCCS Medical Policy Manual.
- ◆ **Authorization and Grievance System:** DES/CMDP must clearly document the rationale for the adverse decision made by the qualified health professional. Also, the Contractor must clearly describe the purpose of the requested service, and in clear language, state the member-specific reason for the decision. Further, DES/CMDP should develop a self-monitoring tool for auditing Notices of Action and report the findings at the medical management meeting. Additionally, DES/CMDP must develop and implement a Notice of Extension letter that is in compliance with the AHCCCS standards and includes the reason for the extension, the correct time frames for making a decision, and the right to grieve the decision to extend the review period. Plus, the Contractor must develop a process that accurately computes the decision timeliness based on the receipt date of the service request. Last, DES/CMDP must revise the Concurrent Review policy to include the process for informing the member or responsible party that an inpatient stay is being denied.
- ◆ **Quality Management:** DES/CMDP should revise the Data Security & Information Technology Utilization policy to comply with AHCCCS requirements. DES/CMDP should continue its corrective actions for childhood immunizations. DES/CMDP should use information and data as described in the AMPM during the recredentialing process. Additionally, the Contractor should revise the Medical Documentation Reviews policy to include all AHCCCS medical record review requirements. Moreover, DES/CMDP must ensure that training and education is available to PCPs regarding behavioral health referral procedures. DES/CMDP must ensure the initiation and coordination of a referral when a behavioral health need has been identified. Last, the Contractor could enhance provider education on the concept of step therapy—explaining that medication should not be changed unless there is a change in the member's medical condition—by including these topics in the Contractor's provider newsletter and provider manual. The Contractor should develop a process to identify members who have completed step therapy and are returning to the care of their PCPs for the treatment of depression, anxiety, or ADHD. The Contractor should also obtain information from the RBHA providers for members who report having tried several medications and participated in step therapy for the treatment of depression, anxiety, or ADHD prior to their current medication regime. DES/CMDP must authorize medications ordered by the PCP that were originally prescribed by a RBHA provider for members who have completed step therapy. The Contractor must monitor its PCPs to ensure that they prescribe the same medications and dosages that were prescribed by the RBHA providers when a member has completed step therapy.

- ◆ **Delivery Systems and Provider Relations:** DES/CMDP should develop policies and procedures for the acknowledgment of and response to provider inquires that include how the Contractor will take system action on identified issues, as appropriate. The Contractor should track provider inquires pursuant to the policy requirements.
- ◆ **Claims and Information Systems:** DES/CMDP should adjust system logic to ensure that reductions are applied appropriately to claims. Also, the Contractor must revise calculations for professional interest paid after 45 days of receipt of a clean claim. Further, DES/CMDP should develop a work plan for promotion of electronic claim submission and payment. Moreover, DES/CMDP must acknowledge through policy the differences in reimbursement rules for services rendered during a prior-period coverage segment. Additionally, the Contractor should build a periodic audit process into the policy regardless of the necessity, based on contractual requirements. Last, DES/CMDP should ensure that the correct denial codes are used and that provider profiles are consistently updated.
- ◆ **Encounters:** DES/CMDP must evaluate and correct adjudicated encounter ratios. Also, the Contractor must continue to monitor the ratio of approved encounters.
- ◆ **Reinsurance:** DES/CMDP must update its policies and procedures to match contract requirements. Last, the Contractor should identify who they will contact for overpayment notification.

## Summary

The results of DES/CMDP's OFR demonstrated that the Contractor was in full compliance for 70 percent of the 93 standards reviewed. The Contractor demonstrated strength in the Maternal and Child Health and EPSDT category, which had no standards requiring a CAP. Nonetheless, DES/CMDP's results demonstrated opportunities for improvement where the Contractor received 31 CAPs for the 93 standards reviewed.

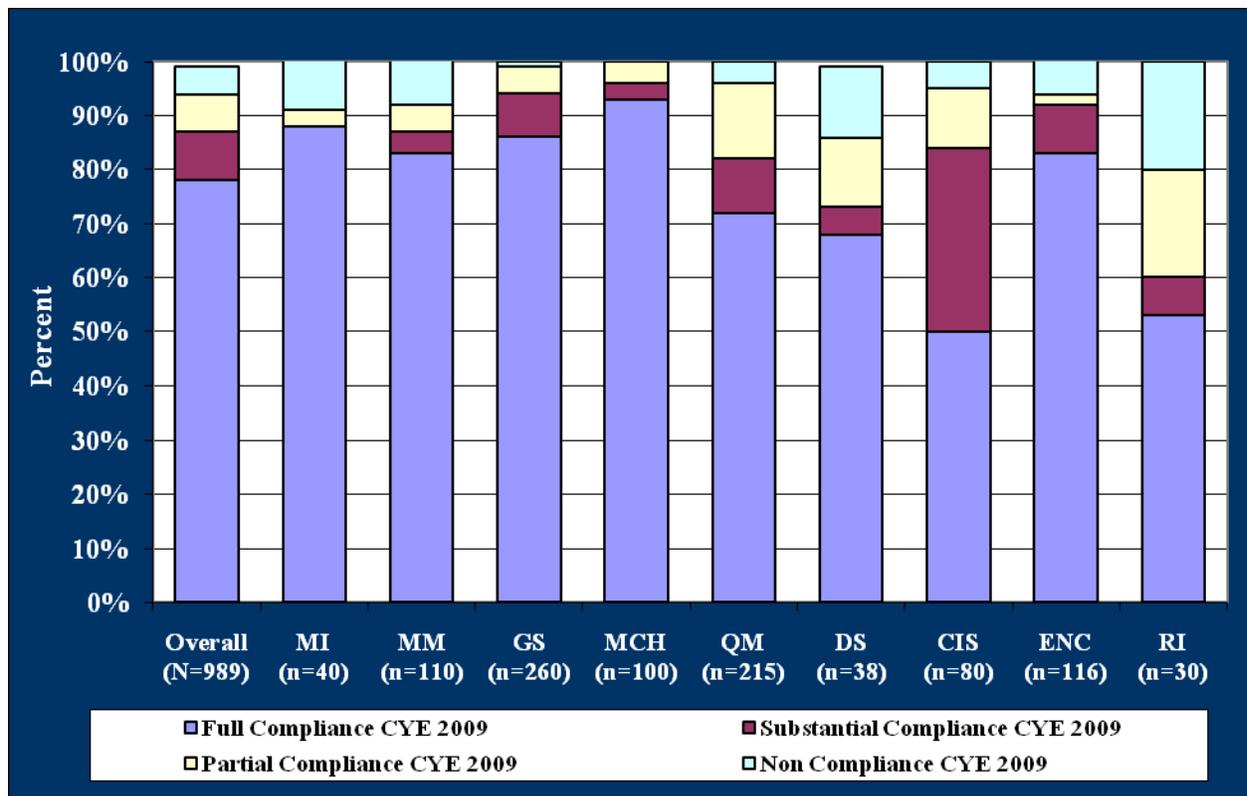
## Comparative Results for Acute Care and DES/CMDP Contractors

The following section presents a comparative analysis of the performance results from AHCCCS' OFR for the 10 Acute Care and DES/CMDP Contractors. Findings are provided on the proportion of each Contractor's compliance standards assessed in full compliance, substantial compliance, partial compliance, and noncompliance. A comparison of the percentage of reviewed compliance standards requiring a CAP is also presented by Contractor.

### Findings

Figure 6-11 shows the overall percentage of each Contractor's reviewed standards that AHCCCS found to be in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars. The left-most bar in the figure shows the proportions for compliance categories across the 10 Contractors.

**Figure 6-11—Categorized Levels of Compliance With Technical Standards for Acute Care and DES/CMDP Contractors<sup>6-11</sup>**



<sup>6-11</sup> The compliance categories are abbreviated as follows: MI=Member Information, MM=Medical Management, GS=Authorization and Grievance System, MCH=Maternal and Child Health and EPSDT, QM=Clinical Quality Management, DS=Delivery Systems and Provider Relations, CIS=Claims and Information Systems, ENC=Encounters, and RI=Reinsurance.

Figure 6-11 shows that the 10 Contractors were in full compliance for 78 percent of the 989 reviewed standards (left-most bar), with fairly wide variation in performance across all nine categories of standards. The Contractors’ strongest performance was for the standards associated with the Maternal and Child Health and EPSDT category, for which AHCCCS scored 93 percent of the standards as fully compliant.

Of the nine categories of standards, the Claims and Information Systems and the Reinsurance categories showed the lowest percentage of standards in full compliance (50 percent and 53 percent, respectively). All other categories scored approximately 70 percent or above compliant for their associated standards.

A comparison of the CAPs across compliance categories highlighted areas for quality improvement activities across the Acute Care and DES/CMDP Contractors as a group. Table 6-11 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed in CYE 2009 for 10 Contractors.

Category	Number of CAPs	% of Total CAPs	Total # of Standards	% of Category Standards
Member Information	8	4%	40	20%
Medical Management	22	10%	110	20%
Authorization and Grievance System	35	15%	260	13%
Maternal and Child Health and EPSDT	9	4%	100	9%
Quality Management	63	28%	215	29%
Delivery Systems and Provider Relations	12	5%	38	32%
Claims and Information Systems	42	18%	80	53%
Encounters	20	9%	116	17%
Reinsurance	17	7%	30	57%
<b>Overall</b>	<b>228</b>	<b>100%</b>	<b>989</b>	<b>23%</b>

Table 6-11 shows that 23 percent of all reviewed OFR standards required a CAP for CYE 2009. Quality Management had the largest number of CAPs (63) of all of the standards, which equaled 28 percent of the total CAPs. These results were followed by 42 CAPs in the Claims and Information Systems category. Together, these two categories represented 46 percent of all CAPs.

All nine categories received at least eight CAPs. The largest percentage of CAPs relative to the number of standards in a category was in the Reinsurance category (57 percent), followed by the Claims and Information Systems category (53 percent).

Figure 6-12 shows the percentage of standards with CAPs for all Acute Care and DES/CMDP Contractors. The left-most bar in the figure shows the overall results across all Contractors.

**Figure 6-12—Percentage of Standards With CAPs for all Acute Care and DES/CMDP Contractors**

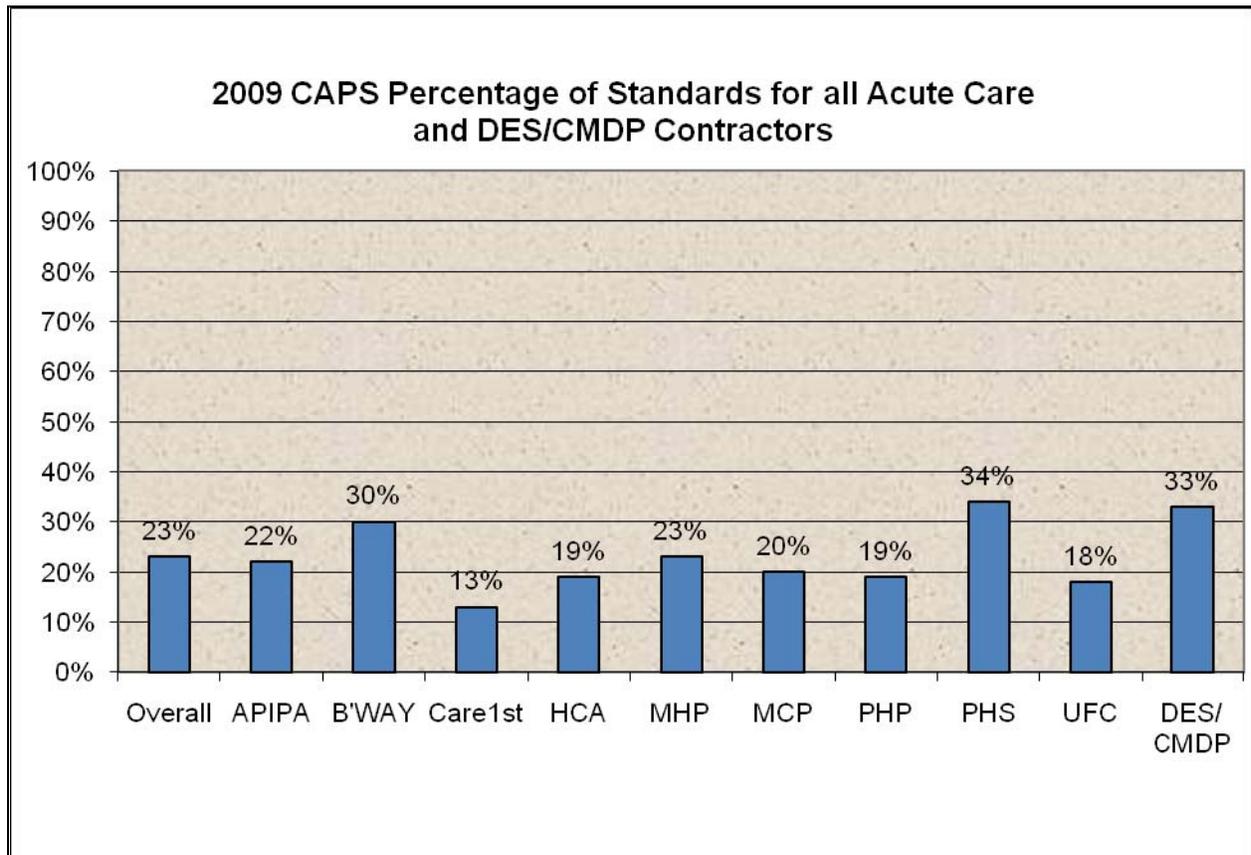


Figure 6-12 shows that 23 percent of all standards across all 10 Contractors received a CAP. The lowest percentage of CAPs was received by Care1st (13 percent), and the highest percentage was received by PHS (34 percent).

**Strengths**

The results from the current assessment show that Maternal and Child Health and EPSDT was a clear strength across the 10 Contractors. The category had only 4 percent of the total number of CAPS and had CAPs for only 9 percent of the assessed standards within the category. The Member Information category also had 4 percent of the total CAPs. These categories were relative strengths across all 10 Contractors.

**Opportunities for Improvement and Recommendations**

With 57 percent of the standards within Reinsurance requiring a CAP, the category was assessed as a high-priority opportunity for improvement across the Contractors. Further, with 53 percent of its standards requiring a CAP, the Claims and Information Systems category was another systemwide opportunity for improvement. Further, the Quality Management and the Delivery Systems and

Provider Relations categories had widespread opportunities for improvement, with 29 percent and 32 percent of their standards requiring a CAP, respectively.

Opportunities for improvement generated by the OFR and assigned CAPs identify areas within the structural operations of each Contractor that require significant attention and improvement. All of the Contractors received CAPs that could be resolved by ensuring that policies and protocols contain all AHCCCS-required elements and associated time frames (e.g., Notice of Action letters to members and service determination notices) and that Contractor staff monitors compliance with these requirements. Other CAPs generated from the CYE 2009 OFR identified opportunities to improve the timeliness, accuracy, and completeness of AHCCCS-required deliverables and reports (e.g., encounter reporting and financial report deliverables). Deficiencies in coordination of care directly impact access to care and the timeliness and quality of care the Contractors provide to members.

Based on AHCCCS' review of Acute Care and DES/CMDP Contractor performance in CYE 2009 and the associated opportunities for improvement identified as a result of the OFR, HSAG recommends the following:

- ◆ Contractors should conduct internal reviews of operational systems to identify barriers that impact their compliance with AHCCCS policies and standards. Specifically, Contractors should cross-reference existing policies and procedures with AHCCCS requirements and ensure, at a minimum, that they are in alignment with both the intent and content of AHCCCS standards.
- ◆ Contractors should develop and implement systems for monitoring the timeliness, accuracy, and completeness of all AHCCCS-required reports and deliverables.
- ◆ Contractors should evaluate their current monitoring programs and activities. When deficiencies are noted, the Contractors should take steps to either develop new procedures and review mechanisms, or augment existing ones. In many cases, Contractors can apply lessons learned from improving performance for one category of standards to other categories.
- ◆ Contractors should review their claims and information systems and their reinsurance policies and bring them into compliance with the relevant AHCCCS standards.

## Summary

With 87 percent of standards being in full or substantial compliance and 8 percent in noncompliance, the CYE 2009 Acute Care and DES/CMDP OFR found overall positive results. Most of the CAPs were related to monitoring, reporting, and communications processes. If the Contractors continue to improve, they should be able to achieve full or almost full compliance in the near future. Nonetheless, both the Claims and Information Systems and the Reinsurance categories require relatively quick attention and a concerted effort to resolve the large percentage of CAPs across Contractors.

## 7. Performance Measure Performance

In accordance with 42 CFR 438.240(b), AHCCCS contractually requires Contractors to have a QAPI program that includes measuring and submitting data to AHCCCS on their performance. Validating MCO and PIHP performance measures is one of the three mandatory Medicaid managed care act external quality review activities described at 42 CFR 438.358(b)(2). The requirement at 438.358(a) allows a state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory activities. Performance results can be reported to a state by the MCOs/PIHPs, or a state can calculate MCO/PIHP performance on the measures for the preceding 12 months. Performance must be reported by the MCOs/PIHPs—or calculated by the state—and validated annually.

As permitted by 42 CFR 438.258(a), AHCCCS elected to conduct the functions associated with the Medicaid managed care act mandatory activity of validating performance measures. 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 performance measure calculation and its data validation activities to prepare this 2008–2009 annual report.

### Conducting the Review

AHCCCS calculated and reported Contractor-specific and statewide aggregate performance rates for the following AHCCCS-selected measures:

- ◆ *Children’s Access to Primary Care Practitioners* (12–24 months, 25 months–6 years, 7–11 years, and 12–19 years)<sup>7-1</sup>
- ◆ *Adults’ Access to Preventative/Ambulatory Health Services* (20–44 years and 45–64 years)<sup>7-2</sup>
- ◆ *Well-Child Visits in the First 15 Months of Life*<sup>7-1, 7-2</sup>
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*<sup>7-1</sup>
- ◆ *Adolescent Well-Care Visits*<sup>7-1</sup>
- ◆ *Annual Dental Visits—2–21 Years*<sup>7-1</sup>
- ◆ *Breast Cancer Screening*<sup>7-2</sup>
- ◆ *Cervical Cancer Screening*<sup>7-2</sup>
- ◆ *Chlamydia Screening—16–24 Years*<sup>7-1, 7-2</sup>
- ◆ *Timeliness of Prenatal Care*<sup>7-1, 7-2</sup>
- ◆ *EPSDT Participation*

Using AHCCCS’ results and statistical analysis of the Contractors’ performance rates, HSAG organized, aggregated, and analyzed the performance data. From its analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality and timeliness of, and access to, the care and services the Contractors provided to AHCCCS members.

<sup>7-1</sup> Not required for PHS

<sup>7-2</sup> Not required for DES/CMDP

### **Objectives for Conducting the Review**

As part of its objectives to measure, report, compare, and continually improve Contractor performance, AHCCCS conducted the following activities:

- ◆ Provided key information about AHCCCS-selected performance measures to each Contractor
- ◆ Used Contractor data AHCCCS collected to calculate the performance measure rates
- ◆ Performed encounter validation according to industry standards

HSAG designed a summary tool to organize and represent the information and data AHCCCS provided for the nine Acute Care and DES/CMDP Contractors' performance with respect to each of the AHCCCS-selected measures. The summary tool focused on HSAG's objectives for aggregating and analyzing the data, which were to:

- ◆ Determine Contractor performance on each of the AHCCCS-selected measures.
- ◆ Compare Contractor performance to AHCCCS' MPS and goal for each measure.
- ◆ Provide data from analyzing the performance results that would allow HSAG to draw conclusions about the quality and timeliness of, and access to, care and services furnished by individual Contractors and statewide across Contractors.
- ◆ Aggregate and assess the AHCCCS-required Contractor CAPs to evaluate performance overall for each Contractor and statewide across Contractors.

### **Methodology for Conducting the Review**

For the review period of CYE 2009 (measurement year ending September 30, 2008), AHCCCS conducted the following activities:

- ◆ Collected Contractor encounter data associated with each of the State-selected measures
- ◆ Calculated, for each measure, Contractor-specific performance rates and statewide aggregate rates across all Contractors
- ◆ Performed encounter validation according to industry standards
- ◆ Reported Contractors' performance results by individual Contractor and in aggregate statewide
- ◆ Compared Contractor performance rates with standards defined by AHCCCS' contract
- ◆ Required Contractors to submit CAPs to AHCCCS for its review and approval when their performance did not meet AHCCCS' MPS for one or more measures

Each Contractor CAP had to include an evaluation of the effectiveness of the Contractor's current interventions and, when necessary, its plans to revise or replace them. AHCCCS required Contractors to include updates on the status and effectiveness of the CAPs in their annual quality management/performance improvement plans and evaluation, an AHCCCS-required contract deliverable.

AHCCCS followed Healthcare Effectiveness Data and Information Set (HEDIS) methodology when calculating the rates to evaluate preventive health care quality. HEDIS, which was developed

and is maintained by NCQA, is a widely used and well accepted set of performance measures for health care providers.

To select the members included in the annual analysis, AHCCCS used HEDIS criteria (e.g., members must have been continuously enrolled with the Contractor for a specified minimum period of time). With few exceptions, AHCCCS used pure HEDIS specifications to calculate Contractor performance rates. For the *EPSDT Participation* measure, which was one of the exceptions, AHCCCS calculated the rate according to a methodology CMS developed for the EPSDT Form 416 report that state Medicaid agencies are required to submit annually to CMS. In addition to calculating and reporting rates for age stratifications as specified by HEDIS, AHCCCS also calculated and reported roll-up rates for two measures (i.e., *Children's Access to PCPs* and *Adults' Access to Preventive/Ambulatory Health Services*).

AHCCCS listed several deviations from the previous HEDIS methodology for data collection, which included the following:

- ◆ ***Adults' Access to Preventive/Ambulatory Health Services***—NCQA added codes to identify some services for the numerators (nursing facility discharge day management). In addition, AHCCCS added Place of Service (POS) codes to better identify hospital emergency department and inpatient services, which should be excluded from the numerator for this measure.
- ◆ ***Breast Cancer Screening—52–69 Years***—NCQA added codes to include diagnostic, as well as screening, mammograms in the numerator.
- ◆ ***Cervical Cancer Screening***—NCQA deleted a code that was used to identify a pelvic and clinical breast exam, which was previously counted toward the numerator, and added codes to exclude women who had laparoscopic hysterectomies from the denominator.
- ◆ ***Children's and Adolescents' Access to PCPs; Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; and Adolescent Well-Care Visits***—AHCCCS added POS codes to better identify hospital emergency department and inpatient services, which should be excluded from the numerators for these measures. AHCCCS also added more codes to identify services provided by physicians' assistants and nurse practitioners for inclusion in the numerators.
- ◆ ***Chlamydia Screening—16–24 Years***—NCQA decreased the upper age limit from 25 to 24 years and added codes to identify sexually active women for the denominator.
- ◆ ***Timeliness of Prenatal Care***—NCQA added more codes to identify live births and prenatal services.

In addition to these changes, NCQA updates its methodology annually to add or delete codes that have been added or retired from standardized coding sets used by providers, such as Current Procedural Terminology (CPT) and International Classification of Diseases, Ninth Revision (ICD-9) coding. AHCCCS makes these coding changes, as well.

In addition, denominators for these measures increased from the previous year's measurement, reflecting significant growth in the AHCCCS program. Some of the growth may be attributed to the inclusion of more members who are covered under health plans' acute care contracts (contract Type A)—primarily adults who are eligible under expanded eligibility of up to 100 percent of the federal poverty level.

AHCCCS used administrative data collected from its automated managed care data system known as the Prepaid Medicaid Management Information System (PMMIS). AHCCCS selected members included in the denominator for each measure from the Recipient Subsystem of PMMIS. As a result, the numerators and the performance rates were based on encounter data (records of services Contractors provided and the associated claims Contractors paid) in the PMMIS. The encounter data reported were based on Contractors' encounters for professional services, which were primarily physician clinic and office visits.

AHCCCS conducts annual validation studies of encounters. Based on the most recent validation study applicable to the data for this report, AHCCCS determined that:

- ◆ Approximately 90 percent of all encounters for Acute Care professional services were complete compared with the associated medical records. An encounter data validation study was not conducted for DES/CMDP during this review period.
- ◆ Approximately 85 percent of encounters were fully accurate compared with services documented in members' medical records.

AHCCCS calculated performance rates based on Contractor-submitted encounters. As a result, AHCCCS noted that rates may have been negatively affected if Contractors did not complete and submit all encounters for services provided that were applicable and could have been included in the calculations for performance for a given measure.

Using the performance rates and statistical analysis AHCCCS calculated for each Contractor, HSAG organized, aggregated, and analyzed the data to draw conclusions about Contractor performance in providing accessible, timely, and quality care and services to AHCCCS members. AHCCCS analyzed Contractor-specific and statewide aggregate performance results for each measure to determine:

- ◆ If Contractor performance rates met or exceeded AHCCCS' MPS or goal.
- ◆ The direction of any change in rates from previous measurement periods (if applicable) and whether the change was statistically significant.
- ◆ If a CAP was required.

AHCCCS required Contractors to submit a CAP to improve their performance on a measure when their performance rates did not achieve the AHCCCS MPS.

Based on its analysis of the data, HSAG drew conclusions about Contractor-specific and statewide aggregate performance in providing accessible, timely, and quality care and services to AHCCCS members. When applicable, HSAG formulated and presented its recommendations to improve Contractor performance rates.

The following sections describe HSAG's findings, conclusions, and recommendations for each Contractor as well as statewide comparative results across the Contractors.

## Contractor-Specific Results

AHCCCS calculated and provided to HSAG Contractor performance rates for the CYE 2009 AHCCCS-selected performance measures for each of the nine Acute Care and DES/CMDP Contractors. The nine Contractors were APIPA, Care1st, HCA, MHP, MCP, PHS, PHP, UFC, and DES/CMDP. The Acute Care Contractor, BHS, was not a Contractor at the time of the measurement periods; therefore, no data were available for this Contractor. The performance measures reported in CYE 2009 were also reported in CYE 2008.

The CYE 2009 performance measures were:

- ◆ *Children's Access to PCPs*
  - 12–24 Months*
  - 25 Months–6 Years*
  - 7–11 Years*
  - 12–19 Years*
- ◆ *Adults' Access to Preventive/Ambulatory Health Services*
  - 20–44 Years*
  - 45–64 Years*
- ◆ *Well-Child Visits—First 15 Months*
- ◆ *Well-Child Visits—3, 4, 5, 6 Years*
- ◆ *Adolescent Well-Care Visits*
- ◆ *Annual Dental Visits—2–21 Years*
- ◆ *Breast Cancer Screening—52–69 Years*
- ◆ *Cervical Cancer Screening*
- ◆ *Chlamydia Screening—16–24 Years*
- ◆ *Timeliness of Prenatal Care*
- ◆ *EPSDT Participation*

Under its Acute Care contract, PHS has fewer performance measures because it serves primarily Medicare-Medicaid dual-eligible adults and any eligible family members who wish to enroll in the plan.

The results for each Contractor are presented next, followed by comparative results across Contractors.

**Arizona Physicians IPA, Inc.**

**Findings**

Table 7-1 presents the performance measure rates for APIPA. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2009 MPS and goal.

Table 7-1—Performance Measurement Review for APIPA						
Performance Measure	Performance for Oct. 1, 2006, to Sept. 30, 2007	Performance for Oct. 1, 2007, to Sept. 30, 2008	Relative Percent Change	Significance Level <sup>A</sup> (p value)	CYE 2009 Minimum Performance Standard	AHCCCS Goal
<i>Children's Access to PCPs (Total)</i>	76.4%	<b>80.7%</b>	<b>5.6%</b>	<b>p&lt;.001</b>	**	**
12–24 Months	81.1%	<b>85.0%</b>	<b>4.8%</b>	<b>p&lt;.001</b>	93%	97%
25 Months–6 Years	75.3%	<b>81.0%</b>	<b>7.5%</b>	<b>p&lt;.001</b>	83%	97%
7–11 Years	75.7%	<b>78.9%</b>	<b>4.3%</b>	<b>p&lt;.001</b>	83%	97%
12–19 Years	77.1%	<b>80.6%</b>	<b>4.6%</b>	<b>p&lt;.001</b>	81%	97%
<i>Adults' Access to Preventive/Ambulatory Health Services (Total)</i>	83.3%	<b>84.0%</b>	<b>0.8%</b>	<b>p=.015</b>	**	**
20–44 Years	81.4%	81.5%	0.2%	p=.646	78%	96%
45–64 Years	87.4%	<b>88.2%</b>	<b>1.0%</b>	<b>p=.035</b>	85%	96%
<i>Well-Child Visits—First 15 Months</i>	55.5%	57.0%	2.8%	p=.187	65%	90%
<i>Well-Child Visits—3, 4, 5, 6 Years</i>	57.6%	<b>62.5%</b>	<b>8.5%</b>	<b>p&lt;.001</b>	64%	80%
<i>Adolescent Well-Care Visits</i>	36.0%	<b>39.8%</b>	<b>10.7%</b>	<b>p&lt;.001</b>	41%	50%
<i>Annual Dental Visits—2–21 Years</i>	58.0%	<b>62.1%</b>	<b>7.2%</b>	<b>p&lt;.001</b>	55%	57%
<i>Breast Cancer Screening—52–69 Years</i>	51.6%	<b>61.5%</b>	<b>19.3%</b>	<b>p&lt;.001</b>	50%	70%
<i>Cervical Cancer Screening</i>	63.4%	63.8%	0.7%	p=.302	65%	90%
<i>Chlamydia Screening—16–24 Years</i>	32.5%	<b>36.6%</b>	<b>12.7%</b>	<b>p&lt;.001</b>	51%	62%
<i>Timeliness of Prenatal Care</i>	62.3%	<b>65.5%</b>	<b>5.2%</b>	<b>p&lt;.001</b>	80%	90%
<i>EPSDT Participation</i>	68.9%	<b>74.3%</b>	<b>7.8%</b>	<b>p&lt;.001</b>	68%	80%

\*\*During CYE 2007, the minimum performance standards and goals for the *Children's Access to PCPs* and *Adults' Access to Preventive/Ambulatory Health Services* measures were established for each age group instead of at the aggregate level, as in previous years.

<sup>A</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the p value is ≤ .05. Rates in bold indicate statistical significance.

Using the AHCCCS CYE 2009 MPS and goals as frames of reference, Table 7-1 highlights some success and continued opportunities for improvement for APIPA. Of the 17 measures for CYE 2009, all of the measures showed an improvement over last year, with 14 of the measures improving by a statistically significant amount. Of the 15 measures with an AHCCCS MPS, 5 of the measures (both measures for *Adults' Access to Preventive/Ambulatory Health Services*, *Annual Dental Visits—2–21 Years*, *Breast Cancer Screening—52–69 Years*, and *EPSDT Participation*) met the AHCCCS MPS. The remaining 10 measures did not meet the AHCCCS MPS. However, all 10

measures that did not meet the AHCCCS MPS demonstrated improvement over the previous year's rates. Only 1 measure (*Annual Dental Visits—2–21 Years*) exceeded the AHCCCS goal. Three of the measures improved by more than a relative 10 percent—*Adolescent Well Care Visits* improved by a relative 10.7 percent, *Breast Cancer Screening—52–69 Years* improved by a relative 19.3 percent, *Chlamydia Screening—16–24 Years* improved by a relative 12.7 percent. However, opportunities for improvement existed for the 10 measures that did not meet the AHCCCS MPS.

## CAPs

APIPA was required to complete 10 CAPs for the 15 measures reported in CYE 2009 with an AHCCCS MPS. This number represented 66.7 percent of the measures and included all of the *Children's Access to PCPs* age-group measures, both *Well-Child Visits* measures, *Adolescent Well-Care Visits*, *Cervical Cancer Screening*, *Chlamydia Screening—16–24 Years*, and *Timeliness of Prenatal Care*. These CAPs correlated with access to, and the quality and timeliness of, services and indicated that APIPA's members were not receiving these services at rates that met the AHCCCS MPS or goals.

## Strengths

The results for APIPA's performance measures show statistically significant improvement in 14 measures. The *Annual Dental Visits—2–21 Years* measure continued to be a strength for the Contractor. Although *Annual Dental Visits—2–21 Years* exceeded the AHCCCS goal in the previous year, the measure continued to improve by a relative 7.2 percent. Both *Adults' Access to Preventive/Ambulatory Health Services* measures, *Breast Cancer Screening—52–69 Years*, and *EPSDT Participation* also continued to be a strength for the Contractor because all four measures exceeded the AHCCCS MPS.

## Opportunities for Improvement and Recommendations

The 10 required CAPs for APIPA represented a clear opportunity for improvement for the Contractor since all of the measures did not meet the AHCCCS MPS. The measures assessed performance relative to access to, and the timeliness and quality of, care. While the measures did not meet the AHCCCS MPS, all of the measures increased, and eight of the measures increased by a statistically significant amount. The greatest opportunities for improvement were with *Timeliness of Prenatal Care*, *Chlamydia Screening—16–24 Years*, *Well-Child Visits—First 15 Months*, and *Children's Access to PCPs—12–24 Months* because these measures must achieve more than a 5 percentage-point improvement to meet the AHCCCS MPS. HSAG recommends that the Contractor implement targeted care coordination efforts for expectant mothers and assist expectant mothers with obtaining obstetrical services. These efforts could have a positive impact on *Timeliness of Prenatal Care* rates. Targeted care coordination for expectant mothers would enable members to establish a relationship with an obstetrician, which would provide another avenue to educate expectant mothers on the importance of establishing a relationship with a pediatrician for their child. By educating and linking expectant mothers to pediatric services prior to delivery, new mothers can establish a relationship with their child's pediatrician to schedule appointments for the new infant after delivery. These strategies could positively impact the rates for *Well-Child Visits—First 15 Months* and *Children's Access to PCPs—12–24 Months*.

In addition to these activities, the Contractor should identify barriers that impact access to care, such as limited transportation to and from health care visits or limited availability of providers during hours that are convenient for members. Access-related barriers could be overcome with increased transportation coordination and expanded office hours for practitioners or clinics. Member awareness of service availability does not necessarily indicate the absence of an accessibility barrier. Therefore, the Contractor should also investigate other factors that impact rates, such as misunderstanding on the part of the member about what services to access and when. Member awareness barriers can be overcome with increased education on periodicity schedules for well-child visits, prenatal care, and preventive care. Since the early detection and treatment of Chlamydia can help prevent adverse health consequences such as pelvic inflammatory disease and infertility, the Contractor should employ targeted outreach strategies to women 16–24 years of age to educate them on the importance of gynecological preventive care. The Contractor should also provide additional education to physicians on the importance of gynecological preventive screenings and remind physicians to include Chlamydia screening in routine examinations.

It is also recommended that APIPA evaluate the interventions currently in place to improve the *Annual Dental Visits—2–21 Years* measure. Since this performance measure exceeded the AHCCCS MPS and goal, lessons learned from quality improvement activities may be useful in improving the rates for other child and adolescent measures that did not meet the AHCCCS MPS.

## Summary

Of the 15 measures with an AHCCCS MPS, 10 measures did not meet the AHCCCS MPS. Each of these measures required a CAP. APIPA demonstrated improvement, with all 17 performance measures improving from the previous measurement and 14 of the measures improving by a statistically significant amount. These improvements show that APIPA implemented successful quality initiatives, although only five measures exceeded the AHCCCS MPS and one measure, *Annual Dental Visits—2–21 Years*, exceeded the AHCCCS goal. While this year's performance represented an improvement over the previous measurement cycle, APIPA still has considerable room for improvement to reach and then to exceed the MPS for all performance measures.

### ***Bridgeway Health Solutions***

BHS was not a contractor in the AHCCCS Acute Care program at the time of the most recent measurement for performance measures. Therefore, there were no performance measure results for BHS.

## Care1st Health Plan

### Findings

Table 7-2 presents the performance measure rates for Care1st. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2009 MPS and goal.

**Table 7-2—Performance Measurement Review for Care1st**

Performance Measure	Performance for Oct. 1, 2006, to Sept. 30, 2007	Performance for Oct. 1, 2007, to Sept. 30, 2008	Relative Percent Change	Significance Level <sup>A</sup> (p value)	CYE 2009 Minimum Performance Standard	AHCCCS Goal
<i>Children's Access to PCPs (Total)</i>	75.7%	<b>79.8%</b>	<b>5.4%</b>	<b>p&lt;.001</b>	**	**
12–24 Months	84.9%	86.3%	1.7%	p=.391	93%	97%
25 Months–6 Years	76.2%	<b>81.6%</b>	<b>7.2%</b>	<b>p&lt;.001</b>	83%	97%
7–11 Years	71.6%	73.2%	2.2%	p=.381	83%	97%
12–19 Years	71.8%	<b>76.7%</b>	<b>6.8%</b>	<b>p=.004</b>	81%	97%
<i>Adults' Access to Preventive/Ambulatory Health Services (Total)</i>	77.2%	<b>80.7%</b>	<b>4.5%</b>	<b>p=.001</b>	**	**
20–44 Years	75.3%	<b>78.5%</b>	<b>4.2%</b>	<b>p=.006</b>	78%	96%
45–64 Years	82.1%	85.1%	3.6%	p=.056	85%	96%
<i>Well-Child Visits—First 15 Months</i>	58.7%	<b>65.8%</b>	<b>12.1%</b>	<b>p=.014</b>	65%	90%
<i>Well-Child Visits—3, 4, 5, 6 Years</i>	62.4%	<b>67.4%</b>	<b>7.9%</b>	<b>p&lt;.001</b>	64%	80%
<i>Adolescent Well-Care Visits</i>	35.2%	<b>43.4%</b>	<b>23.4%</b>	<b>p&lt;.001</b>	41%	50%
<i>Annual Dental Visits—2–21 Years</i>	53.4%	<b>62.2%</b>	<b>16.5%</b>	<b>p&lt;.001</b>	55%	57%
<i>Breast Cancer Screening—52–69 Years</i>	45.8%	<b>53.3%</b>	<b>16.3%</b>	<b>p=.047</b>	50%	70%
<i>Cervical Cancer Screening</i>	59.2%	60.1%	1.5%	p=.551	65%	90%
<i>Chlamydia Screening—16–24 Years</i>	45.8%	43.1%	-5.8%	p=.328	51%	62%
<i>Timeliness of Prenatal Care</i>	79.3%	76.3%	-3.8%	p=.160	80%	90%
<i>EPSDT Participation</i>	70.4%	<b>74.0%</b>	<b>5.1%</b>	<b>p&lt;.001</b>	68%	80%

\*\*During CYE 2007, the minimum performance standards and goals for the *Children's Access to PCPs* and *Adults' Access to Preventive/Ambulatory Health Services* measures were established for each age group instead of at the aggregate level, as in previous years.

<sup>A</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the p value is ≤ .05. Rates in bold indicate statistical significance.

Using the AHCCCS CYE 2009 MPS and goals as frames of reference, Table 7-2 highlights success and continued opportunities for improvement for Care1st. Fifteen of the 17 performance measures demonstrated improvement over the previous measurement period. The remaining two measures (*Chlamydia Screening—16–24 Years* and *Timeliness of Prenatal Care*) declined from the previous measurement period. Eleven of the 15 improvements were statistically significant. Eight of the 15 measures with an AHCCCS MPS exceeded the MPS and one measure (*Annual Dental Visits—2–21 Years*) exceeded the AHCCCS goal. Of the seven measures that did not reach the AHCCCS MPS, two *Children's Access to PCPs* measures (*Children's Access to PCPs—25 Months–6 Years* and *12–*

19 Years) showed statistically significant improvement, and three measures (*Children's Access to PCPs—12–24 Months* and *7–11 Years* and *Cervical Cancer Screening*) showed improvement. The two remaining measures (*Chlamydia Screening—16–24 Years* and *Timeliness of Prenatal Care*) declined from the previous measurement period, although the declines were not statistically significant. Opportunities for improvement existed for the eight measures that did not meet the AHCCCS MPS.

## CAPs

Care1st was required to complete seven CAPs for the 15 measures reported in CYE 2009 with an AHCCCS MPS. This number represented less than half (46.7 percent) of the measures and included all of the *Children's Access to PCPs* measures, *Cervical Cancer Screening*, *Chlamydia Screening—16–24 Years*, and *Timeliness of Prenatal Care*. These CAPs correlated with access to, and the quality and timeliness of, services and indicated that Care1st's members were not receiving these services at rates that met the AHCCCS MPS or goals.

## Strengths

The results for Care1st's performance measures showed statistically significant improvement in 11 measures. The *Annual Dental Visits—2–21 Years* measure continued to be a strength for the Contractor whereby it exceeded the AHCCCS goal and improved over the previous measurement period by a relative 16.5 percent. Eight of the measures (both *Adults' Access to Preventive/Ambulatory Health Services* measures, both *Well-Child Visits* measures, *Adolescent Well-Care Visits*, *Breast Cancer Screening—52–69 Years*, and *EPSDT Participation*) exceeded the AHCCCS MPS and were recognized strengths for the Contractor.

## Opportunities for Improvement and Recommendations

The seven required CAPs for Care1st represented a clear opportunity for improvement for the Contractor since all of the measures did not meet the AHCCCS MPS. The measures assessed performance relative to access to, and the timeliness and quality of, care. While the measures did not meet the AHCCCS MPS, five of the measures increased over the previous measurement period and two measures declined. The greatest opportunities for improvement were with *Children's Access to PCPs—12–24 Months* and *7–11 Years*, *Cervical Cancer Screening*, and *Chlamydia Screening—16–24 Years* because these measures must achieve about a 5 percentage-point improvement to meet the AHCCCS MPS. *Timeliness of Prenatal Care* was also an opportunity for improvement for the Contractor since it had a relative 3.8 percent-point decline from the previous measurement.

HSAG recommends that Care1st identify barriers that impact preventive service rates, such as the rates for the *Cervical Cancer Screening* and *Chlamydia Screening—16–24 Years* measures for female members. Since early detection and treatment of Chlamydia can help prevent adverse health consequences such as pelvic inflammatory disease and infertility, the Contractor should employ targeted outreach strategies to women to educate them on the importance of gynecological preventive care. The Contractor should also provide additional education to physicians on the importance of gynecological preventive screenings and remind physicians to include Chlamydia screening in routine examinations.

In addition to these activities, the Contractor should identify barriers that impact access to care, such as limited transportation to and from health care visits or limited availability of providers during hours that are convenient for members. Access-related barriers could be overcome with increased transportation coordination and expanded office hours for practitioners or clinics. Member awareness of service availability does not necessarily indicate the absence of an accessibility barrier. Therefore, the Contractor should also investigate other factors that impact rates, such as misunderstanding on the part of the member about what services to access and when. Member awareness barriers can be overcome with increased education on periodicity schedules for *Children's Access to PCPs* and *Timeliness of Prenatal Care*. Targeted care coordination for expectant mothers could assist members with establishing a relationship with an obstetrician, which would provide another avenue to educate expectant mothers on the importance of establishing a relationship with a pediatrician for their child. By educating and linking expectant mothers to pediatric services prior to delivery, new mothers can establish a relationship with their child's pediatrician to schedule appointments for the new infant after delivery. These strategies could positively impact the rates for *Children's Access to PCPs*.

It is also recommended that Care1st evaluate the interventions currently in place to improve the *Annual Dental Visits—2–21 Years* measure. Since this performance measure was a recognized strength for Care1st, lessons learned from quality improvement activities may be useful in improving the rates for other child and adolescent measures that did not meet the AHCCCS MPS.

## Summary

Of the 15 measures with an AHCCCS MPS, 7 measures did not meet the AHCCCS MPS and, therefore, required a CAP. Care1st demonstrated improvement, with 15 of the 17 measures improving over the previous measurement period. Eleven measures improved by a statistically significant amount. These improvements show that Care1st has implemented successful quality initiatives to improve performance measure rates. Although only 1 performance measure, *Annual Dental Visits—2–21 Years*, exceeded the AHCCCS goal, 8 measures exceeded the AHCCCS MPS. Although this year's performance represented an improvement over the previous measurement period, Care1st still has room for improvement to reach and then to exceed the MPS for all performance measures.

**Health Choice Arizona**

**Findings**

Table 7-3 presents the performance measure rates for HCA. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2009 MPS and goal.

**Table 7-3—Performance Measurement Review for HCA**

Performance Measure	Performance for Oct. 1, 2006, to Sept. 30, 2007	Performance for Oct. 1, 2007, to Sept. 30, 2008	Relative Percent Change	Significance Level <sup>A</sup> (p value)	CYE 2009 Minimum Performance Standard	AHCCCS Goal
<i>Children's Access to PCPs (Total)</i>	75.3%	<b>78.1%</b>	<b>3.8%</b>	<b>p&lt;.001</b>	**	**
12–24 Months	82.1%	82.7%	0.7%	p=.516	93%	97%
25 Months–6 Years	74.6%	<b>78.7%</b>	<b>5.5%</b>	<b>p&lt;.001</b>	83%	97%
7–11 Years	73.3%	<b>75.7%</b>	<b>3.3%</b>	<b>p=.002</b>	83%	97%
12–19 Years	75.3%	<b>77.2%</b>	<b>2.5%</b>	<b>p=.014</b>	81%	97%
<i>Adults' Access to Preventive/Ambulatory Health Services (Total)</i>	78.8%	<b>79.8%</b>	<b>1.3%</b>	<b>p=.025</b>	**	**
20–44 Years	77.7%	78.4%	1.0%	p=.186	78%	96%
45–64 Years	81.4%	82.6%	1.5%	p=.127	85%	96%
<i>Well-Child Visits—First 15 Months</i>	59.3%	58.0%	-2.2%	p=.408	65%	90%
<i>Well-Child Visits—3, 4, 5, 6 Years</i>	59.0%	<b>61.4%</b>	<b>3.9%</b>	<b>p=.001</b>	64%	80%
<i>Adolescent Well-Care Visits</i>	35.4%	36.3%	2.4%	p=.207	41%	50%
<i>Annual Dental Visits—2–21 Years</i>	57.9%	<b>60.5%</b>	<b>4.4%</b>	<b>p&lt;.001</b>	55%	57%
<i>Breast Cancer Screening—52–69 Years</i>	41.1%	<b>52.5%</b>	<b>27.5%</b>	<b>p&lt;.001</b>	50%	70%
<i>Cervical Cancer Screening</i>	60.5%	59.9%	-1.1%	p=.331	65%	90%
<i>Chlamydia Screening—16–24 Years</i>	39.3%	40.8%	3.7%	p=.274	51%	62%
<i>Timeliness of Prenatal Care</i>	77.0%	75.0%	-2.6%	p=.067	80%	90%
<i>EPSDT Participation</i>	69.2%	<b>70.8%</b>	<b>2.3%</b>	<b>p&lt;.001</b>	68%	80%

\*\*During CYE 2007, the minimum performance standards and goals for the *Children's Access to PCPs* and *Adults' Access to Preventive/Ambulatory Health Services* measures were established for each age group instead of at the aggregate level, as in previous years.

<sup>A</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the p value is ≤ .05. Rates in bold indicate statistical significance.

Using the AHCCCS CYE 2009 MPS and goals as frames of reference, Table 7-3 highlights more opportunities for improvement than strengths for HCA. Of the 17 measures for CYE 2009, 14 of the measures demonstrated improvement over the previous measurement period and the remaining 3 measures declined. Nine of the 14 measures that improved showed statistically significant improvement. Of the 15 measures with an AHCCCS MPS, 4 of the measures (*Adult's Access to Preventive/Ambulatory Health Services—20–44 Years*, *Annual Dental Visits—2–21 Years*, *Breast Cancer Screening—52–69 Years*, and *EPSDT Participation*) exceeded the AHCCCS MPS. The remaining 11 measures did not meet the AHCCCS MPS. Only one measure, *Annual Dental Visits—*

2–21 Years, met the AHCCCS goal. Of the 11 measures that did not reach the AHCCCS MPS, 8 measures demonstrated improvement, 4 measures (*Children’s Access to PCPs—24 Months–6 Years, 7–11 Years, and 12–19 Years* and *Well-Child Visits—3, 4, 5, 6 Years*) showed statistically significant improvement, and 3 measures (*Well-Child Visits—First 15 Months, Cervical Cancer Screening, and Timeliness of Prenatal Care*) declined. Opportunities for improvement existed for the 11 measures that did not meet the AHCCCS MPS.

## CAPs

HCA was required to complete 11 CAPs for the 15 measures reported in CYE 2009 with an AHCCCS MPS. This number represented 73.3 percent of the measures and included all of the *Children’s Access to PCPs* measures, *Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years*, both *Well-Child Visits* measures, *Adolescent Well-Care Visits, Cervical Cancer Screening, Chlamydia Screening—16–24 Years, and Timeliness of Prenatal Care*. These CAPs correlated with access to, and the quality and timeliness of, services and indicated that HCA’s members were not receiving these services at rates that met the AHCCCS MPS or goals.

## Strengths

Of the 17 measures for CYE 2009, 14 of the measures demonstrated improvement over the previous measurement period. Nine of the 14 measures that improved showed statistically significant improvement. *Breast Cancer Screening—52–69 Years* demonstrated the greatest improvement among the measures with a relative 27.5 percent improvement over the previous measurement period. *Annual Dental Visits—2–21 Years* continued to be a strength for the Contractor by exceeding the AHCCCS goal.

## Opportunities for Improvement and Recommendations

The 11 required CAPs for HCA represented a distinct opportunity for improvement for the Contractor since all of the measures did not meet the AHCCCS MPS. The measures assessed performance relative to access to, and the timeliness and quality of, care and included all of the *Children’s Access to PCPs* measures, *Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years*, both *Well-Child Visits* measures, *Adolescent Well-Care Visits, Cervical Cancer Screening, Chlamydia Screening—16–24 Years, and Timeliness of Prenatal Care*.

HSAG recommends that the Contractor identify barriers that impact access to care, such as limited transportation to and from health care visits or limited availability of providers during hours that are convenient for members. Access-related barriers could be overcome with increased transportation coordination and expanded office hours for practitioners or clinics. Member awareness of service availability does not necessarily indicate the absence of an accessibility barrier. Therefore, the Contractor should also investigate other factors that impact rates, such as misunderstanding on the part of the member about what services to access and when. Member awareness barriers can be overcome with increased education on periodicity schedules for well-child visits, adults’ access to preventive/ambulatory health services for those 45 to 64 years of age, prenatal care, and preventive care. Since the early detection and treatment of Chlamydia can help prevent adverse health consequences such as pelvic inflammatory disease and infertility, the Contractor should employ targeted outreach strategies to women to educate them on the importance of gynecological

preventive care. The Contractor should also provide additional education to physicians on the importance of gynecological preventive screenings and remind physicians to include Chlamydia screening in routine examinations.

The Contractor should develop and implement targeted care coordination efforts for expectant mothers and assist expectant mothers with obtaining obstetrical services. These efforts could have a positive impact on *Timeliness of Prenatal Care* rates. Targeted care coordination for expectant mothers would enable members to establish a relationship with an obstetrician. Connecting expectant mothers to prenatal care would provide another avenue to educate expectant mothers on the importance of establishing a relationship with a pediatrician for their child. By educating and linking expectant mothers to pediatric services prior to delivery, new mothers can establish a relationship with their child's pediatrician to schedule appointments for the new infant after delivery. These strategies could positively impact rates for *Well-Child Visits* and *Children's Access to PCPs*.

It is also recommended that HCA evaluate the interventions currently in place to improve the *Annual Dental Visits—2–21 Years* and *Breast Cancer Screening—52–69 Years* measures. Since improved performance for these measures was a recognized strength for HCA, lessons learned from quality improvement activities may be useful in improving the rates for other child, adolescent, and adult preventive care measures that did not meet the AHCCCS MPS.

## Summary

Of the 15 measures with an AHCCCS MPS, 11 measures did not meet the AHCCCS MPS and, therefore, required a CAP. HCA demonstrated improvement, with 14 of the 17 measures improving over the previous measurement period. Nine measures improved by a statistically significant amount. These improvements show that HCA has implemented successful quality initiatives to improve performance measure rates. Only 1 performance measure, *Annual Dental Visits—2–21 Years*, exceeded the AHCCCS goal, and 4 measures exceeded the AHCCCS MPS. Although this year's performance represented an improvement over the previous measurement period, HCA still has room for improvement to reach and then to exceed the MPS for all performance measures.

## Maricopa Health Plan

### Findings

Table 7-4 presents the performance measure rates for MHP. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2009 MPS and goal.

**Table 7-4—Performance Measurement Review for MHP**

Performance Measure	Performance for Oct. 1, 2006, to Sept. 30, 2007	Performance for Oct. 1, 2007, to Sept. 30, 2008	Relative Percent Change	Significance Level <sup>A</sup> (p value)	CYE 2009 Minimum Performance Standard	AHCCCS Goal
<i>Children's Access to PCPs (Total)</i>	66.0%	<b>73.4%</b>	<b>11.2%</b>	<b>p&lt;.001</b>	**	**
12–24 Months	81.6%	82.1%	0.6%	p=.775	93%	97%
25 Months–6 Years	68.1%	<b>75.4%</b>	<b>10.7%</b>	<b>p&lt;.001</b>	83%	97%
7–11 Years***	60.4%	<b>72.1%</b>	<b>19.3%</b>	<b>p&lt;.001</b>	83%	97%
12–19 Years***	61.9%	<b>67.6%</b>	<b>9.2%</b>	<b>p&lt;.001</b>	81%	97%
<i>Adults' Access to Preventive/Ambulatory Health Services (Total)</i>	76.0%	76.4%	0.6%	p=.677	**	**
20–44 Years	71.5%	71.6%	0.2%	p=.919	78%	96%
45–64 Years	81.9%	82.4%	0.5%	p=.759	85%	96%
<i>Well-Child Visits—First 15 Months</i>	57.4%	63.0%	9.7%	p=.052	65%	90%
<i>Well-Child Visits—3, 4, 5, 6 Years</i>	54.7%	<b>63.8%</b>	<b>16.6%</b>	<b>p&lt;.001</b>	64%	80%
<i>Adolescent Well-Care Visits</i>	25.8%	<b>34.7%</b>	<b>34.5%</b>	<b>p&lt;.001</b>	41%	50%
<i>Annual Dental Visits—2–21 Years</i>	50.4%	<b>55.9%</b>	<b>10.7%</b>	<b>p&lt;.001</b>	55%	57%
<i>Breast Cancer Screening—52–69 Years</i>	51.2%	<b>62.1%</b>	<b>21.2%</b>	<b>p=.001</b>	50%	70%
<i>Cervical Cancer Screening</i>	49.3%	<b>57.0%</b>	<b>15.7%</b>	<b>p&lt;.001</b>	65%	90%
<i>Chlamydia Screening—16–24 Years</i>	59.3%	56.5%	-4.7%	p=.360	51%	62%
<i>Timeliness of Prenatal Care</i>	55.4%	<b>48.5%</b>	<b>-12.4%</b>	<b>p=.038</b>	80%	90%
<i>EPSDT Participation</i>	63.6%	<b>69.8%</b>	<b>9.7%</b>	<b>p&lt;.001</b>	68%	80%

\*\*During CYE 2007, the minimum performance standards and goals for the *Children's Access to PCPs* and *Adults' Access to Preventive/Ambulatory Health Services* measures were established for each age group instead of at the aggregate level, as in previous years.

<sup>A</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the p value is ≤ .05. Rates in bold indicate statistical significance.

\*\*\*Due to a change in management, Maricopa Health Plan members were not included in two age groups in the previous remeasurement, which measured services in a two-year period.

Using the AHCCCS CYE 2009 MPS and goals as frames of reference, Table 7-4 highlights more opportunities for improvement than strengths for MHP. Of the 17 measures for CYE 2009, 15 of the measures demonstrated improvement over the previous measurement period and the remaining 2 measures (*Chlamydia Screening—16–24 Years* and *Timeliness of Prenatal Care*) declined. Of the 15 measures with an AHCCCS MPS, 4 of the measures (*Annual Dental Visits—2–21 Years*, *Breast Cancer Screening—52–69 Years*, *Chlamydia Screening—16–24 Years*, and *EPSDT Participation*) exceeded the AHCCCS MPS. The remaining 11 measures did not meet the AHCCCS MPS and

required CAPs. None of the measures met the AHCCCS goal. Of the 11 measures that did not reach the AHCCCS MPS, 10 measures demonstrated improvement, 6 measures (all of the *Children's Access to PCPs* measures, all of the *Adults' Access to Preventive/Ambulatory Health Services* measures, both *Well-Child Visits* measures, *Adolescent Well-Care Visits*, and *Cervical Cancer Screening*) showed statistically significant improvement, and 1 measure (*Timeliness of Prenatal Care*) demonstrated a statistically significant decline. Opportunities for improvement existed for the 11 measures that did not meet the AHCCCS MPS.

## CAPs

MHP was required to complete 11 CAPs for the 15 measures reported in CYE 2009 with an AHCCCS MPS. This number represented 73.3 percent of the measures and included all of the *Children's Access to PCPs* measures, all of the *Adults' Access to Preventive/Ambulatory Health Services* measures, both *Well-Child Visits* measures, *Adolescent Well-Care Visits*, *Cervical Cancer Screening*, and *Timeliness of Prenatal Care*. These CAPs correlated with access to, and the quality and timeliness of, services and indicated that MHP's members were not receiving these services at rates that met the AHCCCS MPS or goals.

## Strengths

The results for MHP's performance measures showed statistically significant improvement in 10 measures. These improvements ranged from a relative 9.2 percent to 34.5 percent, which represented strong quality improvement initiatives to raise performance measure rates. The measures, *Children's Access to PCPs (Total)*, *Children's Access to PCPs—25 Months–6 Years and 7–11 Years*, *Well-Child Visits—3–6 Years*, *Adolescent Well-Care Visits*, *Annual Dental Visits—2–21 Years*, *Breast Cancer Screening—52–69 Years*, and *Cervical Cancer Screening*, had statistically significant improvements of more than a relative 11 percent. Four of the measures (*Annual Dental Visits—2–21 Years*, *Breast Cancer Screening—52–69 Years*, *Chlamydia Screening—16–24 Years*, and *EPSDT Participation*) exceeded the AHCCCS MPS.

## Opportunities for Improvement and Recommendations

The 11 required CAPs for MHP represented a clear opportunity for improvement for the Contractor since all of the measures did not meet the AHCCCS MPS. The measures assessed performance relative to access to, and the timeliness and quality of, care. The greatest opportunities for improvement were with six measures (all of the *Children's Access to PCPs* measures, *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, *Adolescent Well-Care Visits*, *Cervical Cancer Screening*, and *Timeliness of Prenatal Care*) because these measures must achieve more than a 5 percentage-point improvement to meet the AHCCCS MPS.

HSAG recommends that the Contractor implement targeted care coordination efforts for expectant mothers and assist expectant mothers with obtaining obstetrical services. These efforts could have a positive impact on *Timeliness of Prenatal Care* rates, which declined by a relative 12.4 percent from the previous measurement period. Targeted care coordination for expectant mothers would enable members to establish a relationship with an obstetrician. Connecting expectant mothers to prenatal care would provide another avenue to educate expectant mothers on the importance of establishing a relationship with a pediatrician for their child. By educating expectant mothers and

then linking them to pediatric services prior to delivery, new mothers can establish a relationship with their child's pediatrician to schedule appointments for the new infant after delivery. These strategies could positively impact rates for *Well-Child Visits* and *Children's Access to PCPs*.

The Contractor should also identify barriers that impact access to care, such as limited availability of providers during hours that are convenient for members or limited transportation to and from health care visits. Access-related barriers could be overcome with increased transportation coordination and expanded office hours for practitioners or clinics. Member awareness of service availability does not necessarily indicate the absence of an accessibility barrier. Therefore, the Contractor should investigate other factors that impact preventive care service rates, such as misunderstanding on the part of the member about what services to access and when. Member awareness barriers can be overcome with increased education on periodicity schedules for well-child visits, adults' access to preventive/ambulatory health services for those 20 to 44 years of age, prenatal care, and preventive care. In addition, the Contractor should employ targeted outreach strategies to women to educate them on the importance of cervical cancer screenings, provide additional education to physicians on the importance of gynecological preventive screenings, and remind physicians to educate patients and/or make referrals for patients to obtain cervical cancer screenings.

It is also recommended that MHP evaluate the interventions currently in place to improve *Annual Dental Visits—2–21 Years* and *Breast Cancer Screening—52–69 Years* measures, since these measures improved by statistically significant amounts and exceeded the AHCCCS MPS. Because improved performance for these measures was a recognized strength for MHP, lessons learned from quality improvement activities may be useful in improving rates for other child, adolescent, and adult preventive care measures that did not meet the AHCCCS MPS.

## Summary

Of the 15 measures with an AHCCCS MPS, 11 measures did not meet the AHCCCS MPS and, therefore, required a CAP. MHP demonstrated improvement, with 15 of the 17 measures improving over the previous measurement period. Ten measures improved by a statistically significant amount. These improvements show that MHP implemented successful quality initiatives to improve performance measure rates. Four of the measures exceeded the AHCCCS MPS. However, none of the performance measures exceeded the AHCCCS goal. Although this year's performance represented an improvement over the previous measurement period, MHP still has room for improvement to reach and then to exceed the MPS for all performance measures.

## Mercy Care Plan

### Findings

Table 7-5 presents the performance measure rates for MCP. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2009 MPS and goals.

**Table 7-5—Performance Measurement Review for MCP**

Performance Measure	Performance for Oct. 1, 2006, to Sept. 30, 2007	Performance for Oct. 1, 2007, to Sept. 30, 2008	Relative Percent Change	Significance Level <sup>A</sup> (p value)	CYE 2009 Minimum Performance Standard	AHCCCS Goal
<i>Children's Access to PCPs (Total)</i>	78.9%	<b>82.2%</b>	<b>4.2%</b>	<b>p&lt;.001</b>	**	**
12–24 Months	83.2%	<b>85.3%</b>	<b>2.6%</b>	<b>p=.001</b>	93%	97%
25 Months–6 Years	78.7%	<b>83.4%</b>	<b>6.0%</b>	<b>p&lt;.001</b>	83%	97%
7–11 Years	77.5%	<b>79.8%</b>	<b>3.0%</b>	<b>p=.001</b>	83%	97%
12–19 Years	78.5%	<b>80.9%</b>	<b>2.9%</b>	<b>p&lt;.001</b>	81%	97%
<i>Adults' Access to Preventive/Ambulatory Health Services (Total)</i>	83.0%	<b>84.2%</b>	<b>1.5%</b>	<b>p&lt;.001</b>	**	**
20–44 Years	81.2%	<b>82.2%</b>	<b>1.3%</b>	<b>p=.004</b>	78%	96%
45–64 Years	87.0%	<b>88.0%</b>	<b>1.1%</b>	<b>p=.031</b>	85%	96%
<i>Well-Child Visits—First 15 Months</i>	62.6%	<b>59.0%</b>	<b>-5.7%</b>	<b>p=.001</b>	65%	90%
<i>Well-Child Visits—3, 4, 5, 6 Years</i>	68.8%	69.5%	1.1%	p=.089	64%	80%
<i>Adolescent Well-Care Visits</i>	37.4%	<b>41.6%</b>	<b>11.3%</b>	<b>p&lt;.001</b>	41%	50%
<i>Annual Dental Visits—2–21 Years</i>	57.6%	<b>60.2%</b>	<b>4.4%</b>	<b>p&lt;.001</b>	55%	57%
<i>Breast Cancer Screening—52–69 Years</i>	58.9%	<b>68.8%</b>	<b>16.9%</b>	<b>p&lt;.001</b>	50%	70%
<i>Cervical Cancer Screening</i>	64.6%	65.4%	1.2%	p=.083	65%	90%
<i>Chlamydia Screening—16–24 Years</i>	40.0%	39.6%	-0.9%	p=.675	51%	62%
<i>Timeliness of Prenatal Care</i>	76.7%	<b>64.1%</b>	<b>-16.5%</b>	<b>p&lt;.001</b>	80%	90%
<i>EPSDT Participation</i>	74.1%	<b>78.3%</b>	<b>5.7%</b>	<b>p&lt;.001</b>	68%	80%

\*\*During CYE 2007, the minimum performance standards and goals for the *Children's Access to PCPs* and *Adults' Access to Preventive/Ambulatory Health Services* measures were established for each age group instead of at the aggregate level, as in previous years.

<sup>A</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the p value is ≤ .05. Rates in bold indicate statistical significance.

Using the AHCCCS CYE 2009 MPS and goals as frames of reference, Table 7-5 highlights more strengths than opportunities for improvement for MCP. Of the 17 measures for CYE 2009, 14 of the performance measures demonstrated improvement over the previous year, with 12 of the improvements being statistically significant. Three of the measures (*Well-Child Visits—First 15 Months*, *Chlamydia Screening—16–24 Years*, and *Timeliness of Prenatal Care*) declined from the previous review period, and two of those measures (*Well-Child Visits—First 15 Months* and *Timeliness of Prenatal Care*) declined by a statistically significant amount. Nine of the 15 measures with an AHCCCS MPS exceeded the AHCCCS MPS. However, only one measure (*Annual Dental*

*Visits—2–21 Years*) exceeded the AHCCCS goal. Of the six measures that did not meet the AHCCCS MPS, three measures (*Children’s Access to PCPs—12–24 Months, 7–11 Years, and 12–19 Years*) demonstrated statistically significant improvement, two measures (*Well-Child Visits—First 15 Months* and *Timeliness of Prenatal Care*) showed statistically significant declines, and one measure (*Chlamydia Screening—16–24 Years*) declined compared to last year.

## CAPs

MCP was required to complete six CAPs for the 15 measures reported in CYE 2009 with an AHCCCS MPS. This number represented 40 percent of the measures and included 3 of the *Children’s Access to PCPs* measures (*Children’s Access to PCPs—12–24 Months, 7–11 Years, and 12–19 Years*), *Well-Child Visits—First 15 Months*, *Chlamydia Screening—16–24 Years*, and *Timeliness of Prenatal Care*. These CAPs correlated with access to, and the quality and timeliness of, services and indicated that MCP’s members were not receiving these services at rates that met the AHCCCS MPS or goals.

## Strengths

The results for MCP’s performance measures showed statistically significant improvement in 12 measures. These improvements ranged from a relative 1.1 percent to 16.9 percent. Fourteen of the 17 measures demonstrated improvement from the previous review period and 12 of those improvements were statistically significant. The measure, *Breast Cancer Screening—52–69 Years*, demonstrated the greatest improvement, with a relative 16.9 percent increase compared to the previous measurement period. *Annual Dental Visits—2–21 Years* exceeded the AHCCCS goal.

## Opportunities for Improvement and Recommendations

The six required CAPs for MCP represented a clear opportunity for improvement for the Contractor since all of the measures did not meet the AHCCCS MPS. The measures assessed performance relative to access to, and the timeliness and quality of, care. The greatest opportunities for improvement were with *Children’s Access to PCPs—12–24 Months, Well-Child Visits—First 15 Months, Chlamydia Screening—16–24 Years, and Timeliness of Prenatal Care* because these measures must achieve more than a 5 percentage-point improvement to meet the AHCCCS MPS. The Contractor should pay particular attention to the *Well-Child Visits—First 15 Months* and *Timeliness of Prenatal Care* measures because both of these measures declined by statistically significant amounts.

HSAG recommends that the Contractor identify barriers that impact access to care, such as limited transportation to and from health care visits or limited availability of providers during hours that are convenient for members. Access-related barriers could be overcome with increased transportation coordination or expanded office hours for practitioners or clinics. Member awareness of service availability does not necessarily indicate the absence of an accessibility barrier. Therefore, the Contractor should also investigate other factors that impact rates, such as misunderstanding on the part of the member about what services to access and when. Member awareness barriers can be overcome with increased education on periodicity schedules for *Children’s Access to PCPs*, well-child visits, prenatal care, and preventive care. The Contractor should employ targeted outreach strategies to women to educate them on the importance of Chlamydia screening, provide additional

education to physicians on the importance of gynecological preventive screenings, and remind physicians to include Chlamydia screening in routine examinations.

The Contractor should also implement targeted care coordination efforts for expectant mothers and assist expectant mothers with obtaining prenatal services. These efforts could have a positive impact on *Timeliness of Prenatal Care* rates, which declined by a relative 16.5 percent from the previous measurement period. Targeted care coordination for expectant mothers would assist members with establishing a relationship with an obstetrician. Connecting expectant mothers to prenatal care would provide another avenue to educate expectant mothers on the importance of establishing a relationship with a pediatrician for their child. By educating and linking expectant mothers to pediatric services prior to delivery, new mothers can establish a relationship with their child's pediatrician to schedule appointments for the new infant after delivery. These strategies could positively impact rates for *Well-Child Visits—First 15 Months* and *Children's Access to PCPs*.

It is also recommended that MCP evaluate the interventions currently in place to improve *Annual Dental Visits—2–21 Years*, *Breast Cancer Screening—52–69 Years*, and *Adolescent Well-Care Visits* since these measures improved by statistically significant amounts and exceeded the AHCCCS MPS. Because improved performance for these measures was a recognized strength for MCP, lessons learned from quality improvement activities may be useful in improving rates for other child, adolescent, prenatal, and Chlamydia screening measures that did not meet the AHCCCS MPS.

## Summary

Of the 15 measures with an AHCCCS MPS, 9 measures met the AHCCCS MPS. Six of the measures did not meet the AHCCCS MPS and, therefore, required a CAP. MCP demonstrated improvement, with 14 of the 17 measures improving over the previous measurement period. Twelve measures improved by a statistically significant amount. These improvements show that MCP implemented successful quality initiatives to improve performance measure rates. Nine measures exceeded the AHCCCS MPS. One measure exceeded the AHCCCS goal. Although this year's performance represented an improvement over the previous measurement period, MCP still has room for improvement to reach and then to exceed the MPS for all performance measures.

## Phoenix Health Plan

### Findings

Table 7-6 presents the performance measure rates for PHP. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2009 MPS and goal.

Table 7-6—Performance Measurement Review for PHP						
Performance Measure	Performance for Oct. 1, 2006, to Sept. 30, 2007	Performance for Oct. 1, 2007, to Sept. 30, 2008	Relative Percent Change	Significance Level <sup>A</sup> (p value)	CYE 2009 Minimum Performance Standard	AHCCCS Goal
<i>Children's Access to PCPs (Total)</i>	76.4%	<b>82.5%</b>	<b>7.9%</b>	<b>p&lt;.001</b>	**	**
12–24 Months	82.8%	<b>86.4%</b>	<b>4.4%</b>	<b>p&lt;.001</b>	93%	97%
25 Months–6 Years	76.2%	<b>83.8%</b>	<b>9.9%</b>	<b>p&lt;.001</b>	83%	97%
7–11 Years	76.0%	<b>79.0%</b>	<b>4.1%</b>	<b>p&lt;.001</b>	83%	97%
12–19 Years	74.6%	<b>81.8%</b>	<b>9.6%</b>	<b>p&lt;.001</b>	81%	97%
<i>Adults' Access to Preventive/Ambulatory Health Services (Total)</i>	80.5%	<b>84.1%</b>	<b>4.5%</b>	<b>p&lt;.001</b>	**	**
20–44 Years	78.7%	<b>83.4%</b>	<b>5.9%</b>	<b>p&lt;.001</b>	78%	96%
45–64 Years	84.5%	85.5%	1.1%	p=.258	85%	96%
<i>Well-Child Visits—First 15 Months</i>	61.2%	<b>65.3%</b>	<b>6.6%</b>	<b>p=.016</b>	65%	90%
<i>Well-Child Visits—3, 4, 5, 6 Years</i>	59.2%	<b>73.0%</b>	<b>23.4%</b>	<b>p&lt;.001</b>	64%	80%
<i>Adolescent Well-Care Visits</i>	34.3%	<b>51.5%</b>	<b>50.3%</b>	<b>p&lt;.001</b>	41%	50%
<i>Annual Dental Visits—2–21 Years</i>	57.4%	<b>59.6%</b>	<b>3.8%</b>	<b>p&lt;.001</b>	55%	57%
<i>Breast Cancer Screening—52–69 Years</i>	45.5%	<b>55.9%</b>	<b>23.1%</b>	<b>p&lt;.001</b>	50%	70%
<i>Cervical Cancer Screening</i>	57.1%	<b>61.7%</b>	<b>8.1%</b>	<b>p&lt;.001</b>	65%	90%
<i>Chlamydia Screening—16–24 Years</i>	42.8%	42.0%	-1.9%	p=.584	51%	62%
<i>Timeliness of Prenatal Care</i>	68.9%	71.4%	3.6%	p=.063	80%	90%
<i>EPSDT Participation</i>	71.3%	<b>80.2%</b>	<b>12.5%</b>	<b>p&lt;.001</b>	68%	80%
**During CYE 2007, the minimum performance standards and goals for the <i>Children's Access to PCPs</i> and <i>Adults' Access to Preventive/Ambulatory Health Services</i> measures were established for each age group instead of at the aggregate level, as in previous years.						
<sup>A</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the p value is ≤ .05. Rates in bold indicate statistical significance.						

Using the AHCCCS CYE 2009 MPS and goals as frames of reference, Table 7-6 highlights success and continued opportunities for improvement for PHP. Sixteen of the 17 performance measures demonstrated improvement over the previous measurement period. Only one measure (*Chlamydia Screening—16–24 Years*) declined from the previous measurement period. Fourteen of the 16 improvements were statistically significant. Ten of the 15 measures with an AHCCCS MPS exceeded the MPS, and three measures (*Adolescent Well-Care Visits*, *Annual Dental Visits—2–21 Years*, and *EPSDT Participation*) exceeded the AHCCCS goal. Of the five measures that did not

meet the AHCCCS MPS, three measures (*Children's Access to PCPs—12–24 Months, 7–11 Years, and Cervical Cancer Screening*) demonstrated statistically significant improvement.

## CAPs

PHP was required to complete five CAPs for the 15 measures reported in CYE 2009 with an AHCCCS MPS. This number represented 33.3 percent of the measures and included 2 of the *Children's Access to PCPs* measures, *Cervical Cancer Screening*, *Chlamydia Screening—16–24 Years*, and *Timeliness of Prenatal Care*. These CAPs correlated with the access to, and quality and timeliness of, services and indicated that PHP's members were not receiving these services at rates that met the AHCCCS MPS or goals.

## Strengths

The results for PHP's performance measures demonstrated the greatest strengths among the contractors. PHP's performance measures showed statistically significant improvement in 14 measures. The Contractor demonstrated its greatest improvement with *Well-Child Visits—3, 4, 5, 6, Years*, *Adolescent Well-Care Visits*, *Breast Cancer Screening—52–69 Years*, and *EPSDT Participation*, which represented improvement that ranged from a relative 12.5 percent to 50.3 percent. Ten measures exceeded the AHCCCS MPS and three measures (*Adolescent Well-Care Visits*, *Annual Dental Visits—2–21 Years*, and *EPSDT Participation*) exceeded the AHCCCS goal. The *Adolescent Well-Care Visits* measure demonstrated the greatest improvement in terms of the relative percentage change, with a 50.3 percent increase since last year.

## Opportunities for Improvement and Recommendations

The five required CAPs for PHP represented a clear opportunity for improvement for the Contractor since all of the measures did not meet the AHCCCS MPS. The measures assessed performance relative to access to, and the quality and timeliness of, care. While the measures did not meet the AHCCCS MPS, four of the measures increased over the previous measurement period and one measure declined. The greatest opportunities for improvement were with *Children's Access to PCPs—12–24 Months*, *Chlamydia Screening—16–24 Years*, and *Timeliness of Prenatal Care* because these measures must achieve more than a 5 percentage-point improvement to meet the AHCCCS MPS.

HSAG recommends that PHP identify barriers that impact rates for preventive services such as cervical cancer screening and Chlamydia screening for female members. Since the early detection and treatment of Chlamydia can help prevent adverse health consequences such as pelvic inflammatory disease and infertility, the Contractor should employ targeted outreach strategies to women to educate them on the importance of gynecological preventive care. The Contractor should also provide additional education to physicians on the importance of gynecological preventive screenings, remind physicians to include Chlamydia screening in routine examinations, and advise members to receive cervical cancer screenings.

In addition to these activities, the Contractor should identify barriers that impact access to care, such as limited availability of providers during hours that are convenient for members or limited transportation to and from health care visits. Access-related barriers could be overcome with

increased transportation coordination and expanded office hours for practitioners or clinics. Member awareness of service availability does not necessarily indicate the absence of an accessibility barrier. Therefore, the Contractor should investigate other factors that impact preventive care service rates, such as misunderstanding on the part of the member about what services to access and when. Member awareness barriers can be overcome with increased education on periodicity schedules for *Children's Access to PCPs* and *Timeliness of Prenatal care*. Targeted care coordination for expectant mothers would enable members to establish a relationship with an obstetrician, which would provide another avenue to educate expectant mothers on the importance of establishing a relationship with a pediatrician for their child. By educating and linking expectant mothers to pediatric services prior to delivery, new mothers can establish a relationship with their child's pediatrician to schedule appointments for the new infant after delivery. These strategies could positively impact the rates for *Children's Access to PCPs*.

It is also recommended that PHP evaluate the interventions currently in place to improve rates for the *Annual Dental Visits—2–21 Years*, *Adolescent Well-Care Visits*, and *EPSDT Participation* measures. Since these performance measures were a recognized strength for PHP, lessons learned from quality improvement activities may be useful in improving rates for other child and adult measures that did not meet the AHCCCS MPS.

## Summary

PHP's performance this year represented a significant improvement over the previous measurement period. Of the 15 measures with an AHCCCS MPS, 10 measures met the AHCCCS MPS. Five of the measures did not meet the AHCCCS MPS and, therefore, required a CAP. PHP demonstrated improvement as 16 of the 17 measures improved over the previous measurement period. Fourteen measures improved by a statistically significant amount. These improvements show that PHP implemented successful quality initiatives to improve performance measure rates. Three measures met the AHCCCS goal.

## Pima Health Systems

### Findings

Table 7-7 presents the performance measure rates for PHS. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2009 MPS and goal.

Table 7-7—Performance Measurement Review for PHS*						
Performance Measure	Performance for Oct. 1, 2006, to Sept. 30, 2007	Performance for Oct. 1, 2007, to Sept. 30, 2008	Relative Percent Change	Significance Level <sup>A</sup> (p value)	CYE 2009 Minimum Performance Standard	AHCCCS Goal
<i>Adults' Access to Preventive/Ambulatory Health Services (Total)</i>	78.7%	<b>81.0%</b>	<b>2.9%</b>	<b>p=.010</b>	**	**
20–44 Years	77.5%	79.6%	2.7%	p=.064	78%	96%
45–64 Years	81.1%	83.5%	3.0%	p=.094	85%	96%
<i>Breast Cancer Screening—52–69 Years</i>	47.4%	<b>59.5%</b>	<b>25.7%</b>	<b>p&lt;.001</b>	50%	70%
<i>Cervical Cancer Screening</i>	64.3%	63.6%	-1.0%	p=.635	65%	90%
<i>EPSDT Participation</i>	70.3%	<b>75.9%</b>	<b>8.0%</b>	<b>p&lt;.001</b>	68%	80%
*Under its Acute Care contract, PHS has fewer performance measures because it serves primarily Medicare-Medicaid dual-eligible adults and any eligible family members who wish to enroll in the plan.						
**During CYE 2007, the minimum performance standards and goals for the <i>Adults' Access to Preventive/Ambulatory Health Services</i> measures were established for each age group instead of at the aggregate level, as in previous years.						
<sup>A</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the p value is ≤ .05. Rates in bold indicate statistical significance.						

Using the AHCCCS CYE 2009 MPS and goals as frames of reference, Table 7-7 highlights a mixture of success and opportunities for improvement for PHS. Five of the six measures demonstrated improvement over the previous measurement period, and three of the measures (*Adults' Access to Preventive/Ambulatory Health Services [Total]*, *Breast Cancer Screening—52–69 Years*, and *EPSDT Participation*) improved by statistically significant amounts. Only one measure (*Cervical Cancer Screening*) demonstrated a decline in improvement, which was not statistically significant, compared to the previous year. Three of the measures (*Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, *Breast Cancer Screening—52–69 Years*, and *EPSDT Participation*) met the AHCCCS MPS. None of the measures met the AHCCCS goal. Of the two measures that did not meet the AHCCCS MPS, one measure (*Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*) demonstrated an improvement while the other measure (*Cervical Cancer Screening*) demonstrated a decline in performance compared to last year. Neither of the changes were, however, statistically significant.

### CAPs

PHS was required to complete two CAPs for the five measures reported in CYE 2009 with an AHCCCS MPS. This number represented 40 percent of the measures and included *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years* and *Cervical Cancer Screening*. These CAPs

correlated with access to and the quality of services and indicated that PHS' members were not receiving these services at rates that met the AHCCCS MPS or goals.

### Strengths

The results for PHS' performance measures demonstrated statistically significant improvement in three measures. Three measures (*Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, *Breast Cancer Screening—52–69 Years*, and *EPSDT Participation*) exceeded the AHCCCS MPS. None of the measures exceeded the AHCCCS goal. The *Breast Cancer Screening—52–69 Years* measure demonstrated the greatest improvement in terms of relative percentage change, with a 25.7 percent increase over the previous measurement period.

### Opportunities for Improvement and Recommendations

The two required CAPs for PHS represented an opportunity for improvement for the Contractor since the measures did not meet the AHCCCS MPS. The measures assessed performance relative to access to and the quality of care and included *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years* and *Cervical Cancer Screening*.

HSAG recommends that the Contractor identify barriers that impact access to care, such as limited transportation or misunderstanding on the part of the member about what services to access and when. Access-related barriers could be overcome with increased transportation coordination, expanded office hours for practitioners and clinics, or increased education on the availability of preventive services for adults. The Contractor should employ targeted outreach strategies to women to educate them on the importance of cervical cancer screenings, provide additional education to physicians on the importance of gynecological preventive screenings, and remind physicians to educate patients and/or make referrals for patients to obtain cervical cancer screenings.

It is also recommended that PHS evaluate the interventions currently in place to improve rates for the *Breast Cancer Screening—52–69 Years* and *EPSDT Participation* measures. Since improved performance for these measures was a recognized strength for PHS, lessons learned from quality improvement activities may be useful in improving rates for the other measures that did not meet the AHCCCS MPS.

### Summary

This year's performance represented mixed results with some strengths and some opportunities for improvement over the previous measurement period. Of the five measures with an AHCCCS MPS, three of the measures met the AHCCCS MPS. Two of the measures did not meet the AHCCCS MPS and, therefore, required a CAP. PHS demonstrated improvement, with rates for five of the six measures improving over the previous measurement period. Three measures improved by a statistically significant amount. These improvements showed that PHS implemented successful quality initiatives to improve performance measure rates. However, none of the measures met the AHCCCS goal.

## University Family Care

### Findings

Table 7-8 presents the performance measure rates for UFC. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2009 MPS and goal.

**Table 7-8—Performance Measurement Review for UFC**

Performance Measure	Performance for Oct. 1, 2006, to Sept. 30, 2007	Performance for Oct. 1, 2007, to Sept. 30, 2008	Relative Percent Change	Significance Level <sup>A</sup> (p value)	CYE 2009 Minimum Performance Standard	AHCCCS Goal
<i>Children's Access to PCPs (Total)</i>	79.2%	<b>83.0%</b>	<b>4.8%</b>	<b>p&lt;.001</b>	**	**
12–24 Months	83.6%	91.3%	9.2%	p=.086	93%	97%
25 Months–6 Years	75.8%	<b>81.9%</b>	<b>8.1%</b>	<b>p=.003</b>	83%	97%
7–11 Years	77.6%	80.9%	4.1%	p=.106	83%	97%
12–19 Years	82.5%	84.4%	2.4%	p=.213	81%	97%
<i>Adults' Access to Preventive/Ambulatory Health Services (Total)</i>	83.1%	82.8%	-0.3%	p=.837	**	**
20–44 Years	80.4%	79.6%	-1.0%	p=.674	78%	96%
45–64 Years	86.8%	87.1%	0.3%	p=.872	85%	96%
<i>Well-Child Visits—First 15 Months</i>	55.7%	51.6%	-7.5%	p=.611	65%	90%
<i>Well-Child Visits—3, 4, 5, 6 Years</i>	54.4%	58.5%	7.6%	p=.128	64%	80%
<i>Adolescent Well-Care Visits</i>	40.3%	41.6%	3.1%	p=.514	41%	50%
<i>Annual Dental Visits—2–21 Years</i>	59.6%	61.3%	2.8%	p=.186	55%	57%
<i>Breast Cancer Screening—52–69 Years</i>	56.0%	<b>69.6%</b>	<b>24.2%</b>	<b>p=.001</b>	50%	70%
<i>Cervical Cancer Screening</i>	61.2%	61.8%	0.9%	p=.804	65%	90%
<i>Chlamydia Screening—16–24 Years</i>	62.9%	57.7%	-8.3%	p=.237	51%	62%
<i>Timeliness of Prenatal Care</i>	81.1%	<b>58.8%</b>	<b>-27.5%</b>	<b>p&lt;.001</b>	80%	90%
<i>EPSDT Participation</i>	69.5%	70.6%	1.6%	p=.551	68%	80%

\*\*During CYE 2007, the minimum performance standards and goals for the *Children's Access to PCPs* and *Adults' Access to Preventive/Ambulatory Health Services* measures were established for each age group instead of at the aggregate level, as in previous years.

<sup>A</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the p value is ≤ .05. Rates in bold indicate statistical significance.

Using the AHCCCS CYE 2009 MPS and goals as frames of reference, Table 7-8 highlights success and continued opportunities for improvement for UFC. Twelve of the 17 performance measures demonstrated improvement over the previous measurement period. The remaining five measures (*Adults' Access to Preventive/Ambulatory Health Services (Total)* and *20–44 Years, Well-Child Visits—First 15 Months, Chlamydia Screening—16–24 Years* and *Timeliness of Prenatal Care*) declined from the previous measurement period. Three of the 12 improvements were statistically significant. Eight of the 15 measures with an AHCCCS MPS exceeded the MPS, and one measure (*Annual Dental Visits—2–21 Years*) exceeded the AHCCCS goal. Of the seven measures that did

not reach the AHCCCS MPS, only one measure (*Children's Access to PCPs—25 Months–6 Years*) showed statistically significant improvement and four measures (*Children's Access to PCPs—12–24 Months* and *7–11 Years*, *Well-Child Visits—3, 4, 5, 6 Years*, and *Cervical Cancer Screening*) showed improvement. The two remaining measures (*Well-Child Visits—First 15 Months* and *Timeliness of Prenatal Care*) declined from the previous measurement period. Opportunities for improvement existed for the seven measures that did not meet the AHCCCS MPS.

## CAPs

UFC was required to complete seven CAPs for the 15 measures reported in CYE 2009 with an AHCCCS MPS. This number represented 46.7 percent of the measures and included the following measures: *Children's Access to PCPs—12–24 Months*, *Children's Access to PCPs—25 Months–6 Years*, *Children's Access to PCPs—7–11 Years*, *Well-Child Visits—First 15 Months*, *Well-Child Visits—3, 4, 5, 6 Years*, *Cervical Cancer Screening*, and *Timeliness of Prenatal Care*. These CAPs correlated with access to, and the quality and timeliness of, services and indicated that UFC's members were not receiving these services at rates that met the AHCCCS MPS or goals.

## Strengths

The results for UFC's performance measures showed statistically significant improvement in three measures. The *Annual Dental Visits—2–21 Years* measure proved to be a strength for the Contractor since it exceeded the AHCCCS goal. Eight of the measures (*Children's Access to PCPs—12–19 Years*, both *Adults' Access to Preventive/Ambulatory Health Services* measures, *Adolescent Well-Care Visits*, *Annual Dental Visits—2–21 Years*, *Breast Cancer Screening—52–69 Years*, *Chlamydia Screening—16–24 Years*, and *EPSDT Participation*) exceeded the AHCCCS MPS. *Breast Cancer Screening—52–69 Years* increased by a relative 24.2 percent.

## Opportunities for Improvement and Recommendations

The seven required CAPs for UFC represented an opportunity for improvement for the Contractor since all of the measures did not meet the AHCCCS MPS. The measures assessed performance relative to access to, and the quality and timeliness of, care. While the measures did not meet the AHCCCS MPS, five of the measures increased over the previous measurement period and two measures declined. The greatest opportunities for improvement were with the *Well-Child Visits* measures because these measures must achieve more than a 5 percentage-point improvement to meet the AHCCCS MPS. *Timeliness of Prenatal Care* was also an opportunity for improvement for the Contractor since it had a relative 27.5 percent decline from the previous measurement.

HSAG recommends that UFC identify barriers that impact rates for preventive services such as cervical cancer screenings for female members. The Contractor should also provide additional education to physicians on the importance of gynecological preventive screenings and remind physicians to educate patients and/or provide referrals for women to get screened for cervical cancer.

In addition to these activities, the Contractor should also identify barriers that impact access to care, such as limited availability of providers during hours that are convenient for members or limited transportation to and from health care visits. Access-related barriers could be overcome with

expanded office hours for practitioners or clinics or increased transportation coordination. Member awareness of service availability does not necessarily indicate the absence of an accessibility barrier. Therefore, the Contractor should investigate other factors that impact preventive care service rates, such as misunderstanding on the part of the member about what services to access and when. Member awareness barriers can be overcome with increased education on periodicity schedules for *Children's Access to PCPs*, *Well-Child Visits*, and *Timeliness of Prenatal Care*. The sharp decline in the *Timeliness of Prenatal Care* measure should be a concern for the Contractor. Targeted care coordination for expectant mothers is important and would enable members to establish a relationship with an obstetrician, which would provide another avenue to educate expectant mothers on the importance of establishing a relationship with a pediatrician for their child. By educating and linking expectant mothers to pediatric services prior to delivery, new mothers can establish a relationship with their child's pediatrician to schedule appointments for the new infant after delivery. These strategies could positively impact rates for *Well-Child Visits* and *Children's Access to PCPs*.

It is also recommended that UFC evaluate the interventions currently in place to improve rates for the *Annual Dental Visits—2–21 Years* and *Breast Cancer Screening—52–69 Years* measures. Since *Annual Dental Visits—2–21 Years* is a recognized strength and *Breast Cancer Screening—52–69 Years* increased by a relative 24.2 percent, lessons learned from quality improvement activities for both of these measures may be useful in improving the rates for other child and preventive measures that did not meet the AHCCCS MPS.

## Summary

Of the 15 measures with an AHCCCS MPS, 7 measures did not meet the AHCCCS MPS and, therefore, required a CAP. UFC demonstrated improvement, with rates for 12 of the 17 measures improving over the previous measurement period. However, only three measures improved by a statistically significant amount, and one measure declined by a statistically significant amount. Although only one performance measure, *Annual Dental Visits—2–21 Years*, exceeded the AHCCCS goal, eight measures exceeded the AHCCCS MPS. These results showed that while UFC has met the AHCCCS MPS for eight measures, opportunities to improve performance measure rates still exist for UFC.

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

### Findings

Table 7-9 presents the performance measure rates for DES/CMDP. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2009 MPS and goal.

Table 7-9—Performance Measurement Review for DES/CMDP						
Performance Measure	Performance for Oct. 1, 2006, to Sept. 30, 2007	Performance for Oct. 1, 2007, to Sept. 30, 2008	Relative Percent Change	Significance Level <sup>A</sup> (p value)	CYE 2009 Minimum Performance Standard	AHCCCS Goal
<i>Children's Access to PCPs (Total)</i>	85.5%	<b>87.5%</b>	<b>2.4%</b>	<b>p=.014</b>	**	**
<i>12–24 Months</i>	91.3%	88.8%	-2.8%	p=.197	93%	97%
<i>25 Months–6 Years</i>	79.0%	<b>84.0%</b>	<b>6.4%</b>	<b>p&lt;.001</b>	83%	97%
<i>7–11 Years</i>	85.0%	86.4%	1.7%	p=.546	83%	97%
<i>12–19 Years</i>	92.5%	92.7%	0.2%	p=.877	81%	97%
<i>Well-Child Visits—3, 4, 5, 6 Years</i>	62.5%	62.5%	0.0%	p=.995	64%	80%
<i>Adolescent Well-Care Visits</i>	61.0%	<b>64.3%</b>	<b>5.5%</b>	<b>p=.043</b>	41%	50%
<i>Annual Dental Visits—2–21 Years</i>	71.8%	<b>74.9%</b>	<b>4.3%</b>	<b>p=.002</b>	55%	57%
<i>EPSDT Participation</i>	100.0%	100.0%	N/A	N/A	68%	80%

**\*\***During CYE 2007, the minimum performance standards and goals for the *Children's Access to PCPs* measures were established for each age group instead of at the aggregate level, as in previous years.

Using the AHCCCS CYE 2009 MPS and goals as frames of reference, Table 7-9 highlights success and some opportunities for improvement for DES/CMDP. Eight of the nine performance measures demonstrated sustained or improved performance over the previous measurement period. Six of the eight measures with an AHCCCS MPS exceeded the AHCCCS MPS. Two measures (*Well-Child Visits—3, 4, 5, 6 Years* and *EPSDT Participation*) were unchanged from the previous measurement period, and one measure (*Children's Access to PCPs—12–24 Months*) declined. Four of the seven improvements (*Children's Access to PCPs [Total]*, *Children's Access to PCPs—25 Months–6 Years*, *Adolescent Well-Care Visits*, and *Annual Dental Visits—2–21 Years*) were statistically significant. Three measures (*Adolescent Well-Care Visits*, *Annual Dental Visits—2–21 Years*, and *EPSDT Participation*) exceeded the AHCCCS goal.

### CAPs

DES/CMDP was required to complete two CAPs for the eight measures reported in CYE 2009 with an AHCCCS MPS. This number represented 25 percent of the measures and included *Children's Access to PCPs—12–24 Months* and *Well-Child Visits—3, 4, 5, 6 Years*. These CAPs correlated with access to and the quality of services and indicated that DES/CMDP's members were not receiving these services at rates that met the AHCCCS MPS or goals.

## Strengths

The results for DES/CMDP's performance measures showed statistically significant improvements in four measures (*Children's Access to PCPs [Total]*, *Children's Access to PCPs—25 Months—6 Years*, *Adolescent Well-Care Visits*, and *Annual Dental Visits—2—21 Years*). Seven of the nine measures demonstrated improvement compared to the previous year. The measure, *Children's Access to PCPs—25 Months—6 Years*, demonstrated the greatest increase in terms of relative percentage change, with a 6.4 percent increase over the previous measurement period. Three of the measures (*Adolescent Well-Care Visits*, *Annual Dental Visits—2—21 Years*, and *EPSDT Participation*) exceeded the AHCCCS goals and were recognized strengths for the Contractor.

## Opportunities for Improvement and Recommendations

The two required CAPs (*Children's Access to PCPs—12—24 Months* and *Well-Child Visits—3, 4, 5, 6 Years*) represented an opportunity for improvement for the Contractor since neither measure met the AHCCCS MPS. The measures assessed performance relative to access to and the quality of care. One measure, *Children's Access to PCPs—12—24 Months*, declined over the previous measurement period, although the decline was not statistically significant. This measure also represented the greatest opportunity for improvement because the measure must achieve nearly a 5 percentage-point improvement to meet the AHCCCS MPS.

HSAG recommends that DES/CMDP identify barriers that impact access to care, such as limited transportation or misunderstanding on the part of the member about what services to access and when. These access-related barriers could be overcome with increased transportation coordination and increased education on periodicity schedules for *Children's Access to PCPs* and *Well-Child Visits*. It is also recommended that DES/CMDP evaluate the interventions currently in place to improve *Adolescent Well-Care Visits*, *Annual Dental Visits—2—21 Years*, and *EPSDT Participation*. Lessons learned from quality improvement activities for these measures may be useful in improving the rates for other children's measures that did not meet the AHCCCS MPS.

## Summary

Of the eight measures with an AHCCCS MPS, six met the AHCCCS MPS and two measures required a CAP. DES/CMDP demonstrated improvement, with rates for six of the nine measures improving over the previous measurement period and two measures remaining unchanged. Four measures improved by a statistically significant amount. Three measures exceeded the AHCCCS goal. These results show that DES/CMDP has implemented successful quality initiatives to improve performance measure rates and has room to improve rates for the two measures that did not meet the AHCCCS MPS.

## Comparative Results for Acute Care and DES/CMDP Contractors

AHCCCS calculated and reported the Acute Care and DES/CMDP Contractor rates for the same set of performance measures in CYE 2009 as in CYE 2008. In general, the methodologies for generating the rates remained constant over the two-year period, ensuring the comparability of the results across the years.

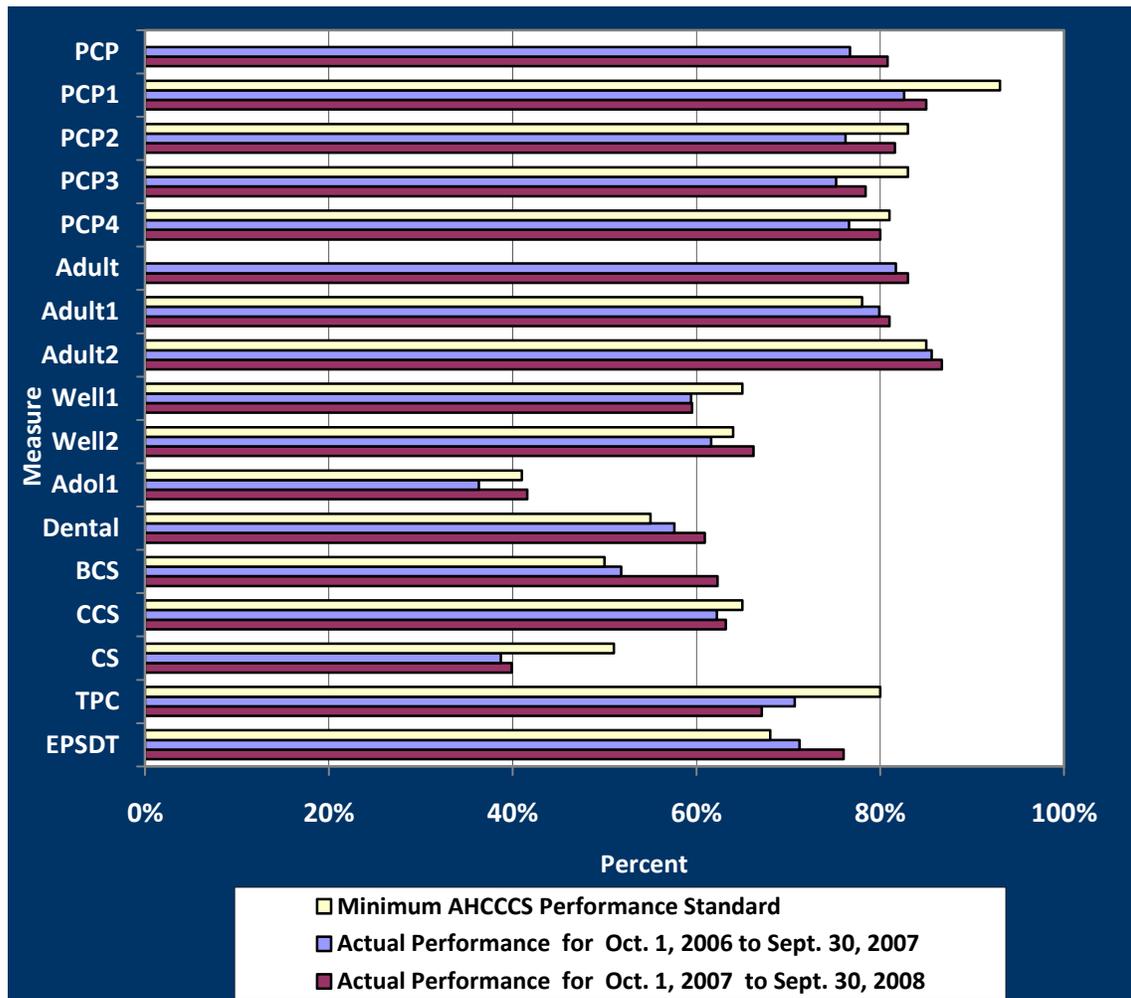
### Findings

Table 7-10 presents the performance measure rates for all Acute Care and DES/CMDP Contractors. The table displays the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and the AHCCCS CYE 2009 MPS and goal.

Table 7-10—Performance Measurement Review for Acute Care and DES/CMDP Contractors						
Performance Measure	Performance for Oct. 1, 2006, to Sept. 30, 2007	Performance for Oct. 1, 2007, to Sept. 30, 2008	Relative Percent Change	Significance Level <sup>^</sup> (p value)	CYE 2009 Minimum Performance Standard	AHCCCS Goal
<i>Children's Access to PCPs (Total)</i>	76.7%	<b>80.8%</b>	<b>2.9%</b>	<b>p&lt;.001</b>	**	**
12–24 Months***	82.6%	<b>85.0%</b>	<b>7.2%</b>	<b>p&lt;.001</b>	93%	97%
25 Months–6 Years***	76.2%	<b>81.6%</b>	<b>4.2%</b>	<b>p&lt;.001</b>	83%	97%
7–11 Years***	75.2%	<b>78.4%</b>	<b>4.4%</b>	<b>p&lt;.001</b>	83%	97%
12–19 Years***	76.6%	<b>80.0%</b>	<b>5.4%</b>	<b>p&lt;.001</b>	81%	97%
<i>Adults' Access to Preventive/Ambulatory Health Services (Total)<sup>^</sup></i>	81.7%	<b>83.0%</b>	<b>1.6%</b>	<b>p&lt;.001</b>	**	**
20–44 Years <sup>^</sup>	79.9%	<b>81.0%</b>	<b>1.4%</b>	<b>p&lt;.001</b>	78%	96%
45–64 Years <sup>^</sup>	85.6%	<b>86.7%</b>	<b>1.2%</b>	<b>p&lt;.001</b>	85%	96%
<i>Well-Child Visits—First 15 Months***<sup>^</sup></i>	59.4%	59.5%	0.2%	p=.857	65%	90%
<i>Well-Child Visits—3, 4, 5, 6 Years***</i>	61.6%	<b>66.2%</b>	<b>7.5%</b>	<b>p&lt;.001</b>	64%	80%
<i>Adolescent Well-Care Visits***</i>	36.3%	<b>41.6%</b>	<b>14.5%</b>	<b>p&lt;.001</b>	41%	50%
<i>Annual Dental Visits—2–21 Years ***</i>	57.6%	<b>60.9%</b>	<b>5.8%</b>	<b>p&lt;.001</b>	55%	57%
<i>Breast Cancer Screening—52–69 Years<sup>^</sup></i>	51.8%	<b>62.3%</b>	<b>20.2%</b>	<b>p&lt;.001</b>	50%	70%
<i>Cervical Cancer Screening<sup>^</sup></i>	62.2%	<b>63.2%</b>	<b>1.7%</b>	<b>p&lt;.001</b>	65%	90%
<i>Chlamydia Screening—16–24 Years***<sup>^</sup></i>	38.7%	<b>39.9%</b>	<b>3.0%</b>	<b>p=.022</b>	51%	62%
<i>Timeliness of Prenatal Care***<sup>^</sup></i>	70.7%	<b>67.1%</b>	<b>-5.1%</b>	<b>p&lt;.001</b>	80%	90%
<i>EPSDT Participation</i>	71.2%	<b>76.0%</b>	<b>6.7%</b>	<b>p&lt;.001</b>	68%	80%
**During CYE 2007, the minimum performance standards and goals for the <i>Children's Access to PCPs</i> and <i>Adults' Access to Preventative/Ambulatory Health Services</i> measures were established for each age group instead of at the aggregate level, as in previous years.						
<sup>^</sup> Significance levels (p values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the p value is ≤ .05. Rates in bold indicate statistical significance.						
***Because of a change in its contract, Pima Health System members were not included in the current measurement.						
<sup>^</sup> CMDP was not included in the current or previous measurements.						

Using the AHCCCS CYE 2009 MPS and goals as frames of reference, Table 7-10 shows that 16 of the 17 measures demonstrated improvement compared to the previous year. Fifteen of the measures that improved did so by a statistically significant amount. The *Timeliness of Prenatal Care* measure declined by a statistically significant amount. Seven of the 15 measures with an AHCCCS MPS exceeded the AHCCCS MPS. However, only one measure, *Annual Dental Visits—2–21 Years*, exceeded the AHCCCS goal. Of the eight measures that did not meet the AHCCCS MPS, six measures showed statistically significant improvement, one demonstrated improvement, and one measure (*Timeliness of Prenatal Care*) declined.

**Figure 7-1—MPS and Previous and Current Performance Measure Rates for Acute Care and DES/CMDP Contractors<sup>7-3</sup>**



<sup>7-3</sup> The performance measure names have been abbreviated as follows: PCP=Children's Access to PCPs (Total); PCP1=12–24 Months; PCP2=25 Months–6 Years; PCP3=7–11 Years; PCP4=12–19 Years; Adult=Adults' Access to Preventive/Ambulatory Health Services (Total); Adult1=20–44 Years; Adult2=45–64 Years, Well1=Well-Child Visits—First 15 Months; Well2=Well-Child Visits—3, 4, 5, 6, Years; Adol1=Adolescent Well-Care Visits; Dental=Annual Dental Visits—2–21 Years; BCS=Breast Cancer Screening—52–69 Years; CCS=Cervical Cancer Screening; CS=Chlamydia Screening (16–24 Years); TPC=Timeliness of Prenatal Care; EPSDT=EPSDT Participation.

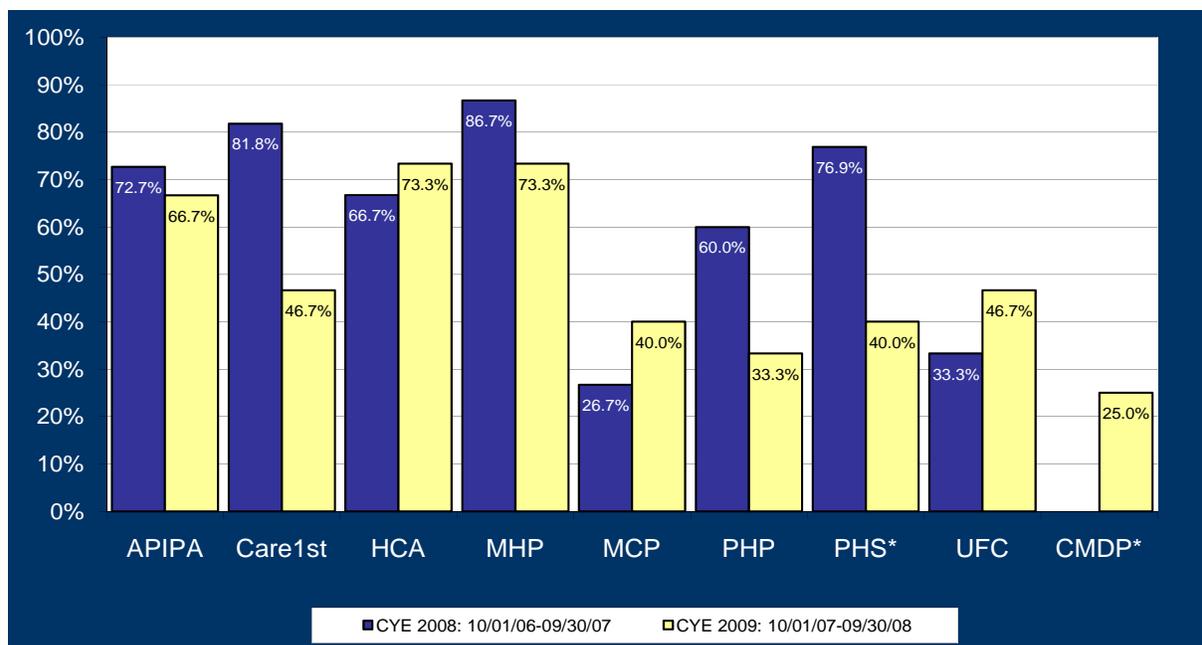
Figure 7-1 is a graphical depiction of the results presented in Table 7-10. Figure 7-1 demonstrates that all the results in CYE 2009 improved over results in CYE 2008, except for the *Timeliness of Prenatal Care* measure, which showed a statistically significant decline.

Table 7-11 presents the Acute Care and DES/CMDP Contractors’ required CAPs for the previous and the current review cycles for the 15 continuing measures with an AHCCCS MPS from both the previous and current reviews. The table shows each of the performance measures, the previous number of CAPs required, the CYE 2008 MPS, the current number of CAPs required, and the CYE 2009 MPS. Please note, the AHCCCS MPS increased from CYE 2008 to CYE 2009 for 11 measures, stayed the same for 3 measures, and decreased for 1 measure.

<b>Table 7-11—Performance Measures—Corrective Action Plans Required for Acute Care and DES/CMDP Contractors</b>				
<b>Performance Measure</b>	<b>CYE 2008</b>		<b>CYE 2009</b>	
	<b>Number of CAPs (10/1/2006– 9/30/2007)</b>	<b>Minimum Performance Standard</b>	<b>Number of CAPs (10/1/2007– 9/30/2008)</b>	<b>Minimum Performance Standard</b>
<i>Children's Access to PCPs (Total)</i> <sup>A</sup>		n/a		
12–24 Months	8	85%	8	93%
25 Months–6 Years	7	78%	5	83%
7–11 Years	5	77%	7	83%
12–19 Years	6	79%	5*	81%
<i>Adults’ Access to Preventive/Ambulatory Health Services (Total)</i> <sup>B</sup>		n/a		
20–44 Years	4	78%	1	78%
45–64 Years	4	83%	3	85%
<i>Well-Child Visits—First 15 Months</i> <sup>A,B</sup>	7	70%	5	65%
<i>Well-Child Visits—3, 4, 5, 6 Years</i> <sup>A</sup>	3	56%	5	64%
<i>Adolescent Well-Care Visits</i> <sup>A</sup>	6	37%	3	41%
<i>Annual Dental Visits—2–21 Years</i> <sup>A</sup>	1	51%	0	55%
<i>Breast Cancer Screening—52–69 Years</i>	4	50%	0	50%
<i>Cervical Cancer Screening</i>	1	57%	7	65%
<i>Chlamydia Screening—16–25 Years</i>	4	43%	5	51%
<i>Timeliness of Prenatal Care</i>	3	70%	7	80%
<i>EPSDT Participation</i>	1	68%	0	68%
<b>Total Number of CAPs</b>	<b>64</b>		<b>56</b>	
<sup>A</sup> Pima Health System was not included in these measures.				
<sup>B</sup> DES/CMDP was not included in these measures.				
* One Contractor's rate (Mercy Care Plan) was 0.1 percentage point below the MPS				

Overall, CAPs increased for *Children’s Access to PCPs—7–11 Years* and *Well-Child Visits—3, 4, 5, 6 Years*, *Cervical Cancer Screening*, *Chlamydia Screening*, and *Timeliness of Prenatal Care*. The CAPs remained the same for one measure (*Children’s Access to PCPs—12–24 Months*) and decreased for the remaining nine measures. The MPS increased for 11 measures and the total number of CAPs decreased by eight, from 64 CAPs in CYE 2008 to 56 in CYE 2009. The number of CAPs for *Adolescent Well-Care Visits* and *Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years* decreased by at least half. There were no CAPs for *Annual Dental Visits—2–21 Years*, *Breast Cancer Screening—52–69*, and *EPSDT Participation* in CYE 2009. From CYE 2008 to CYE 2009, there was a decrease in the number of CAPs for nine measures and an increase in the number of CAPs for five measures.

**Figure 7-2—Corrective Action Plans Required for Acute Care and DES/CMDP Contractors**



\* The total number of measures reported by these plans was less than those for the other plans. In 2009, PHS collected only the following measures: *Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years* and *45–64 Years* and *EPSDT Participation*. CMDP did not collect the following measures in 2008 or 2009: *Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years* and *45–64 Years*, and *Well-Child Visits—First 15 Months of Life*.

Figure 7-2 shows the percentage of CAPs received by each of the Acute Care and DES/CMDP Contractors. The percentage of CAPs increased between CYE 2008 and CYE 2009 for the following four plans: HCA, MCP, UFC and CMDP. The increase in CAPs could be attributed to the increase in the AHCCCS MPS for 11 measures. Five plans—APIPA, Care1st, MHP, PHP, and PHS—decreased the percentage of CAPs from CYE 2008 to CYE 2009. It is important to note, however, that the total number of measures reported by PHS and CMDP during CYE 2008 and CYE 2009 was less than the total number of measures for the other plans.

## Strengths

Overall, there were eight fewer CAPs in CYE 2009 than in CYE 2008 for measures evaluated in both years. The reduced number of CAPs for CYE 2009 demonstrates a positive trend for performance improvement because of the increased AHCCCS MPS for 11 of the measures in CYE 2009. The *Annual Dental Visits—2–21 Years*, *Breast Cancer Screening—52–69*, and *EPSDT Participation* measures demonstrated clear strengths among all Acute Care and DES/CMDP Contractors that reported rates for these measures. There were no CAPs required for these measures. *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* was also a recognized strength because only one Contractor received a CAP for this measure. For *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years* and *Adolescent Well-Care Visits*, three Contractors received CAPs for these measures.

## Opportunities for Improvement and Recommendations

Based on the results of this review, the quality improvement efforts implemented by the Contractors to increase rates has positively impacted the overall rates for the Acute Care and DES/CMDP Contractor performance measures. However, there are a number of performance measures that require targeted strategies to improve performance, such as all of the *Children's Access to PCPs* measures, *Well-Child Visits*, *Cervical Cancer Screening*, and *Timeliness of Prenatal Care*. The *Timeliness of Prenatal Care* measure demonstrated a statistically significant decrease for the Contractors overall, and all seven Contractors that reported this measure received a CAP. Of the eight Contractors that reported rates for *Cervical Cancer Screening*, seven of the Contractors received a CAP. Of the seven Contractors who reported rates for *Chlamydia Screening—16–24 Years*, five of the Contractors received CAPs for this measure.

Overall, HSAG recommends that the Contractors identify barriers that impact rates for preventive services such as cervical cancer screenings and Chlamydia screenings for female members. Since the rate for *Breast Cancer Screening—52–69 Years* demonstrated statistically significant improvement (with a relative increase of 20.2 percent), the barriers that impact Chlamydia and cervical cancer screening rates may not be related to accessibility of services. Instead the results may indicate that there is a need to increase education that Chlamydia screenings and cervical cancer screenings should occur. Since the early detection and treatment of Chlamydia can help prevent adverse health consequences such as pelvic inflammatory disease and infertility, all Contractors should identify and employ targeted outreach strategies to women to educate them on the importance of gynecological preventive care. Contractors should also provide additional education to physicians on the importance of gynecological preventive screenings and remind physicians to include Chlamydia screening in routine examinations.

In addition to these activities, all Contractors should identify barriers that impact access to care for children's services. Contractors should identify if barriers are related to limited transportation to obtain care or limited availability of practitioner or clinic visits. Access-related barriers could be overcome with increased transportation coordination and expanded office hours for practitioners or clinics. Member awareness of service availability does not necessarily indicate the absence of an accessibility barrier. Therefore, the Contractor should investigate other factors that impact preventive care service rates, such as misunderstanding on the part of the member about what

services to access and when. Member awareness barriers can be overcome with increased education on periodicity schedules for *Children's Access to PCPs* and *Well-Child Visits*.

In addition, Contractors should identify barriers that have reduced *Timeliness of Prenatal Care* rates, which declined by a statistically significant amount. Targeted care coordination for expectant mothers could assist members with establishing a relationship with an obstetrician and potentially assist the member with obtaining prenatal services according to the periodicity schedule recommended by ACOG. Prenatal visits may also provide another avenue to educate expectant mothers on the importance of establishing a relationship with a pediatrician for their child. By educating and linking expectant mothers to pediatric services prior to delivery, new mothers can establish a relationship with their child's pediatrician to schedule appointments for the new infant after delivery. These strategies could positively impact rates for *Children's Access to PCPs*.

Since the improvement strategies employed to increase rates for *Annual Dental Visits—2–21 Years*, *Breast Cancer Screening—52–69 Years*, and *EPSDT Participation* have proven to be successful, Contractors should evaluate the interventions currently in place to improve those measures. Since these performance measures are a recognized strength for the Contractors, lessons learned from quality improvement activities may be useful in improving rates for the other child and adult measures that did not meet the AHCCCS MPS.

## Summary

The Acute Care and DES/CMDP Contractors demonstrated improved rates in CYE 2009 compared to CYE 2008. The highlight for all Contractors was the *Annual Dental Visits—2–21 Years* rate, which exceeded the AHCCCS MPS and goal for all Acute Care and DES/CMDP Contractors who reported a rate for this measure. *Breast Cancer Screening—52–69 Years* and *EPSDT Participation* demonstrated clear strengths among all Acute Care and DES/CMDP Contractors that reported rates for those measures because there were no CAPs required for each of these measures. Still, there were a number of performance measures that required targeted strategies to improve performance, such as all of the *Children's Access to PCPs* measures, *Well-Child Visits*, *Cervical Cancer Screening*, and *Timeliness of Prenatal Care*.

Overall, the performance measure results for CYE 2009 demonstrated that Contractors employed several aggressive strategies to bring the Acute Care and DES/CMDP Contractors' performance into alignment with AHCCCS' expectations and the MPS. Opportunities still exist, however, for those performance measures that did not meet or exceed the AHCCCS MPS and required a CAP.

## 8. Performance Improvement Project Performance

In accordance with 42 CFR 438.240(d), AHCCCS contractually requires Contractors to have a QAPI program that: (1) includes an ongoing program of PIPs designed to achieve favorable effects on health outcomes and enrollee 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

The CFR citation above also requires the completion of each PIP in a reasonable amount of time to provide aggregate information on the success of PIPs so that new information on quality of care is produced every year.

One of the three external review-related activities mandated by the Medicaid managed care act and described at 42 CFR 438.358(b)(1) is the annual validation of MCO and PIHP PIPs required by the state and under way during the preceding 12 months. The requirement at 438.358(a) allows a state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory and optional EQR-related activities. AHCCCS elected to conduct the functions associated with the Medicaid managed care act mandatory activity of validating its Contractors' PIPs. In accordance with and satisfying the requirements of 42 CFR 438.364(a)(1), AHCCCS contracted with HSAG as an EQRO to use the information AHCCCS obtained from its PIP data collection, calculation, and validation activities to prepare this 2008–2009 annual report.

### Conducting the Review

AHCCCS requires Contractors to participate in AHCCCS-selected PIPs. AHCCCS-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 enrollee needs, care, and services for a broad spectrum of members.

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

In CYE 2009, AHCCCS began baseline measurement of a new PIP for the Acute Care Contractors and DES/CMDP, which was *Adolescent Well-Care Visits*.

## Objectives for Conducting the Review

In its objectives for evaluating Contractor PIPs, AHCCCS:

- ◆ Ensured that each Contractor had an ongoing performance improvement program of projects that focused on clinical and/or nonclinical areas for the services it furnished to members.
- ◆ Ensured that each Contractor measured performance using objective and quantifiable quality indicators.
- ◆ Ensured that each Contractor implemented systemwide interventions to achieve improvement in quality.
- ◆ Evaluated the effectiveness of each Contractor's interventions.
- ◆ Ensured that each Contractor planned and initiated activities to increase or sustain its improvement.
- ◆ Ensured that each Contractor reported to the State data/information it collected for each project in a reasonable period to allow timely information on the status of PIPs.
- ◆ Calculated and validated the PIP results from Contractor data/information.
- ◆ Reviewed the impact and effectiveness of each Contractor's performance improvement program.
- ◆ Required each Contractor to have an ongoing process to evaluate the impact and effectiveness of its performance improvement program.

HSAG designed a summary tool to organize and represent the information and data AHCCCS provided for the nine Acute Care and DES/CMDP Contractors' performance on the AHCCCS-selected PIP. The summary tool focused on HSAG's objectives for aggregating and analyzing the data, which were to:

- ◆ Determine Contractor performance on the AHCCCS-selected PIP.
- ◆ Provide data from analyzing the PIP results that would allow HSAG to draw conclusions about the quality and timeliness of, and access to, care and services furnished by individual Contractors and statewide across the Contractors.
- ◆ Assess the Contractors' performance improvement interventions to provide an overall evaluation of performance for each Contractor and statewide across Contractors.

## Methodology for Conducting the Review

AHCCCS develops a methodology to measure performance in a standardized way across Contractors for each mandated PIP and follows quality control processes to ensure the collection of valid and reliable data. The study indicators AHCCCS selects for each PIP are based on current clinical knowledge or health services research. The methodology states the study question, the population(s) included, any sampling methods, and methods to collect the data. AHCCCS collects the data from the encounter subsystem of its PMMIS system. To ensure the reliability of the data, AHCCCS conducts data validation studies to evaluate the completeness, accuracy, and timeliness of the data. AHCCCS may also request that Contractors collect additional data. In these cases,

AHCCCS requires the Contractors to submit documentation to verify that indicator criteria were met.

Following data collection and encounter validation, AHCCCS reports Contractor results and an analysis and discussion of possible interventions. Contractors conduct additional analysis of their data and performance improvement interventions. After a year of intervention, the first remeasurement of performance is conducted in the third year of a PIP. AHCCCS requires Contractors to evaluate the effectiveness of their interventions and report to AHCCCS the results of their evaluation and any new or revised interventions. Contractors whose performance does not demonstrate improvement from baseline to remeasurement are required to report to AHCCCS their proposed actions to revise, replace, and/or initiate new interventions.

To determine if improved Contractor performance is sustained, AHCCCS conducts a second remeasurement. If Contractors do not sustain their performance, they must report to AHCCCS their planned changes to interventions.

If results of the second remeasurement demonstrate that a Contractor's performance was improved and the improvement was sustained, AHCCCS considers the PIP closed for that Contractor. If the Contractor's performance was not improved and the improvement was not sustained, the PIP remains open and continues for another remeasurement cycle. When a PIP is considered closed for a Contractor, the Contractor's final report and any follow-up or ongoing activities are due 180 days after the end of the project (typically the end of the contract year). AHCCCS prepared a standardized format for documenting PIP activities (the PIP Reporting Format). AHCCCS encourages Contractors to use the PIP Reporting Format to document their analyses of baseline and remeasurement results, implementation of interventions, and assessment of improvement.

AHCCCS conducted its review and assessment of Contractor performance using the applicable criteria found in *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities* (U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002). The protocol includes 10 distinct steps:

- ◆ Review the selected study topic(s)
- ◆ Review the study question(s)
- ◆ Review the selected study indicator(s)
- ◆ Review the identified study population(s)
- ◆ Review the sampling methods (if sampling was used)
- ◆ Review the Contractor's data collection procedures
- ◆ Assess the Contractor's improvement strategies
- ◆ Review the data analysis and the interpretation of study results
- ◆ Assess the likelihood that reported improvement is real improvement
- ◆ Assess whether the Contractor has sustained its documented improvement.

The methodology for evaluating each of the 10 steps is covered in detail in the CMS protocol, including acceptable and not acceptable examples of each step.

As noted above, not all steps were applicable to AHCCCS' evaluation of the Contractors' performance because AHCCCS:

- ◆ Selected the study topics, questions, indicators, and populations.
- ◆ Defined sampling methods, if applicable.
- ◆ Collected all or part of the data.
- ◆ Calculated Contractor performance rates.

Throughout the process, AHCCCS maintained confidentiality in compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. The files were maintained on a secure, password-protected computer. Only AHCCCS employees who analyzed the data had access to the database, and all employees were required to sign confidentiality agreements. Only the minimum amount of necessary information to complete the project was collected. Upon completion of each study, all information was removed from the AHCCCS computer and placed on a compact disc to be stored in a secure location.

AHCCCS provided the overall evaluation reports and plan-specific results to HSAG for its review and analysis for this 2008–2009 annual report.

Based on its analysis of the data, HSAG drew conclusions about Contractor-specific and statewide aggregate performance in providing accessible, timely, and quality care and services to AHCCCS members. When applicable, HSAG formulated and presented its recommendations to improve Contractor performance rates.

The following sections describe HSAG's findings, conclusions, and recommendations for each Contractor, as well as statewide comparative results across the Contractors.

## Contractor-Specific Results

AHCCCS provided performance data for the CYE 2009 PIP for nine Acute Care and DES/CMDP Contractors. The nine Contractors were: APIPA, Care1st, HCA, MHP, MCP, PHS, PHP, UFC, and DES/CMDP. The Contractor, BHS, was not an AHCCCS Contractor at the time of the baseline measurement period, so AHCCCS did not have PIP data available for this Contractor. The PIP conducted by all Contractors for CYE 2009 was *Adolescent Well-Care Visits* and focused on increasing the rate of annual well-care visits among members 12–21 years of age and reducing any disparities in preventive care visits between non-Hispanic White members and members from other races or with other ethnicities. The CYE 2009 measurement is the initial baseline measurement for the PIP. The measurement period was October 1, 2006, to September 30, 2007.

AHCCCS' goal was for at least 50 percent of adolescents to have an annual well-care (preventive) visit.

## Arizona Physicians IPA

APIPA has contracted with AHCCCS since 1982.

### Findings

Table 8-1 presents the baseline PIP results for the *Adolescent Well-Care Visits* PIP for APIPA. The Contractor’s baseline rate of 36 percent was 14 percentage points lower than the AHCCCS goal of 50 percent.

PIP Measure	Baseline Period Oct. 1, 2006, to Sept. 30, 2007	AHCCCS Goal
Percentage of members with one or more adolescent well-care visits.	36.0%	50%

As part of its PIP processes, APIPA reported the use of quality improvement activities to increase adolescent well-care visit rates, such as identifying providers who are committed to leading initiatives with each of the key populations to act as an advisory group and developing adolescent-friendly materials. APIPA also reported that it would analyze data by age, gender, and ethnicity to determine where disparities exist.

### Strengths

Since this was the baseline measurement period, no strengths in Contractor performance have been identified.

### Opportunities for Improvement and Recommendations

Since APIPA’s PIP rate did not meet the AHCCCS goal of 50 percent, APIPA should develop additional quality interventions to increase the percentage of members with one or more adolescent well-care visits. Additionally, HSAG recommends that the Contractor explore potential barriers that impact rates, such as identifying if members have difficulty in accessing preventive services or if members require additional education on the types of services available and the importance of obtaining preventive health care visits.

### Summary

The APIPA adolescent well-care visits rate of 36 percent was 14 percentage points lower than the AHCCCS goal of 50 percent. APIPA should identify barriers that impact performance and apply additional quality interventions to improve its rate for adolescent well-care visits.

### ***Bridgeway Health Solutions***

BHS was not a Contractor in the AHCCCS Acute Care program at the time of the baseline measurement. Therefore, there were no PIP results for BHS.

## Care1st Health Plan

Care1st has contracted with AHCCCS since 2003.

### Findings

Table 8-2 presents the baseline PIP results for the *Adolescent Well-Care Visits* PIP for Care1st. The Contractor’s baseline rate of 35.2 percent was 14.8 percentage points lower than the AHCCCS goal of 50 percent.

<b>PIP Measure</b>	<b>Baseline Period Oct. 1, 2006, to Sept. 30, 2007</b>	<b>AHCCCS Goal</b>
Percentage of members with one or more adolescent well-care visits.	35.2%	50%

As part of its PIP processes, Care1st reported the use of quality improvement activities to increase rates for adolescent well-care visits, which included:

- ◆ Providing written reminders and telephonic outreach to adolescents and their parents to educate them on the importance of preventive care visits.
- ◆ Conducting telephonic member surveys to inquire about a member’s ethnicity, date of last well check, and relationship with the members’ PCP.
- ◆ Verifying member ethnicity during EPSDT outreach to verify that member ethnicity is being tracked properly.

In addition, Care1st reported that it would obtain a report of adolescent well-care visit rates by ethnicity to target outreach efforts to specific populations to reduce disparities.

### Strengths

Since this was the baseline measurement period, no strengths in Contractor performance had been identified.

### Opportunities for Improvement and Recommendations

Since Care1st’s PIP rate did not meet the AHCCCS goal of 50 percent, Care1st should develop additional quality interventions to increase the percentage of members with one or more adolescent well-care visits. Additionally, HSAG recommends that the Contractor determine if planned interventions were successful and potentially expand the member survey to inquire about the barriers members experience in accessing preventive service for adolescents.

## Summary

The Care1st adolescent well-care visit rate of 35.2 percent was 14.8 percentage points lower than the AHCCCS goal of 50 percent. Care1st should apply additional quality interventions to meet or exceed the AHCCCS goal of having 50 percent of adolescents receive a well-care visit.

## Health Choice Arizona

HCA has contracted with AHCCCS since 1990.

### Findings

Table 8-3 presents the baseline PIP results for the *Adolescent Well-Care Visits* PIP for HCA. The Contractor’s baseline rate of 35.4 percent was 14.6 percentage points lower than the AHCCCS goal of 50 percent.

Table 8-3—Performance Improvement Projects—Adolescent Well-Care Visits for HCA		
PIP Measure	Baseline Period Oct. 1, 2006, to Sept. 30, 2007	AHCCCS Goal
Percentage of members with one or more adolescent well-care visits.	35.4%	50%

As part of its PIP processes, HCA reported the use of quality improvement activities to increase rates for adolescent well-care visits, which included:

- ◆ Distributing enhanced prevention education outreach materials targeting adolescents, parents of adolescent members, and providers regarding the importance of adolescent well-care visits and immunizations.
- ◆ Implementing a Web-based provider roster application that identifies members who are due for an EPSDT/well-child visit. Providers will be able to use the roster to conduct outreach and schedule appointments.
- ◆ Providing targeted member outreach to EPSDT members who were identified as not seeing their assigned provider and to members with no claims history for EPSDT/well-child visits. Using this information, the EPSDT/Health Promotion Unit will educate members on the importance of EPSDT/well-child visits, assist with scheduling, and arrange transportation if necessary.
- ◆ Conducting focus groups and disseminating surveys to providers, parents, and adolescents. HCA will use the feedback to identify barriers linked to low numbers of adolescent well-care visits.
- ◆ Implementing targeted education with specific messages based on feedback from surveys and focus groups.
- ◆ Working with schools and developing a teen-to-teen message about well visits.
- ◆ Providing a member incentive for adolescents who receive well visits and sending a visit completion certificate to HCA.

### Strengths

Since this was the baseline measurement period, no strengths in Contractor performance had been identified.

## Opportunities for Improvement and Recommendations

Since HCA's PIP rate did not meet the AHCCCS goal of 50 percent, the Contractor should develop additional quality interventions to increase the percentage of members with one or more adolescent well-care visits. Additionally, HSAG recommends that the Contractor explore potential barriers that impact rates, such as identifying if members have difficulty in accessing preventive services or if members require additional education on the types of services available and the importance of obtaining preventive health care.

## Summary

The HCA adolescent well-care visit rate of 35.4 percent was 14.6 percentage points lower than the AHCCCS goal of 50 percent. HCA should apply additional quality interventions to meet or exceed the AHCCCS goal of having 50 percent of adolescents receive a well-care visit.

**Maricopa Health Plan**

MHP has contracted with AHCCCS since 1982.

**Findings**

Table 8-4 presents the baseline PIP results for the *Adolescent Well-Care Visits* PIP for MHP. The Contractor’s baseline rate of 25.8 percent was 24.2 percentage points lower than the AHCCCS goal of 50 percent and was the lowest rate among the Acute Care Contractors and DES/CMDP.

Table 8-4—Performance Improvement Projects— <i>Adolescent Well-Care Visits</i> for MHP		
PIP Measure	Baseline Period Oct. 1, 2006, to Sept. 30, 2007	AHCCCS Goal
Percentage of members with one or more adolescent well-care visits.	25.8%	50%

As part of its PIP processes, MHP reported the use of quality improvement activities to increase the adolescent well-care visit rates, which included:

- ◆ Providing regular postcard mailings to members and member newsletter articles, which included topics such as the human papillomavirus (HPV) vaccine, family planning, well-child exam/EPSDT, the Physical Exam Expressway, teen health, and yearly checkups for teens.
- ◆ Distributing provider communication and provider newsletter articles, which included topics such as HPV vaccine coverage, EPSDT form submission, improving disparities in adolescent well-care visits, influenza, and understanding EPSDT.
- ◆ Implementing a member incentive program. This included distributing a Wal-Mart gift card to members who had an adolescent well-care visit.
- ◆ Educating providers on the use of the ManagedCare.com Web site to monitor members on their panel and proactively schedule members for adolescent well-care visits and other services.
- ◆ Providing automated outreach calls to parents of adolescents that included educational content and a reminder to schedule an adolescent well-care visit.
- ◆ Promoting teen-friendly services, such as Body Basics: An Adolescent Provider Tool Kit and Web-based education for teens.
- ◆ Distributing the *Adolescent Well-Care Visits* PIP fact sheet, which included an adolescent immunization schedule.
- ◆ Distributing lists to providers of assigned members due for an adolescent well-care visit.
- ◆ Distributing reminders to parents when an adolescent well-care visit is due.

MHP reported that it did not detect any racial or ethnic disparities in adolescent well-care visit rates and, therefore, implemented the aforementioned quality improvement activities for the population as a whole, rather than targeting interventions for subpopulations.

## Strengths

Since this was the baseline measurement period, no strengths in Contractor performance had been identified.

## Opportunities for Improvement and Recommendations

Since MHP's PIP rate did not meet the AHCCCS goal of 50 percent, HSAG recommends that the Contractor explore potential barriers that impact rates, such as identifying if members have difficulty in accessing the services, and expand the use of targeted intervention strategies that were determined to be the most successful to improve adolescent well-care rates. Although no disparities were detected during the baseline measurement, MHP should continue to monitor adolescent well-care visit rates by ethnicity to verify that no disparities exist.

## Summary

The MHP adolescent well-care visit rate of 25.8 percent was 24.2 percentage points lower than the AHCCCS goal of 50 percent. MHP should apply additional quality interventions to meet or exceed the AHCCCS goal of having 50 percent of adolescents receive a well-care visit.

### Mercy Care Plan

MCP has contracted with AHCCCS since 1983.

### Findings

Table 8-5 presents the baseline PIP results for the *Adolescent Well-Care Visits* PIP for MCP. The Contractor’s baseline rate of 37.4 percent was 12.6 percentage points lower than the AHCCCS goal of 50 percent.

Table 8-5—Performance Improvement Projects—Adolescent Well-Care Visits for MCP		
PIP Measure	Baseline Period Oct. 1, 2006, to Sept. 30, 2007	AHCCCS Goal
Percentage of members with one or more adolescent well-care visits.	37.4%	50%

As part of its PIP processes, MCP reported the use of quality improvement activities to increase adolescent well-care visit rates, which included:

- ◆ Providing telephonic outreach to members, such as prerecorded reminder messages to the parents/guardians of members 12 years of age to remind them about the importance of obtaining immunizations.
- ◆ Conducting outreach telephone calls to a random selection of guardians of Native American and African-American adolescents who had no claim for a well visit with a PCP in the measurement year and the prior year. The outreach telephone calls were planned to assist those members in scheduling a well exam with their medical provider. Additionally, the calls offered the incentive of a \$15 Target gift card for completing a well exam with their provider.
- ◆ Providing written reminders to members, such as immunization reminder letters to MCP adolescents; HPV immunization mailings to female members, 11 to 20 years of age; and a “Get Vaxed” reminder card, which included member-specific immunization data to remind parents/guardians of the importance of obtaining immunizations.
- ◆ Promoting health guidelines through the member handbook and the MCP Web site.
- ◆ Offering movie tickets as an incentive to guardians of adolescents who had not received a well-child visit during the year.
- ◆ Providing additional provider outreach, such as face-to-face meetings with practitioners or office staff to review MCP members included in their patient panel who needed an adolescent well-care visit and mailings to practitioners that listed MCP members due to receive an EPSDT visit, as required by the EPSDT periodicity schedule.

MCP also reported that it would research disparity regarding adolescent well-care visits by ethnicity and modify outreach activities based on review of the data.

## Strengths

Since this was the baseline measurement period, no strengths in Contractor performance had been identified.

## Opportunities for Improvement and Recommendations

Since MCP's PIP rate did not meet the AHCCCS goal of 50 percent, MHP should determine if planned interventions were successful and expand the use of targeted intervention strategies determined to be the most successful to improve adolescent well-care rates. HSAG also recommends that the Contractor explore potential barriers that impact rates, such as identifying if members have difficulty in accessing the services.

## Summary

The MCP adolescent well-care visit rate of 37.4 percent was 12.6 percentage points lower than the AHCCCS goal of 50 percent. MCP should expand the use of quality interventions determined to be the most successful to meet or exceed the AHCCCS goal of having 50 percent of adolescents receive a well-care visit.

## Phoenix Health Plan, LLC

PHP has contracted with AHCCCS since 1983.

### Findings

Table 8-6 presents the baseline PIP results for the *Adolescent Well-Care Visits* PIP for PHP. The Contractor’s baseline rate of 34.3 percent was 15.7 percentage points lower than the AHCCCS goal of 50 percent.

Table 8-6—Performance Improvement Projects—Adolescent Well-Care Visits for PHP		
PIP Measure	Baseline Period Oct. 1, 2006, to Sept. 30, 2007	AHCCCS Goal
Percentage of members with one or more adolescent well-care visits.	34.3%	50%

As part of its PIP processes, PHP reported the use of quality improvement activities to increase the adolescent well-care visit rates, which included:

- ◆ Educating providers through newsletters, mailings, provider meetings.
- ◆ Implementing incentives for providers who meet pay-for-performance measure standards.
- ◆ Conducting medical record audits and educating providers on the need to improve rates for adolescent well-care visits.
- ◆ Issuing Televox phone call reminders to members due for immunizations. The number of attempts to reach parents/members was extended from one attempt to three. Member outreach by staff also allowed staff to offer assistance to members and/or guardians with making appointments or coordinating transportation. Bilingual staff provided outreach to members with limited English proficiency.
- ◆ Distributing educational outreach materials to members, such as EPSDT reminder letters sent for well-child visits and newsletters.
- ◆ Implementing the Smart Choices Club (member payment incentives) program. This included sending Smart Choice gift cards to 12-year-olds when they received a well-care visit.

PHP reported that it would track adolescent well-care visits by county and race to determine if interventions should be targeted separately in different geographic areas and different populations.

### Strengths

Since this was the baseline measurement period, no strengths in Contractor performance had been identified.

### Opportunities for Improvement and Recommendations

Since PHP’s PIP rate did not meet the AHCCCS goal of 50 percent, PHP should determine if planned interventions were successful and expand the use of targeted intervention strategies

determined to be the most successful to improve adolescent well-care visit rates. HSAG also recommends that the Contractor explore potential barriers that impact rates, such as identifying if members have difficulty in accessing the services.

### **Summary**

The PHP adolescent well-care visit rate of 34.3 percent was 15.7 percentage points lower than the AHCCCS goal of 50 percent. PHP should expand the use of quality interventions determined to be the most successful to meet or exceed the AHCCCS goal of having 50 percent of adolescents receive a well-care visit.

## Pima Health System

PHS has contracted with AHCCCS since 1983.

### Findings

Table 8-7 presents the baseline PIP results for the *Adolescent Well-Care Visits* PIP for PHS. The Contractor’s baseline rate of 34.7 percent was 15.3 percentage points lower than the AHCCCS goal of 50 percent.

Table 8-7—Performance Improvement Projects—Adolescent Well-Care Visits for PHS		
PIP Measure	Baseline Period Oct. 1, 2006, to Sept. 30, 2007	AHCCCS Goal
Percentage of members with one or more adolescent well-care visits.	34.7%	50%

As part of its PIP processes, PHS reported the use of quality improvement activities to increase adolescent well-care visit rates, which included:

- ◆ Ensuring that adolescents were aware of EPSDT services and understood the importance of the services through educational materials and outreach, such as the member handbook, health promotion packages, member newsletter, notification letters, nonadherent reminder letters and phone calls, and member home visits.
- ◆ Coordinating transportation to visits.
- ◆ Providing PCP outreach to include a monthly roster of members due for preventive visits.
- ◆ Implementing increased provider education for providers with low participation rates. PHS also planned to request corrective action plans from providers with unsatisfactory participation rates.

### Strengths

Since this was the baseline measurement period, no strengths in Contractor performance had been identified.

### Opportunities for Improvement and Recommendations

Since the Contractor’s PIP rate did not meet the AHCCCS goal of 50 percent, PHS should determine which interventions were successful and expand the use of targeted intervention strategies determined to be the most successful to improve adolescent well-care visit rates. Additionally, PHS should implement strategies to identify and reduce or eliminate ethnic disparities in adolescent well-care visit rates.

### Summary

The PHS adolescent well-care visit rate of 34.7 percent was 15.3 percentage points lower than the AHCCCS goal of 50 percent. PHS should expand the use of quality interventions determined to be

the most successful to meet or exceed the AHCCCS goal of having 50 percent of adolescents receive a well-care visit.

## University Family Care

UFC has contracted with AHCCCS since 1997.

### Findings

Table 8-8 presents the baseline PIP results for the *Adolescent Well-Care Visits* PIP for PHS. The Contractor’s baseline rate of 40.3 percent was 9.7 percentage points lower than the AHCCCS goal of 50 percent, but was the second-highest rate among the Acute Care Contractors and DES/CMDP.

PIP Measure	Baseline Period Oct. 1, 2006, to Sept. 30, 2007	AHCCCS Goal
Percentage of members with one or more adolescent well-care visits.	40.3%	50%

As part of its PIP processes, PHS reported the use of quality improvement activities to increase adolescent well-care visit rates, which included:

- ◆ Member outreach and mailings, such as postcards and member newsletter articles, which included topics such as the HPV vaccine, family planning, the well-child exam/EPSDT, the Physical Exam Expressway, teen health, and yearly checkups for teens.
- ◆ Member incentive programs, such as a Wal-Mart gift card to members who had an adolescent well-care visit.
- ◆ Automated outreach calls to parents of adolescents that included educational content and a reminder to schedule an adolescent well-care visit.
- ◆ Promotion of teen-friendly services, such as Body Basics: An Adolescent Provider Tool Kit and Web-based education for teens.
- ◆ Distribution of the *Adolescent Well-Care Visits* PIP fact sheet, which included an adolescent immunization schedule.
- ◆ A letter to parents reminding them to take their child in for an adolescent well-care visit.
- ◆ Provider newsletter articles, which included topics such as HPV vaccine coverage, EPSDT form submission, improving disparities in adolescent well-care visits, influenza, and understanding EPSDT.
- ◆ Education for providers to use the ManagedCare.com Web site to monitor members on their panel and proactively schedule members for adolescent well-care visits and other services.
- ◆ A letter to providers that included a list of assigned members due for an adolescent well-care visit.

UFC reported that it did not detect any racial or ethnic disparities in adolescent well-care visit rates and, therefore, implemented the aforementioned quality improvement activities for the population as a whole rather than targeting interventions for subpopulations.

## Strengths

Since this was the baseline measurement period, no strengths in Contractor performance had been identified.

## Opportunities for Improvement and Recommendations

Since UFC's PIP rate did not meet the AHCCCS goal of 50 percent, UFC should determine if planned interventions were successful and expand the use of targeted intervention strategies determined to be the most successful to improve adolescent well-care visit rates. Although no disparities were detected during the baseline measurement, UFC should continue to monitor adolescent well-care visit rates by ethnicity to verify that no disparities exist.

## Summary

The UFC adolescent well-care visit rate of 40.3 percent was 9.7 percentage points lower than the AHCCCS goal of 50 percent. UFC should explore additional barriers that impact rates by identifying, for example, if members have difficulty in accessing services and expand the use of successful quality interventions to meet or exceed the AHCCCS goal of having 50 percent of adolescents receive a well-care visit.

**Arizona Department of Economic Security/Comprehensive Medical and Dental Program**

DES/CMDP has contracted with AHCCCS since 2003.

**Findings**

Table 8-9 presents the baseline PIP results for the *Adolescent Well-Care Visits* PIP for DES/CMDP. The Contractor’s baseline rate of 61 percent was 11 percentage points higher than the AHCCCS goal of 50 percent and was the highest rate among the Acute Care Contractors. DES/CMDP was the only Contractor to meet or exceed the AHCCCS goal.

Table 8-9—Performance Improvement Projects—Adolescent Well-Care Visits for DES/CMDP		
PIP Measure	Baseline Period Oct. 1, 2006, to Sept. 30, 2007	AHCCCS Goal
Percentage of members with one or more adolescent well-care visits.	61.0%	50%

As part of its PIP processes, DES/CMDP reported the use of quality improvement activities to increase adolescent well-care visit rates, which included:

- ◆ Issuing semiannual reminder cards to caregivers for well visits.
- ◆ Providing additional provider education during on-site visits.
- ◆ Distributing newsletter articles to members/caregivers, providers, and custodial agency representatives about preventive care.

DES/CMDP reported that there were no racial disparities detected in the baseline measurement.

**Strengths**

Although this was the baseline measurement, the DES/CMDP adolescent well-care visit rate was higher than the AHCCCS goal of 50 percent, which was a noted strength for the Contractor.

**Opportunities for Improvement and Recommendations**

HSAG recommends that DES/CMDP continue to expand the use of its most successful interventions to continue to improve its rate for adolescent well-care visits. Although no disparities were detected during the baseline measurement, DES/CMDP should continue to monitor adolescent well-care visit rates by race and ethnicity to verify that no disparities exist.

**Summary**

The DES/CMDP adolescent well-care visit rate of 61.0 percent was 11 percentage points higher than the AHCCCS goal of 50 percent. DES/CMDP should further enhance its improvement activities to ensure that the improvement in its rates is sustained and, ideally, increased over time.

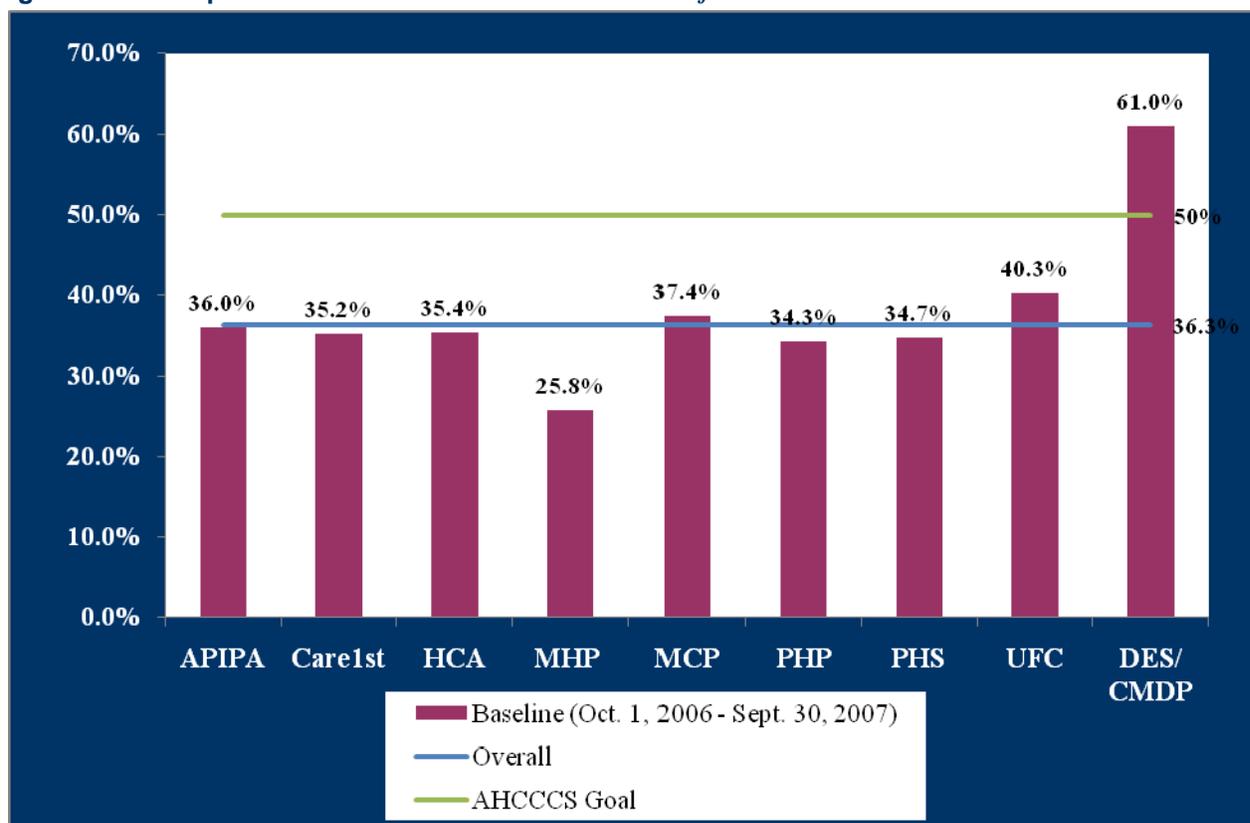
## Comparative Results for Acute Care and DES/CMDP Contractors

AHCCCS calculated and reported the Contractors’ performance results for the *Adolescent Well-Care Visits* PIP that it mandated for the Acute Care and DES/CMDP Contractors.

### Findings

Figure 8-1 presents a comparison of rates for the *Adolescent Well-Care Visits* PIP. The figure presents baseline measurement rates for each of the Acute Care and DES/CMDP Contractors.

**Figure 8-1—Comparison of Adolescent Well-Care Rates for Acute Care and DES/CMDP Contractors<sup>8-1</sup>**



The overall average rate of adolescent well-care visits was 36.3 percent, which was 13.7 percentage points below the AHCCCS goal of 50 percent. Three of the Contractors—MCP, UFC, and DES/CMDP—had rates above the average rate of 36.3 percent. DES/CMDP had the highest rate among the Contractors and exceeded the AHCCCS goal of 50 percent by 11 percentage points. MHP had the lowest rate among the contractors at 25.8 percent.

<sup>8-1</sup> The Contractors’ names are abbreviated as follows: APIPA=Arizona Physicians IPA, Care1st=Care1st Health Plan, HCA=Health Choice Arizona, MHP=Maricopa Health Plan, MCP=Mercy Care Plan, PHP=Phoenix Health Plan, PHS=Pima Health Systems, UFC=University Family Care, and DES/CMDP=Arizona Department of Economic Security/Community Medical and Dental Program.

## **Strengths**

Figure 8-1 demonstrates the relative strength of DES/CMDP for its adolescent well-care visits rate of 61 percent compared to the other Acute Care Contractors whose rates were all below the AHCCCS goal of 50 percent.

## **Opportunities for Improvement and Recommendations**

Except for DES/CMDP, whose rate was above the AHCCCS goal, the Acute Care Contractors should conduct causal/barrier analyses to identify obstacles that impact adolescent well-care visit rates. The analyses could include identifying if members have difficulty in accessing the services or if members require additional education on the types of services available and the importance of obtaining preventive health care visits. At the next remeasurement, Contractors should determine if planned interventions were successful and enhance current interventions or develop new quality initiatives to increase the percentage of members with one or more adolescent well-care visits. Additionally, all Contractors should continue to track adolescent well-care visit rates by race and ethnicity to identify if any disparities exist. If it is determined that disparities exist in Contractor data, Contractors should develop quality improvement strategies that target disparate populations to increase adolescent preventive care visit rates.

## **Summary**

Only one Contractor, DES/CMDP, exceeded the AHCCCS goal for adolescent well-care visit rate of 50 percent. The remaining Contractors' adolescent well-care visit rates ranged from 25.8 percent for MHP to 40.3 percent for UFC. All Acute Care Contractors and DES/CMDP should conduct causal/barrier analyses to identify the specific barriers that impact rates and implement targeted interventions to increase rates of adolescent well-care visits.