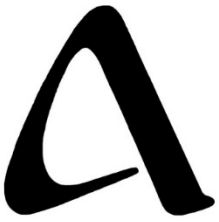
Arizona Health Care Cost Containment System



AHCCCS

2015–16 External Quality Review Annual Report

for

Arizona Department of Health Services/Division of Behavioral Health Services

December 2016

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

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

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

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

As part of the 2015 Budget Session, the legislature mandated that the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) merge with AHCCCS. Efforts to integrate the two organizations began in April 2015, and the process was finalized on July 1, 2016. The AHCCCS/DBHS clinical teams were some of the first to integrate, which led to a review of deliverables and expectations. Many of ADHS/DBHS' deliverables were waived as staff were either leaving or integrating into the AHCCCS team.

While AHCCCS made the decision to suspend most deliverables that would typically be submitted for EQRO review (as well as most other ADHS/DBHS deliverables), AHCCCS did maintain the requirement for the Quality Management/Improvement evaluation for CYE 2015. The organizational review, performance measure, and PIP reporting activities were suspended as AHCCCS made the determination to not push encounter data to ADHS/DBHS once the merge was underway. All PIP requirements were pushed to the Regional Behavioral Health Authority (RBHA) level, and AHCCCS ran ADHS/DBHS-specific data internally versus having ADHS/DBHS complete that work.

However, AHCCCS contracted with Health Services Advisory Group, Inc. (HSAG) to conduct the optional activity of administering and reporting the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[1-1]) Health Plan Survey for Medicaid members enrolled in the statewide Seriously Mentally Ill (SMI) program.

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

In addition, AHCCCS contracted with HSAG, as its EQRO, to prepare this annual technical report. This report presents a description of the three mandatory activities as well as explanations of how AHCCCS normally conducts them; however, findings from each of these activities, as well as HSAG's analysis and assessment of ADHS/DBHS' performance and recommendations to improve performance, will not be presented because AHCCCS has waived ADHS/DBHS from performing those activities. ADHS/DBHS did perform a CAHPS survey in CYE 2015—the results and HSAG's recommendations for improvement are presented in Section 9 of this report.

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

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

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

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

This Executive Summary includes an overview of the process AHCCCS uses to conduct the three mandatory activities and a high-level summary of the results of the CAHPS Health Plan Survey for Medicaid members enrolled in the statewide SMI program. The results include a description of HSAG's findings with respect to ADHS/DBHS' performance as measured by the CAHPS Survey. Additional sections of this 2015–2016 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 2015–2016 EQR activities.
- Section 4—An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care programs and those that are specific to ADHS/DBHS.
- Section 5—An overview of ADHS/DBHS' best and emerging practices.
- Section 6 (Organizational Assessment and Structure Performance)—An overview of the steps AHCCCS takes to complete an organizational review, including how the review is conducted, as well as the objectives and the methodology for conducting the review.

- Section 7 (Performance Measure Performance)—An overview of the steps AHCCCS takes to determine performance measure performance, including how the review is conducted, as well as the objectives and the methodology for conducting the review.
- Section 8 (Performance Improvement Project Performance)—An overview of the steps AHCCCS takes to measure performance improvement projects performance, including how the review is conducted, as well as the objectives and the methodology for conducting the review.
- Section 9 (CAHPS Results)—A presentation of the CAHPS Health Plan Survey for Medicaid members enrolled in the statewide SMI program.

Overview of the 2015–2016 External Review

As mentioned above, AHCCCS waived the three mandatory activities (Operational Review, Performance Measure Performance, and Performance Improvement Project Performance) because of the ADHS/DBHS and AHCCCS merger. Accordingly, the following section provides a high-level summary of HSAG's findings and conclusions regarding the CAHPS Health Plan Surveys.

Performance Measures Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Statewide Seriously Mentally Ill Program

The CAHPS Health Plan Surveys are standardized survey instruments that measure members' satisfaction levels with their healthcare. In 2015, HSAG administered the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®[1-2]) supplemental set to adult members in the AHCCCS SMI program in Greater Arizona (i.e., adult SMI members not living in Maricopa county) who met age and enrollment criteria. This survey was administered using a region-level sampling methodology, consisting of members receiving services through Northern Arizona Regional Behavioral Health Authority (NARBHA) and Cenpatico/ Community Partnership of Southern Arizona (Cenpatico/CPSA), and followed standard survey administration protocols in accordance with National Committee for Quality Assurance (NCQA) specifications. These standard protocols promote the comparability of resulting CAHPS data.

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

[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Findings

Table 1-1 presents the 2015 Adult Medicaid CAHPS survey results for the Greater Arizona SMI program in aggregate, NARBHA, and Cenpatico/CPSA. The table displays the results for each of the CAHPS survey measures: 2015 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response); three-point mean scores; and overall 2015 member satisfaction ratings (i.e., star ratings).[1-3,1-4]

Table 1-1—Adult Medicaid CAHPS Results for the Greater Arizona SMI Program

Measure	Greater AZ SMI Program		NARBHA		Cenpatico/CPSA	
	2015 Rate	Star Rating and Three-Point Mean	2015 Rate	Star Rating and Three-Point Mean	2015 Rate	Star Rating and Three-Point Mean
Global Ratings						
Rating of Health Plan	**42.8%**	★ **2.15**	42.7%	★ 2.16	42.9%	★ 2.13
Rating of All Health Care	**42.6%**	★ **2.16**	39.0%	★ 2.14	44.1%	★ 2.18
Rating of Personal Doctor	**54.3%**	★ **2.36**	53.1%	★ 2.37	54.8%	★ 2.34
Rating of Specialist Seen Most Often	**54.4%**	★ **2.39**	54.3%	★ 2.39	54.4%	★ 2.40
Composite Measures						
Getting Needed Care	**75.7%**	★ **2.19**	76.1%	★ 2.19	75.6%	★ 2.19
Getting Care Quickly	**79.8%**	★ **2.31**	81.1%	★ 2.33	79.2%	★ 2.29
How Well Doctors Communicate	**84.0%**	★ **2.46**	86.6%	★★ 2.49	83.0%	★ 2.43
Customer Service	**82.4%**	★ **2.36**	84.1%	★ 2.39	81.8%	★ 2.34
Shared Decision Making	**79.9%**	NA	80.4%	NA	79.7%	NA
Individual Item Measures						
Coordination of Care	**69.9%**	NA	73.0%	NA	68.6%	NA

[1-3] NCQA's benchmarks and thresholds for the adult Medicaid population were used to derive the overall member satisfaction ratings (i.e., star ratings). Given the potential differences in the demographics of these populations (i.e., adult Medicaid and SMI), caution should be exercised when interpreting these results.

[1-4] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

Measure	Greater AZ SMI Program		NARBHA		Cenpatico/CPSA	
	2015 Rate	Star Rating and Three-Point Mean	2015 Rate	Star Rating and Three-Point Mean	2015 Rate	Star Rating and Three-Point Mean
Health Promotion and Education	**76.0%**	NA	73.9%	NA	76.9%	NA

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

Indicates a rate 5 percentage points or more above the 2014 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2014 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

Conclusions

Based on the evaluation of the overall member satisfaction ratings (i.e., star ratings) for the Greater Arizona SMI program, NARBHA, and Cenpatico/CPSA, priority assignments were assigned for each CAHPS measure. The priority assignments are grouped into four main categories for quality improvement (QI)—top, high, moderate, and low priority—and are based on the results of the NCQA comparisons. Table 1-2 shows how the priority assignments were determined for each CAHPS measure.

Table 1-2—Derivation of Priority Assignments on Each CAHPS Measure

NCQA Comparisons (Star Ratings)	Priority Assignments
★	Top
★★	High
★★★	Moderate
★★★★	Low
★★★★★	Low

In addition to the overall member satisfaction ratings (i.e., star ratings), the 2015 top-box rates for each CAHPS survey measure for the Greater Arizona SMI program, NARBHA, and Cenpatico/CPSA were compared to 2014 NCQA CAHPS Adult Medicaid national averages to further identify specific areas that should be targeted for QI initiatives.

Recommendations

Based on the overall performance on the CAHPS survey measures (i.e., star ratings and comparisons of 2015 top-box rates to 2014 NCQA national averages), recommendations for improvement were identified. These recommendations include best practices and other proven strategies that may be used or adapted by the program and RHBAs to target improvement in the areas of *Rating of Health Plan*,

Rating of All Health Care, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate*.

To improve overall performance on the *Rating of Health Plan* global rating, QI activities should target identifying alternatives to one-on-one physician visits, health plan operations, and promoting QI initiatives. To improve members' satisfaction on the *Rating of All Health Care* global rating, QI activities should focus on identifying potential barriers to patients' access to care, patient and family engagement and advisory councils, and integrated care. To improve performance on the *Rating of Personal Doctor* global rating, QI activities should target scheduling, physician-patient communication, and improving shared decision making. To improve the overall performance of the *Rating of Specialist Seen Most Often* global rating, QI activities should target planned visit management, skills training, and telemedicine. To improve satisfaction related to the *How Well Doctors Communicate* measure, QI activities should focus on communication tools and improving health literacy.

2. Background

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

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

History of the AHCCCS Medicaid Managed Care Program

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

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

In addition, in CYE 2014 AHCCCS collaborated with behavioral health partners to create a more streamlined system that reduced barriers to care for members, in particular integrating the physical and behavioral healthcare for its members. On April 1, 2014, approximately 17,000 members with SMI in Maricopa County were transitioned to a single plan, Mercy Maricopa Integrated Care, to manage both their physical and behavioral health needs. On October 1, 2015, this model was launched statewide through contracts with Health Choice Integrated Care in Northern Arizona and Cenpatico Integrated Care in Southern Arizona. AHCCCS contracts with five of Arizona's American Indian tribes that provide behavioral health services to persons living on reservations. Each tribe contracts with a network of service providers similar to health plans to deliver a range of behavioral healthcare services.

In the past, AHCCCS contracted with ADHS/DBHS, a managed care organization (MCO) that served as the single State authority to provide coordination, planning, administration, regulation, and monitoring

of all facets of the State public behavioral health system. However, as part of the 2015 Budget Session, the legislature mandated that ADHS/DBHS merge with AHCCCS. Efforts to integrate the two organizations began in April 2015, and the process was finalized on July 1, 2016.

AHCCCS' Strategic Plan

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

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

AHCCCS Strategic Goals and related Strategies were as follows:

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

- Increase transparency by providing relevant financial and quality information.
- Implement and maintain shared savings requirements for all ALTCS and Acute Care Contractors excluding Children's Rehabilitative Services (CRS), Comprehensive Medical and Dental Program (CMDP), and the RBHA.
- Modernize hospital payments to better align incentives, increase efficiency and improve the quality of care provided to members.
- Establish robust Payment Modernization stakeholder input opportunities.

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

- Achieve the Program Integrity Plan goals that improve Third Party Liability (TPL), Coordination of Benefits (COB), and Fraud and Abuse programs.

AHCCCS must pursue continuous quality improvement.

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

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

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

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

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

AHCCCS Quality Strategy

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

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

AHCCCS has had a formal QAPI plan in place since 1994, established and submitted an initial quality strategy to CMS in 2003, and has continued to update and submit revisions of the strategy as needed to CMS. AHCCCS' QAPI strategy was last revised in October 2012. The AHCCCS Administration oversees the overall effectiveness of its QAPI strategy with several divisions/offices within the agency sharing management responsibilities. For specific initiatives and issues, AHCCCS frequently involves other internal and/or external collaborations/participants. Due to the anticipated release date of the Final Rule for Medicaid Managed Care, AHCCCS chose to suspend any further revisions to its Quality Strategy until final guidance was available from CMS. AHCCCS anticipates completing a comprehensive review of its Quality Strategy after the Final Rule is released to avoid duplication of effort.

Quality Strategy Scope, Goals, and Objectives

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

AHCCCS uses a workgroup model for considering and deciding whether to add new clinical or nonclinical projects for enhancing the well-being of its members. The first step is to review the current components of AHCCCS' quality initiatives and examine the various processes in place to develop, review, and revise quality measures. Following the review, the workgroup reviews AHCCCS' materials that define and illustrate the agency's focus on quality, its approach to quality improvement, and existing quality measurement initiatives and processes. AHCCCS is also diligent in identifying and

incorporating opportunities to improve care coordination through designing new or enhancing current projects and programs that include more than one aspect of a member's healthcare needs.

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

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

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

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

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

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

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

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

Operational Performance Standards

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

For CYE 2015, because of the administrative simplification and merger of ADHS/DBHS and AHCCCS, an operational review was not conducted.

Performance Measure Requirements and Targets

AHCCCS has been a leader in developing, implementing, and holding Contractors accountable to performance measurements. AHCCCS' consistent approach for performance expectations has resulted in performance measures with most rates at or above the NCQA HEDIS national Medicaid mean.

AHCCCS has made the decision to transition to measures found in the CMS Core Measure Sets that provide a better opportunity to shift the systems toward indicators of health outcomes, access to care, and member satisfaction.

For all lines of business, AHCCCS developed new performance measures that became effective October 1, 2013, which aligned with the start of the five-year contract period for Acute Care plans, the newly integrated CRS, and the SMI plans. This allowed AHCCCS to align with the CMS measure sets for the Children's Health Insurance Program Reauthorization Act (CHIPRA) Core Measure Set, the Adult Core Measure Set, and Meaningful Use.

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

AHCCCS has undergone extensive planning efforts, including barrier and risk identification, in its effort to implement the performance measure transition. To assist in the transition and to reduce risks that AHCCCS identified, AHCCCS used HSAG to perform the measurement calculations for the CYE 2014 measurement period. Contractors were given data for planning and implementation efforts. Workgroups, new reporting mechanisms, increased opportunities for technical assistance, and a more transparent reporting process are all efforts to assist the plans prior to the end of the measurement period, allowing them to make the necessary adjustments and payment reform initiatives that align with the performance measure thresholds. Finally, AHCCCS contracted with a vendor that is capable and interested in partnering to develop and implement measures from the CMS Core and other measures sets in addition to maintaining the traditional HEDIS measures.

For CYE 2015, because of the administrative simplification and merger of ADHS/DBHS and AHCCCS, the performance measure performance review was not conducted.

Performance Improvement Project Requirements and Targets

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

For the AHCCCS-mandated PIPs, AHCCCS and the Contractors measure performance for at least two years after the Contractor reports baseline rates and implements interventions to show not only

improvement, but also sustained improvement, as required by the Medicaid managed care regulations. AHCCCS requires Contractors to demonstrate improvement, and then sustain the improvement over at least one subsequent remeasurement cycle to ensure institutionalization of the interventions. AHCCCS requires Contractors to submit reports evaluating their data and interventions and propose new or revised interventions, if necessary.

For CYE 2015, because of the administrative simplification and merger of ADHS/DBHS and AHCCCS, performance improvement projects were waived.

3. Description of EQR Activities

Mandatory Activities

As part of the 2015 Budget Session, the legislature mandated that ADHS/DBHS merge with AHCCCS. The merger resulted in an administrative simplification that allowed the same level of service to members, but streamlined the behavioral health system.

Due to the transition of staff, AHCCCS made the decision to suspend most deliverables that would typically be submitted for EQRO review. The organizational review, performance measure, and PIP reporting activities were suspended as AHCCCS made the determination to not push encounter data to DBHS once the merge was underway.

Optional Activities

AHCCCS contracted with HSAG to conduct the following optional activity:

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

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

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

AHCCCS Quality Initiatives

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

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

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

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

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

- Healthcare reform modernization—Participated with other state government agencies in developing the necessary infrastructure to manage a State Insurance Exchange while also pursuing opportunities to ensure coordination of care between the Medicaid program and those plans that participate in the exchange in order to manage utilization and transition of care.
- Worked collaboratively with the Arizona Association of Health Plans (AzAHP) representing the organizations that contract with AHCCCS to create a new Credentialing Alliance (CA) aimed at making the credentialing and recredentialing process easier for providers through eliminating duplication of efforts and reducing administrative burdens. Prior to establishing the CA, providers had to apply for credentials with each Contractor, whereas with the CA, providers need only apply for credentialing/recredentialing once and their status is accepted by all AHCCCS Contractors.

Selecting and Initiating New Quality Improvement Initiatives

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

In selecting and initiating new quality improvement initiatives, AHCCCS:

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

Collaborates/Initiatives

During the reporting period, AHCCCS pursued a number of notable initiatives aimed at promoting a thoughtful and innovative healthcare system. AHCCCS looked at both internal and external

opportunities to build processes that promote access, quality, and cost savings. Additionally, AHCCCS continued to expand stakeholder engagement efforts to ensure well-rounded consideration of initiatives prior to implementation.

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

- Administrative Simplification—Through support from the Governor's Office, AHCCCS and ADHS/DBHS began efforts to merge the two agencies, with the focus being on streamlining efforts and maximizing effectiveness of dollars spent on the two agencies. The transition began in April 2015 and successfully concluded on July 1, 2016. Over 100 employees moved from ADHS/DBHS to AHCCCS and were merged into existing divisions and units, further strengthening the subject matter expertise of each area. The Clinical Quality Management unit was one of the first to complete full integration, with all staff members moving to AHCCCS by September 2015. Additional information can be found at: https://www.azahcccs.gov/Members/Downloads/Resources/AdminSimplificationPresentation.pdf.
- CMS Approval for Greater Arizona SMI Integration—CMS approved AHCCCS' request to have single Contractors serve northern and southern Arizona for individuals diagnosed with a serious mental illness. The approval brought greater focus to integrated health, care coordination, and innovative models for service delivery to some of the most vulnerable populations that AHCCCS serves. Awards were made in CYE 2015 by ADHS/DBHS, and integrated care for Greater Arizona officially began on October 1, 2016. Additional information can be found at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html.
- Value-Based Purchasing Initiatives—AHCCCS is promoting a number of value-based purchasing (VBP) initiatives for both providers and Contractors. Implementation of initiatives are now contractually mandated, with the requirements increasing each year. Additionally, AHCCCS leverages VBP strategies with the Contractors on certain performance measures, strengthening the focus on initiatives that AHCCCS deems as most meaningful to the populations served. Additional information related to VBP initiatives can be found in AHCCCS Contractor contracts, in the AHCCCS Contractor Operations Manual, and at: https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/valuebasedpurchasing.html.
- Testing Experience and Functional Tools (TEFT) Experience of Care Survey for ALTCS populations—As one of nine states participating in the TEFT grant from CMS, Arizona participated in the first round of the Experience of Care Survey. The survey that was tested in the pilot and field tests was developed following the CAHPS process. Arizona believes that this innovative tool will provide valuable insight on member perspectives for those receiving home and community-based services. AHCCCS will conduct a second-round survey in 2017.
- ICD-10 implementation—While this was a national requirement, AHCCCS conducted extensive testing leading up to the implementation, resulting in a seamless transition. AHCCCS and Contractor technical teams worked closely together to ensure readiness for the implementation, further highlighting the benefits of having strong relationships with Contractors.

- Medicare and Medicaid Alignment for Duals—Arizona leads the nation with the highest percentage of duals aligned in the same plan for Medicaid and Medicare outside of demonstration authority. Arizona has over 60,000 members enrolled in the same plan for Medicare and Medicaid. AHCCCS increased alignment by 20,000 members in the past two years and has a continued goal of increasing dual alignment from the current 60,000 to 75,000 members. AHCCCS conducted a study to determine the impact that plan alignment has for dual-eligible members. The study compared national data for dual members enrolled in traditional Medicare fee-for-service to aligned dual-eligible members served by one of the AHCCCS health plans. The study found that the aligned AHCCCS dual members exhibited a 31 percent lower rate of hospitalization, a 43 percent lower rate of days spent in a hospital, a 9 percent lower emergency department use, and a 21 percent lower readmission rate.
- Electronic Health Record (EHR)—AHCCCS is responsible for the implementation of Arizona's Medicaid EHR Incentive Program. The AHCCCS EHR program provides incentive payments to eligible professionals and eligible hospitals as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology. AHCCCS designed this incentive program to support providers in the transition of health information technology and to instill the use of EHRs in meaningful ways to help improve the quality, safety, and efficiency of patient care.
- Direct Care Workforce Development—In March 2004, the Governor formed the Citizens' Workgroup on the Long Term Care Workforce (Workgroup). The purpose of the workgroup was to study the issue of the direct care workforce and provide recommendations regarding potential strategies to improve the workforce. Significant activities have occurred throughout the years. In CY 2015, AHCCCS created online computer-based training (CBT) modules to support users in learning how to set up accounts and enter and access data within the online database. The CBT modules are an effective technical assistance tool for users. Additionally, AHCCCS and the health plans formally incorporated the utilization of the online database into monitoring and auditing tools for both direct care service agencies and approved direct care worker training and testing programs.
- Emergency Medical Services (EMS): Treat and Refer Initiative—AHCCCS began the process of studying treatment deferrals with the City of Mesa EMS teams. The study found that EMS took members to the emergency department for treatment because AHCCCS did not have any other mechanism for payment when EMS teams were called to transport members. AHCCCS and the Mesa EMS team decided to explore a broad-based approach to EMS care. For example, AHCCCS is currently working on opening code sets to allow EMS teams to treat and release members as appropriate and bill for those evaluations, versus billing for transport and creating an emergency department fee for the member. It is expected that EMS teams will use their training to complete a thorough assessment of the member and make the best decision for the member's care, while limiting unnecessary treatment. Members that need emergent services will be expeditiously transported; however, if there is not an emergency situation, the EMS teams can make recommendations for home care and timely follow-up with primary care physicians.
- Innovations in Childhood Obesity—AHCCCS was selected by the Center for Health Care Strategies to participate in an initiative to decrease childhood obesity for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) population. AHCCCS formed a collaborative workgroup to drive these improvements across the State. AHCCCS selected a federally qualified health center in

partnership with this initiative to work to collect data and implement interventions. AHCCCS Contractors joined the workgroup that is driving the intensive planning efforts related to these directives.

5. Contractor Best and Emerging Practices

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

- In December 2014, AHCCCS sought and received approval from CMS to amend the State's current 1115 waiver. This amendment allowed for the integration of physical and behavioral health services for individuals living with SMI in Greater Arizona requiring the ADHS/DBHS to serve as the only managed care plan for both acute and behavioral health conditions. The objective of this integration project was to reduce the fragmentation of care that this population currently experiences as they navigate the multiple systems of care in order to receive their physical and behavioral health services. Subsequently, in April 2015 AHCCCS and ADHS/DBHS began an effort termed "administrative simplification" that merged the two agencies, with the focus on streamlining efforts and maximizing effectiveness of dollars spent on the two agencies. The transition was successfully concluded on July 1, 2016.
- AHCCCS sought to maintain alignment for Medicare/Medicaid members (formerly referenced as "dual eligible") with SMI who are currently enrolled in acute care health plans that are also Special Needs Plans (SNPs) by requiring the ADHS/DBHS subcontractor to become a Medicare Dual Special Needs Plan (D-SNP) and passively enrolling those Medicare/Medicaid members into the D-SNP. These changes improved care coordination and health outcomes for individuals with SMI in Greater Arizona, increased the ability for ADHS/DBHS to collect and analyze data to better assess the health needs of its members, streamlined the current fragmented healthcare delivery system, reduced costs by decreasing hospital utilizations, and promoted sharing of information between physical and behavioral health providers. AHCCCS and ADHS/DBHS implemented the SMI Integrated RBHAs statewide on October 1, 2015.
- ADHS/DBHS required Contractors to conduct on-site provider monitoring for all subcontractors at least annually. One purpose of this requirement was to assure that the Tribal/ Regional Behavioral Health Authorities (T/RBHAs) were monitoring the service delivery system and provider network in their contracted geographic services areas. As part of the provider monitoring, Contractors were required to implement processes to verify the accuracy and timeliness of reported data, interrater reliability exercises, and the standardized collection of service information.
- ADHS/DBHS required Contractors to incorporate the FOCUS [Find an opportunity; Organize a team; Clarify the process; Understand the problem; Select a desired outcome] PDSA model for continuous quality improvement in corrective action plans (CAPs). The Contractor CAPs included: (1) measurable goals and objectives; (2) interventions, activities, and tasks; (3) responsible parties; and (4) start and completion dates for each activity and task identified in the submitted CAP, as well as systemic interventions that included, but were not limited to training, policy review and revision, technical assistance, and focused reviews. Contractor CAPs were required to use evidence-based practices when available, in the reported interventions to meet and/or exceed performance

expectations. ADHS/DBHS approved and monitored all Contractor CAPs and mandated that Contractors report CAP performance quarterly.

- ADHS/DBHS required its Contractors to complete provider profiling quarterly. Minimum data elements included ADHS/DBHS performance measures, grievance system data, morbidity and mortality measures, and utilization management measures. Contractors were required to develop a provider profile for each subcontractor and take corrective actions for any identified deficiencies. This action was intended to improve member outcomes; support quality practice; and effect positive change for the contractor, providers, service sites, and members.

6. Organizational Assessment and Structure Performance

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

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

During CYE 2015 AHCCCS conducted focused ORs on areas wherein the Contractor was determined to not be fully compliant during the previous OR. AHCCCS did not conduct a CYE 2015 focused OR of ADHS/DBHS. AHCCCS elected to waive the ADHS/DBHS OR for CYE 2015 for the following reasons:

- The intent of the CYE 2015 focused OR was to follow up on the findings of the 2014 full OR; however, ADHS/DBHS did not conduct a full OR in 2014.
- Arizona Law, 2015 Chapter 19, Section 9 (SB 1480) required that after June 30, 2016, the responsibility for behavioral health services for AHCCCS members will be administered through AHCCCS directly, not through ADHS/DBHS. In March 2015, at the beginning of the CYE 2015 OR cycle, SB 1480 was signed. As a result, AHCCCS did not conduct a focused OR of ADHS/DBHS.

7. Performance Measure Performance

As part of the 2015 Budget Session, it was announced that the Division of Behavioral Health Services (DBHS) would merge with AHCCCS, with the process finalizing on July 1, 2016. Efforts to integrate the two organizations began in April 2015. The AHCCCS/DBHS clinical teams were some of the first to integrate, which led to a review of deliverables and expectations. Many of the ADHS/DBHS deliverables were waived as staff were either leaving or integrating into the AHCCCS team.

AHCCCS made the decision to suspend most deliverables that would typically be submitted for EQRO review (as well as most other ADHS/DBHS deliverables); however, AHCCCS did maintain the requirement for the Quality Management/Improvement evaluation for CYE 2015. The performance measure reporting was suspended as AHCCCS made the determination to not push encounter data to ADHS/DBHS once the merge was underway.

The following information includes the manner in which AHCCCS conducts the validation of performance measures.

Conducting the Review

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

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

Objectives for Conducting the Review

As part of its objectives to measure, report, compare, and continually improve Contractor performance, AHCCCS conducts the following activities:

- Provides key information about AHCCCS-selected performance measures to each Contractor.
- Collects Contractor data for use in calculating the performance measure rates.
- Performs encounter data validation according to industry standards.

AHCCCS uses a summary tool to organize and represent the information and data AHCCCS provides to Contractors for the Contractors' performance with respect to each of the AHCCCS-selected measures.

The summary tool focuses on AHCCCS' 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' minimum performance standard (MPS) and goal for each measure.
- Provide data from analyzing the performance results that would allow AHCCCS to draw conclusions about 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 statewide across Contractors.

Methodology for Conducting the Review

AHCCCS uses an EQRO, HSAG, to perform its performance measure validation. HSAG conducts the validation activities as outlined in CMS' publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 1, 2012.[7-1]

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

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

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

Information Systems Capabilities Assessment Tool (ISCAT)—The Contractor is required to submit a completed ISCAT that provides information on its information systems, processes used for collecting and processing data, and processes used for performance measure calculation. Upon receipt by HSAG,

[7-1] Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

the ISCAT undergoes a cursory review to ensure each section is complete and all applicable attachments are present. HSAG then thoroughly reviews all documentation, noting any potential issues, concerns, and items that need additional clarification. Where applicable, HSAG uses the information provided in the ISCAT to begin completion of the review tools.

Source code (programming language) for performance measure generation—The Contractor is required to submit computer programming language/source code it uses to generate the performance measure being validated. HSAG completes a line-by-line review on the supplied source code to ensure compliance with the State-defined performance measure specification. HSAG identifies areas of deviation from the specification, evaluating the impact to the measure and assessing the degree of bias (if any).

Supporting documentation—The Contractor submits documentation to HSAG that provides additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviews all supporting documentation, identifying issues or areas needing clarification for further follow-up.

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

- **Opening session**—The opening session includes introductions of the validation team and key Contractor staff involved in the PMV activities. Discussion during the session covers the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—The evaluation includes a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluates the processes used to collect and calculate the performance measure, including accurate numerator and denominator identification, and algorithmic compliance (which evaluates whether rate calculations are performed correctly, all data are combined appropriately, and numerator events are counted accurately). Based on the desk review of the ISCAT, HSAG conducts interviews with key Contractor staff familiar with the processing, monitoring, and calculation of the performance measure. HSAG uses the interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures are used and followed in daily practice.
- **Overview of data integration and control procedures**—The overview includes discussion and observation of source code logic, a review of how all data sources are combined, and a review of how the analytic file is produced for reporting the performance measure rates. HSAG performs primary source verification to further validate the output files; however, this review is not conducted using actual source data. HSAG also reviews any supporting documentation provided for data integration. This session addresses data control and security procedures as well.

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

HSAG produces a report that includes all of the Contractor results of the review, any findings that are pertinent, strengths, and opportunities for improvement.

8. Performance Improvement Project Performance

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

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

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

The annual validation of MCO and PIHP PIPs required by a state and in progress during the preceding 12 months is one of the three EQR-related activities mandated by the Medicaid managed care act and described at 42 CFR 438,358(b)(1). The requirement at 42 CFR 438.358(a) allows a state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory and optional EQR-related activities.

As part of the 2015 Budget Session, it was announced that ADHS/DBHS would merge with AHCCCS, with the process finalizing on July 1, 2016. Efforts to integrate the two organizations began in April 2015. The AHCCCS/DBHS clinical teams were some of the first to integrate, which led to a review of deliverables and expectations. Many of the ADHS/DBHS deliverables were waived as staff were either leaving or integrating into the AHCCCS team.

AHCCCS made the decision to suspend most deliverables that would typically be submitted for EQRO review (as well as most other ADHS/DBHS deliverables); however, AHCCCS did maintain the requirement for the Quality Management/Improvement evaluation for CYE 2015. The PIP reporting was suspended as AHCCCS made the determination to not push encounter data to ADHS/DBHS once the merge was underway. All PIP requirements were pushed to the Regional Behavioral Health Authority (RBHA) level, and AHCCCS ran DBHS-specific data internally versus having ADHS/DBHS complete that work.

The following information includes the manner in which AHCCCS conducts the validation of performance improvement projects.

Conducting the Review

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

- Are selected through the analysis of internal and external data and trends and through Contractor input.

- Take into account comprehensive aspects of member needs, care, and services for a broad spectrum of members.

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

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

Objectives for Conducting the Review

In its objectives for evaluating Contractor PIPs, AHCCCS:

- Ensures that each Contractor has an ongoing performance improvement program of projects that focuses on clinical and/or nonclinical areas for the services it furnishes to members.
- Ensures that each Contractor measures performance using objective and quantifiable quality indicators.
- Ensures that each Contractor implements system wide interventions to achieve improvement in quality.
- Evaluates the effectiveness of each Contractor's interventions.
- Ensures that each Contractor plans and initiates activities to increase or sustain its improvement.
- Ensures that each Contractor reports to the State data/information it collects for each project in a reasonable period to allow timely information on the status of PIPs.
- Calculates and validates the PIP results from the Contractor data/information.
- Reviews the impact and effectiveness of each Contractor's performance improvement program.
- Requires each Contractor to have an ongoing process to evaluate the impact and effectiveness of its performance improvement program.

AHCCCS uses a summary tool to organize and represent the information and data AHCCCS provides for Contractors for the Contractors' performance with respect to each of the AHCCCS-selected measures. The summary tool focused on AHCCCS' 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 AHCCCS 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 provide an overall evaluation of performance for each Contractor and statewide across Contractors.

Methodology for Conducting the Review

AHCCCS developed a methodology to measure performance and follows quality control processes to ensure the collection of valid and reliable data. The study indicators AHCCCS selects for PIPs are based on current clinical knowledge or health services research. The PIP 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 Prepaid Medical Management Information System (PMMIS). 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 provides an analysis and discussion of possible interventions. Contractors may conduct additional data analyses and performance improvement interventions. After a year of intervention, the first remeasurement of performance will be conducted in the third year of the PIP. AHCCCS requires Contractors to evaluate the effectiveness of their interventions and report the results of their evaluation and any new or revised interventions to AHCCCS. Contractors whose performance does not demonstrate improvement from baseline to remeasurement will be required to report their proposed actions to revise, replace, and/or initiate new interventions to AHCCCS.

To determine if improved Contractor performance is sustained, AHCCCS will conduct a second remeasurement. If Contractors do not sustain their performance, they will be required to report their planned changes to interventions to AHCCCS.

If results of the second remeasurement demonstrate that a Contractor's performance improved and the improvement was sustained, AHCCCS will consider the PIP closed for that Contractor. If the Contractor's performance was not improved or the improvement was not sustained, the PIP will remain open and continue 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 uses a standardized format for documenting PIP activities (i.e., Performance Improvement Project 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 conducts its review and assessment of Contractor performance using the applicable criteria found in CMS' PIP protocol.[8-1] The protocol includes 10 distinct steps:

- Review the selected study topic(s).
- Review the study question(s).
- Review the identified study populations.
- Review the selected study indicators.
- Review the sampling methods (if sampling was used).
- Review the Contractor's data collection procedures.
- Review the data analysis and the interpretation of the study's results.
- Assess the Contractor's improvement strategies.
- 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 examples of each step.

As noted above, not all steps are applicable to AHCCCS' evaluation of the Contractors' performance because AHCCCS:

- Selects the study topics, questions, indicators, and populations.
- Defines sampling methods, if applicable.
- Collects all or part of the data.
- Calculates Contractor performance rates.

Throughout the process, AHCCCS maintains confidentiality in compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. Member-specific data files are maintained on a secure, password-protected computer. Only AHCCCS employees who analyze the data had access to the database, and all employees are required to sign confidentiality agreements. Only the minimum amount of necessary information to complete the project is collected. Upon completion of each study, all information is removed from the AHCCCS computer and placed on a compact disc to be stored in a secure location.

Based on its analysis of the data, AHCCCS draws conclusions about Contractor-specific and statewide performance in providing accessible, timely, and quality care and services to members.

[8-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2014.

9. Consumer Assessment of Healthcare Providers and Systems Results

CAHPS—Adult Survey

In 2015, as an optional EQR activity, AHCCCS elected to conduct member satisfaction surveys of adult Medicaid members enrolled in the AHCCCS Seriously Mentally Ill (SMI) program in Greater Arizona (Greater Arizona SMI program) receiving behavioral health services through Northern Arizona Regional Behavioral Health Authority (NARBHA) and Cenpatico/Community Partnership of Southern Arizona (Cenpatico/CPSA). AHCCCS contracted with HSAG to administer and report the results of CAHPS Health Plan Surveys. This report presents the adult Medicaid CAHPS survey results for NARBHA and Cenpatico/CPSA, as well as aggregate results for the Greater Arizona SMI program (i.e., NARBHA and Cenpatico/CPSA combined).

Methodology for Conducting CAHPS Surveys

Overview

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

Objectives

As part of its objectives to measure, report, compare, and continually improve program performance, AHCCCS elected to conduct a CAHPS survey of adult Medicaid members enrolled in AHCCCS and receiving behavioral health services through NARBHA and Cenpatico/CPSA. The primary objective of the CAHPS survey was to effectively and efficiently obtain information on adult Medicaid members' levels of satisfaction with their healthcare experiences.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set to adult members. Adult members eligible for the survey were 18 years of age or older as of April 30, 2015.

A mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys) was used. Adult members completed the surveys from June to September 2015. The CAHPS surveys were administered in English and Spanish. Members that were

identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Members that were not identified as Spanish-speaking received an English version of the survey.

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

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

For each of the composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite measure response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always"; or (2) "No" or "Yes." A positive, or top-box, response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

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

Additionally, to assess the overall performance of NARBHA's, Cenpatico/CPSA's, and the Greater Arizona SMI program's adult Medicaid populations, each of the CAHPS global ratings (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) and four of the CAHPS composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*) were scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[9-1] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[9-2] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating using the following percentile distributions:[9-3]

[9-1] National Committee for Quality Assurance. *HEDIS® 2015, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2014.

[9-2] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2015*. Washington, DC: NCQA, August 4, 2014.

[9-3] NCQA does not provide benchmarks and thresholds for the *Shared Decision Making* composite measure, or *Coordination of Care* and *Health Promotion and Education* individual item measures; therefore, overall member satisfaction ratings could not be derived for these CAHPS measures.

★★★★★ indicates a score at or above the 90th percentile

★★★★ indicates a score at or between the 75th and 89th percentiles

★★★ indicates a score at or between the 50th and 74th percentiles

★★ indicates a score at or between the 25th and 49th percentiles

★ indicates a score below the 25th percentile

For purposes of this report, the NARBHA, Cenpatico/CPSA, and Greater Arizona SMI program aggregate survey findings were compared to 2014 NCQA CAHPS Adult Medicaid national averages. For the adult Medicaid CAHPS survey results, a measure is highlighted when the measure's rate was 5 percentage points or more higher or lower than the NCQA national average.[9-4]

Description of Data Obtained

For the Greater Arizona SMI program, HSAG calculated adult Medicaid CAHPS Survey results for each surveyed region (i.e., NARBHA and Cenpatico/CPSA) and statewide program aggregate results. The following sections describe HSAG's findings, conclusions, and recommendations for NARBHA, Cenpatico/CPSA, and the Greater Arizona SMI program.

Results/Findings

Table 9-1 presents the 2015 CAHPS survey results for NARBHA. The table displays the following information: 2015 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2015 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[9-5,9-6,9-7]

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

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

[9-6] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[9-7] Due to the changes to the *Shared Decision Making* composite measure, the 2014 NCQA national average is not available for this measure; thus, comparisons to NCQA national data could not be performed.

Table 9-1—Adult Medicaid CAHPS Results for NARBHA

Measure	2015 NARBHA Rates	Three-Point Mean	Star Rating
Global Ratings			
Rating of Health Plan	42.7%	2.16	★
Rating of All Health Care	39.0%	2.14	★
Rating of Personal Doctor	53.1%	2.37	★
Rating of Specialist Seen Most Often	54.3%	2.39	★
Composite Measures			
Getting Needed Care	76.1%	2.19	★
Getting Care Quickly	81.1%	2.33	★
How Well Doctors Communicate	86.6%	2.49	★★
Customer Service	84.1%	2.39	★
Shared Decision Making	80.4%	NA	NA
Individual Item Measures			
Coordination of Care	73.0%	NA	NA
Health Promotion and Education	73.9%	NA	NA

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

Indicates a rate 5 percentage points or more above the 2014 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2014 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

The overall member satisfaction ratings revealed that NARBHA scored:

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

Table 9-2 presents the 2015 CAHPS survey results for Cenpatico/CPSA. The table displays the following information: 2015 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2015 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[9-8,9-9,9-10]

[9-8] NCQA's benchmarks and thresholds for the adult Medicaid population were used to derive the overall member satisfaction ratings (i.e., star ratings); therefore, caution should be exercised when interpreting these results.

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

[9-10] Due to the changes to the *Shared Decision Making* composite measure, the 2014 NCQA national average is not available for this measure; thus, comparisons to NCQA national data could not be performed.

Table 9-2—Adult Medicaid CAHPS Results for Cenpatico/CPSA

Measure	2015 Cenpatico/CPSA Rates	Three-Point Mean	Star Rating
Global Ratings			
Rating of Health Plan	42.9%	2.13	★
Rating of All Health Care	44.1%	2.18	★
Rating of Personal Doctor	54.8%	2.34	★
Rating of Specialist Seen Most Often	54.4%	2.40	★
Composite Measures			
Getting Needed Care	75.6%	2.19	★
Getting Care Quickly	79.2%	2.29	★
How Well Doctors Communicate	83.0%	2.43	★
Customer Service	81.8%	2.34	★
Shared Decision Making	79.7%	NA	NA
Individual Item Measures			
Coordination of Care	68.6%	NA	NA
Health Promotion and Education	76.9%	NA	NA

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

Indicates a rate 5 percentage points or more above the 2014 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2014 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

The overall member satisfaction ratings revealed that Cenpatico/CPSA scored:

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

Table 9-3 presents the 2015 CAHPS survey results for the Greater Arizona SMI program in aggregate. The table displays the following information: 2015 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response), three-point mean scores, and overall 2015 member satisfaction ratings (i.e., star ratings) for each of the CAHPS survey measures.[9-11,9-12,9-13]

[9-11] NCQA's benchmarks and thresholds for the adult Medicaid population were used to derive the overall member satisfaction ratings (i.e., star ratings); therefore, caution should be exercised when interpreting these results.

[9-12] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure or the *Coordination of Care* and *Health Promotion and Education* individual item measures, three-point mean scores are not presented and overall member satisfaction ratings (i.e., star ratings) cannot be assigned for these measures.

[9-13] Due to the changes to the *Shared Decision Making* composite measure, the 2014 NCQA national average is not available for this measure; thus, comparisons to NCQA national data could not be performed.

Table 9-3—Adult Medicaid CAHPS Results for the Greater Arizona SMI Program

Measure	2015 Greater Arizona SMI Program Rates	Three-Point Mean	Star Rating
Global Ratings			
Rating of Health Plan	42.8%	2.15	★
Rating of All Health Care	42.6%	2.16	★
Rating of Personal Doctor	54.3%	2.36	★
Rating of Specialist Seen Most Often	54.4%	2.39	★
Composite Measures			
Getting Needed Care	75.7%	2.19	★
Getting Care Quickly	79.8%	2.31	★
How Well Doctors Communicate	84.0%	2.46	★
Customer Service	82.4%	2.36	★
Shared Decision Making	79.9%	NA	NA
Individual Item Measures			
Coordination of Care	69.9%	NA	NA
Health Promotion and Education	76.0%	NA	NA

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

Indicates a rate 5 percentage points or more above the 2014 NCQA CAHPS national average.

Indicates a rate 5 percentage points or more below the 2014 NCQA CAHPS national average.

NA indicates results are not available for the CAHPS measure.

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

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

Conclusions

Based on an evaluation of the overall member satisfaction ratings (i.e., star ratings) and comparisons of the top-box rates to 2014 NCQA CAHPS Adult Medicaid national averages, HSAG identified priority areas for NARBHA, Cenpatico/CPSA, and the Greater Arizona SMI program, as follows:

- For NARBHA, the priority areas identified were *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*.
- For Cenpatico/CPSA, the priority areas identified were *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate*.

- For the Greater Arizona SMI program in aggregate, the priority areas identified were *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate*.

Recommendations

HSAG identified recommendations for improvement for NARBHA, Cenpatico/CPSA, and the Greater Arizona SMI program in aggregate based on its performance on the CAHPS survey measures. The following are recommendations of best practices and other proven strategies that may be used or adapted to target improvement in each of these areas.

Rating of Health Plan

To improve the overall *Rating of Health Plan*, quality improvement (QI) activities should target alternatives to one-on-one visits, program operations, and promoting QI initiatives.

Alternatives to One-on-One Visits

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

Program Operations

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

Promote Quality Improvement Initiatives

Implementation of organization-wide QI initiatives are most successful when staff at every level are involved; therefore, creating an environment that promotes QI in all aspects of care can encourage organization-wide participation in QI efforts. Methods for achieving this can include aligning QI goals to the mission and goals of the program organization, establishing program-level performance measures,

clearly defining and communicating collected measures to providers and staff, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, by monitoring and reporting the progress of QI efforts internally, the program can assess whether QI initiatives have been effective in improving the quality of care delivered to members. Specific QI initiatives aimed at engaging employees can include quarterly employee forums, an annual all-staff assembly, topic-specific improvement teams, leadership development courses, and employee awards.

Rating of All Health Care

To improve the overall *Rating of All Health Care* measure, QI activities should target member perception of access to care, patient and family engagement and advisory councils, and integrated care.

Access to Care

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

Patient and Family Engagement Advisory Councils

Since both patients and families have the direct experience of an illness or healthcare system, their perspectives can provide significant insight when performing an evaluation of healthcare processes. Therefore, the RBHAs/SMI program should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members, providing new perspectives and serving as a resource to healthcare processes. Patient interviews on services received and family inclusion in care planning can be an effective strategy for involving members in the design of care and obtaining their input and feedback on how to improve the delivery of care. Further, involvement in advisory councils can provide a structure and process for ongoing dialogue and creative problem-solving between the RBHAs/SMI program and its members.

Integrated Care

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

Rating of Personal Doctor

To improve the *Rating of Personal Doctor* measure, QI activities should target maintaining truth in scheduling, physician-patient communication, and improving shared decision making.

Maintain Truth in Scheduling

The RBHAs/SMI program can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. The SMI program could provide assistance or instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time. One method for evaluating appropriate scheduling of various appointment types is to measure the amount of time it takes to complete the scheduled visit. This type of monitoring will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times. Additionally, by measuring the amount of time it takes to provide care, both health plans and physician offices can identify where streamlining opportunities exist.

Physician-Patient Communication

The RBHAs/SMI program should encourage physician-patient communication to improve patient satisfaction and outcomes. Indicators of good physician-patient communication include providing clear explanations, listening carefully, and being understanding of patients' perspectives. Programs can also create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication. Training sessions can include topics such as improving listening techniques, patient-centered interviewing skills, collaborative communication which involves allowing the patient to discuss and share in the decision-making process, as well as effectively communicating expectations and goals of healthcare treatment. In addition, workshops can include training on the use of tools that improve physician-patient communication. Examples of effective tools include visual medication schedules and the "Teach Back" method, which has patients communicate back the information the physician has provided.

Improving Shared Decision Making

The RBHAs/SMI program should encourage skills training in shared decision making for all physicians. Implementing an environment of shared decision making and physician-patient collaboration requires physician recognition that patients have the ability to make choices that affect their healthcare. Therefore, one key to a successful shared decision making model is ensuring that physicians are properly trained. Training should focus on providing physicians with the skills necessary to facilitate the shared decision making process; ensuring that physicians understand the importance of taking each patient's values into consideration; and understanding patients' preferences and needs. Effective and efficient training methods include seminars and workshops.

Rating of Specialist Seen Most Often

To improve the overall performance on the *Rating of Specialist Seen Most Often* global rating, QI activities should target planned visit management, skills training, and telemedicine.

Planned Visit Management

The RBHAs/SMI program should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure these patients are receiving the appropriate attention at the appropriate time. This triggering system should be used to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons. For example, after a planned visit, follow-up contact with patients could be scheduled within the reminder system to ensure patients understood all information provided to them and/or to address any questions they may have.

Skills Training for Specialists

The RBHAs/SMI program can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients. According to a 2009 review of more than 100 studies published in the journal *Medical Care*, patients' adherence to recommended treatments and management of chronic conditions is 12 percent higher when providers receive training in communication skills. By establishing skills training for specialists, the RBHAs/SMI program cannot only improve the quality of care delivered to its members but also their potential health outcomes.

Telemedicine

The RBHAs/SMI program may want to explore the option of telemedicine with their provider networks to address issues with provider access in certain geographic areas. Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine such as live, interactive videoconferencing allows providers to offer care from a remote location. Physician specialists located in urban and rural settings can diagnose and treat patients in communities where there is a shortage of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Furthermore, the local provider is more involved in the consultation process and more informed about the care the patient is receiving.

How Well Doctors Communicate

To improve members' satisfaction under the *How Well Doctors Communicate* measure, QI activities should focus on communication tools and improving health literacy.

Communication Tools for Patients

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

Improve Health Literacy

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