AHCCCS

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Janet Napolitano, **Governor**
Anthony D. Rodgers, **Director**

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May 31, 2007

Steven Rubio, MGA, BSN, RN
Project Officer, Division of State Demonstrations and Waivers
Center for Medicaid and State Operations
Center for Medicare and Medicaid Services
Mailstop: S2-01-06
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Dear Mr. Rubio:

In accordance with Special Term and Condition paragraph 26, enclosed please find the Quarterly Progress Report for January 1, 2007 through March 31, 2007 which also includes the Quarterly Budget Neutrality Tracking Schedule and the Quarterly Quality Initiative, including the Quarterly Update for the Children's Rehabilitative Services Action Plan.

If you have any questions about the enclosed report, please contact Theresa Gonzales at (602) 417-4732.

Sincerely,

Monica Coury
AHCCCS
Office of Intergovernmental Relations

Enclosure

c: Ron Reepen

AHCCCS Quarterly Report
January 1, 2007-March 31, 2007

Title

Arizona Health Care Cost Containment System- AHCCCS, A Statewide Approach to Cost Effective Health Care Financing

Section 1115 Quarterly Report

Demonstration Year: 24
Federal Fiscal Quarter: 2nd Quarter /2007 (January 1, 2007-March 31, 2007)

Introduction:

As written in Special Term and Condition paragraph 26, the State submits the following quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration.

Enrollment Information:

Population Groups (as hard coded in the CMS 64)	Current Enrollees (to date)	Voluntary Disenrolled in current Quarter	Involuntary Disenrolled in current Quarter
Acute AFDS/SOBRA	**804,625**	**1,509**	**311,721**
Acute SSI	**130,148**	**98**	**16,659**
Acute AC/MED	**140,202**	**279**	**49,176**
Family Planning	**9,342**	**18**	**2,329**
LTC DD	**19,064**	**13**	**1,170**
LTC EPD	**26,604**	**32**	**3,489**
Total	**1,198,414**	**2,998**	**387,433**

Outreach/Innovative Activities:

The Community Relations unit of AHCCCS continues to operate with two staff members. Community Relations staff continues to focus on community education efforts, as the state is not funded to do outreach to increase membership. Community education activities include presenting to community, non-profit groups, and local governments about Medicaid and SCHIP programs. The unit also educates the community about policies changes and works to build partnerships with stakeholders who serve our members and applicants, as well as attend and participate in community events across the state.

Operational/Policy Developments/Issues:

On January 25, AHCCCS was awarded a Medicaid Transformation Grant in the amount of $11,752,500 over the next two years from the Centers for Medicare and Medicaid (CMS) to develop and implement a web-based health information exchange (HIE) utility to give all Medicaid providers instant access to patient's health records at the point of service. The electronic health record (EHR) available through this project will include patient demographics and eligibility information, patient problem lists, medications, lab tests orders/results, radiological results and images, inpatient discharge summaries, and clinical notes. The Federal funds will support its planning, design, development, testing, implementation and evaluation.

This project will transform the AHCCCS Medicaid program and the patient care process. Providing timely patient health information at the point of service will improve the quality, efficiency and effectiveness of Arizona's Medicaid program. Real time health information access will result in reduction of medical errors, reduction of redundant testing and procedures, better coordination of care for chronic diseases, increased preventive interventions, reduction in the inappropriate use of the emergency room, and lower administrative costs. When aggregated, these benefits will save significant state and federal taxpayer dollars (in Medicaid, SCHIP, and IHS) as well as beneficiary and provider frustration.

These federal dollars were part of the Deficit Reduction Act of 2005. A total of $150 million will be distributed nationally over the next two years. Arizona's award was the largest single grant award from this solicitation. The Federal Department of Health and Human Services estimates that the national implementation of health information sharing could save $140 billion.

An internal team was formed to analyze and implement the various requirements under Arizona's Waiver. In January, AHCCCCS submitted a proposed updated DSH payment methodology to CMS. A call was held in March where CMS provided feedback. AHCCCS and CMS will continue to work together on the methodology. A subgroup at AHCCCS continues to meet on the implementation of the Spouses as Paid Caregiver Program. AHCCCS will send CMS any materials related to the program as soon as they are finalized.

Consumer Issues:

The Table below provides a summary of the types of complaints or problems by consumers. The Division of Member Services continues to work on improvements in the system to track customer contacts. More information will be included in the next report.

Complaint Issue	Jan	Feb	March	Total
ALTCS	4	4	4	12
Can't get coverage (eligibility issues)	158	80	74	312
Caregiver issues				

Credentialing				
DES				
Equipment				
Fraud				
Good customer service				
Information	79	66	35	180
Lack of documentation				
Lack of providers				
Malfunctioning equipment				
Medicare	9	30	19	58
Medicare Part D				
Member reimbursement				
Misconduct				
No notification				
No payment				
Nursing home POS				
Optical coverage				
Over income				
Paying bills	44	50	48	142
Policy				
Poor customer service				
Prescription				
Prescription denial				
Process				
Surgical procedures				
Termination of coverage	0	7	3	10

Quality Assurance/Monitoring Activity:

Attached is a description of AHCCCS' Quality Assurance/Monitoring Activities during the quarter. The attachment also includes updates on implementation of the AHCCCS Quality Assessment and Performance Improvement Strategy, in accordance with Balanced Budget Act (BBA) requirements.

AHCCCS also submitted action plan updates regarding the Children's Rehabilitative Services Administration this past quarter.

HIFA Issues:

It is expected the Legislature will continue funding for the HIFA demonstration. Below is enrollment information for the quarter:

HIFA Parents ever enrolled 56,199.
HIFA Parents enrolled at any time between 1/1/2007 and 3/31/2007: 16,540.

HIFA Parent enrollment:
1/1/2007: 13,849
2/1/2007: 13,717
3/1/2007: 14,078

ESI Issues:

Reoccuring meetings were schedule to discuss details of the program and formulate a proposal for CMS.

Family Planning Extension Program:

In February, CMS approved a revised version of Attachment C of the Special Terms and Conditions for Arizona's waiver as a technical update to include the code for implanon.

AHCCCS submitted its final methodology incorporating feedback from CMS to ensure the integrity of annual eligibility determinations of individuals covered under the family planning extension program (FPEP). System requirements are in the process of being finalized as well as a review of the necessary rule revisions.

AHCCCS is in the process of establishing a mechanism to monitor utilization of family planning services by women covered under the demonstration. Currently, AHCCCS has in place a process for monitoring utilization of these members on an annual basis. Reliable quarterly data are not yet available for the current quarter because of the lag time that Contractors have in submitting encounters for services. AHCCCS expects to have utilization information for the next quarterly report, covering the first quarter of CYE 2007. For the contract year ending Sept. 30, 2006, AHCCCS recipient and encounter data show 13,222 unduplicated recipients enrolled with the FPEP extension program, with 2,870 recipients using services, for a utilization rate of 21.7 percent.

During the quarter, AHCCCS submitted a draft Evaluation Plan for the FPEP Demonstration to CMS and made revisions as requested. An initial base year fertility rate for CYE 2003 also was submitted. As of the end of the quarter, AHCCCS and CMS were working on refining the methodology to calculate the base year rate. Also during the quarter, AHCCCS submitted to CMS copies of Contractor written materials that are distributed to family planning demonstration enrollees.

Family Planning Enrollment:
1/1/2007: 8,805
2/1/2007: 8,340
3/1/2006: 8,939

Enclosures/Attachments:

Attached is the Budget Neutrality Tracking Schedule and the Quality Assurance/Monitoring Activities, including the CRS update updated for the quarter.

State Contact(s):

Theresa Gonzales
801 E. Jefferson St., MD- 4200
Phoenix, AZ 85034
602-417-4732

Date Submitted to CMS:

May 31, 2007

Attachments:

Quarterly Budget Neutrality Tracking Schedule
Quarterly Quality Initiative
CRS Quarterly Update

Quarterly Tracking Mar'07 Qtr....

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2007 Update.doc (

Arizona Health Care Cost Containment System
Budget Neutrality Tracking Report
For the Period Ended March 31, 2007

I. CALCULATION OF BUDGET NEUTRALITY LIMIT BY DEMONSTRATION YEAR (WITHOUT WAIVER CEILING FEDERAL SHARE)

WAIVER PERIOD APRIL 1, 2001 THROUGH SEPTEMBER 30, 2006:

Medicaid Enrollment Group	FFY 1999 PM/PM (Base Year)	Trend Rate	DY 01 PM/PM	Effective FMAP	Federal Share PM/PM	Member Months QE 6/01	QE 9/01	Total	Federal Share Budget Neutrality Limit FFY 2001	
AFDC/SOBRA	$208.71	1.09495	250.23	68.76%	172.05	1,174,019	1,308,868	2,482,887	$ 427,192,687	
SSI	$414.28	1.0688	473.25	68.59%	324.59	266,245	275,436	541,681	175,824,029	
									$ 603,016,716	MAP Subtotal
									75,946,612	Add DSH Allotment
									$ 678,963,328	Total BN Limit

	DY 01 PM/PM			Member Months QE 12/01	QE 3/02	QE 6/02	QE 9/02	Total	Federal Share Budget Neutrality Limit FFY 2002	
AFDC/SOBRA	273.98	68.76%	188.39	1,435,198	1,525,590	1,595,531	1,684,942	6,241,261	$ 1,175,800,085	
SSI	505.81	68.59%	346.92	284,729	291,396	297,904	304,542	1,178,571	408,871,482	
									$ 1,584,671,567	MAP Subtotal
									86,014,710	Add DSH Allotment
									$ 1,670,686,277	Total BN Limit

	DY 02 PM/PM			Member Months QE 12/02	QE 3/03	QE 6/03	QE 9/03	Total	Federal Share Budget Neutrality Limit FFY 2003	
AFDC/SOBRA	300.00	71.59%	214.78	1,774,572	1,844,530	1,939,464	2,028,576	7,587,142	$ 1,629,575,161	
SSI	540.60	71.27%	385.30	310,929	317,950	325,714	333,505	1,288,098	496,302,121	
									$ 2,125,877,283	MAP Subtotal
									82,215,000	Add DSH Allotment
									$ 2,208,092,283	Total BN Limit

	DY 03 PM/PM			Member Months QE 12/03	QE 3/04	QE 6/04	QE 9/04	Total	Federal Share Budget Neutrality Limit FFY 2004	
AFDC/SOBRA	328.48	71.75%	235.68	2,041,476	2,016,948	2,015,187	2,094,777	8,168,388	$ 1,925,165,946	
SSI	577.80	71.18%	411.29	343,693	347,531	354,479	361,292	1,406,995	578,683,841	
									$ 2,503,849,786	MAP Subtotal
									95,369,400	Add DSH Allotment
									$ 2,599,219,186	Total BN Limit

	DY 04 PM/PM			Member Months QE 12/04	QE 3/05	QE 6/05	QE 9/05	Total	Federal Share Budget Neutrality Limit FFY 2005	
AFDC/SOBRA	359.67	69.84%	251.18	2,200,055	2,179,769	2,207,612	2,210,537	8,797,973	$ 2,209,861,729	
SSI	617.55	69.20%	427.37	371,115	376,970	381,638	383,236	1,512,959	646,586,885	
									$ 2,856,448,613	MAP Subtotal
									95,369,400	Add DSH Allotment
									$ 2,951,818,013	Total BN Limit

		DY 05 PM/PM			Member Months QE 12/05	QE 3/06	QE 6/06	QE 9/06	Total	Federal Share Budget Neutrality Limit FFY 2006	
AFDC/SOBRA		393.82	69.35%	273.10	2,207,788				2,207,788	$ 602,947,771	
SSI		660.04	68.71%	453.53	384,439				384,439	174,355,439	
AFDC/SOBRA	Post MMA	392.97	69.35%	272.51		2,170,673	2,164,981	2,152,525	6,488,179	1,768,099,857	
SSI	Adj	590.02	68.71%	405.42		384,013	380,391	379,354	1,143,758	463,701,547	
										$ 3,009,104,614	MAP Subtotal
										95,369,400	Add DSH Allotment
										$ 3,104,474,014	Total BN Limit

Arizona Health Care Cost Containment System
Budget Neutrality Tracking Report
For the Period Ended March 31, 2007

I. CALCULATION OF BUDGET NEUTRALITY LIMIT BY DEMONSTRATION YEAR (WITHOUT WAIVER CEILING FEDERAL SHARE)

WAIVER PERIOD OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2011:

	FFY 2006 PM/PM	Trend Rate	DY 06 PM/PM	Effective FMAP	Federal Share PM/PM	Member Months QE 12/06	QE 3/07	QE 6/07	QE 9/07	Total	Federal Share Budget Neutrality Limit FFY 2007	
AFDC/SOBRA	392.97	1.072	421.27	68.38%	288.04	2,150,197	2,135,069			4,285,266	$ 1,234,346,816	
SSI	590.02	1.072	632.50	67.87%	429.26	377,334	374,417			751,751	322,694,516	
ALTCS-DD		1.072	3516.33	66.55%	2340.25	55,552	56,194			111,746	261,513,254	
ALTCS-EPD		1.072	3409.91	66.58%	2270.29	74,500	73,516			148,016	336,039,924	
											$ 2,154,594,510	MAP Subtotal
											95,369,400	Add DSH Allotment
											$ 2,249,963,910	Total BN Limit

Based on CMS-64 certification date of 4/30/07

Arizona Health Care Cost Containment System
Budget Neutrality Tracking Report
For the Period Ended March 31, 2007

II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT - BY QUARTER, BY DATE OF PAYMENT

	Budget Neutrality Limit - Federal Share			Expenditures from CMS-64, Schedule B - Federal Share								
WAIVER PERIOD APRIL 1, 2001 THROUGH SEPTEMBER 30, 2006:												
	MAP	DSH	Total	AFDC/SOBRA	SSI	AC/MED				DSH	Total	VARIANCE
QE 6/01	$ 288,415,996	$ -	$ 288,415,996	$ 141,986,847	$ 59,681,038	$ 31,346,872	$ -	$ -	$ -	$ 49,741,851	$ 294,745,993	$ (6,329,997)
QE 9/01	314,600,720	75,946,612	390,547,332	190,394,084	89,174,119	35,440,263	-	-	-	9,964,155	319,071,317	71,476,015
QE 12/01	369,157,582	-	369,157,582	212,600,041	91,278,326	54,069,757	-	-	-	-	357,948,124	11,209,458
QE 3/02	388,499,585	-	388,499,585	279,700,520	129,324,172	69,531,395	-	-	-	(59,706,006)	412,762,000	(24,262,415)
QE 6/02	403,933,634	-	403,933,634	251,569,392	119,396,617	69,516,073	-	-	-	-	440,482,082	(36,548,448)
QE 9/02	423,080,765	86,014,710	509,095,475	254,526,472	100,795,403	72,123,681	-	-	-	-	427,445,556	81,649,919
QE 12/02	500,945,085	-	500,945,085	283,042,237	112,605,459	81,611,127	-	-	-	-	477,258,823	23,686,262
QE 3/03	518,675,925	-	518,675,925	307,833,501	124,015,853	83,135,076	-	-	-	-	514,984,430	3,691,495
QE 6/03	542,057,417	-	542,057,417	335,897,265	153,636,989	103,921,589	-	-	-	-	593,455,843	(51,398,426)
QE 9/03	564,198,856	82,215,000	646,413,856	326,904,740	130,779,492	99,910,965	-	-	-	-	557,595,197	88,818,659
QE 12/03	622,502,832	-	622,502,832	342,194,130	141,669,588	117,472,377	-	-	-	-	601,336,095	21,166,737
QE 3/04	618,300,485	-	618,300,485	356,575,718	144,541,374	121,487,252	-	-	-	-	622,604,344	(4,303,859)
QE 6/04	620,743,091	-	620,743,091	378,397,587	178,126,369	119,699,074	-	-	-	-	676,223,030	(55,479,939)
QE 9/04	642,303,378	95,369,400	737,672,778	357,025,418	145,285,954	127,097,490	-	-	-	-	629,408,862	108,263,916
QE 12/04	711,208,379	-	711,208,379	374,496,706	153,711,596	134,379,346	-	-	-	-	662,587,648	48,620,731
QE 3/05	708,615,198	-	708,615,198	389,097,040	171,977,149	152,130,280	-	-	-	-	713,204,469	(4,589,271)
QE 6/05	717,603,705	-	717,603,705	400,547,496	165,585,571	167,446,873	-	-	-	-	733,579,940	(15,976,235)
QE 9/05	719,021,332	95,369,400	814,390,732	413,657,520	174,077,443	162,560,598	-	-	-	-	750,295,561	64,095,171
QE 12/05	777,303,210	-	777,303,210	404,061,498	191,370,840	160,614,226	-	-	-	-	756,046,564	21,256,646
QE 3/06	747,218,447	-	747,218,447	405,005,129	235,354,779	118,877,866	-	-	-	-	759,237,774	(12,019,327)
QE 6/06	744,198,886	-	744,198,886	141,514,299	(35,409,090)	184,960,886	-	-	-	509,691,703	800,757,798	(56,558,912)
QE 9/06	740,384,070	95,369,400	835,753,470	400,869,032	166,963,246	193,842,243	-	-	-	17,513,729	779,188,250	56,565,220

WAIVER PERIOD OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2011:

	MAP	DSH	Total	AFDC/SOBRA	SSI	AC/MED	ALTCS-DD	ALTCS-EPD	Family Plan	DSH/CAHP	Total	VARIANCE
QE 12/06	1,080,467,860	-	1,080,467,860	433,715,853	176,371,015	190,249,157	124,180,959	154,103,335	270,452	-	1,078,890,771	1,577,089
QE 3/07	1,074,126,650	95,369,400	1,169,496,050	420,960,087	175,385,343	175,652,301	128,103,178	160,067,805	265,323	15,570,598	1,076,004,635	93,491,415
QE 6/07												
QE 9/07												
QE 12/07												
QE 3/08												
QE 6/08												
QE 9/08												
QE 12/08												
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QE 6/10												
QE 9/10												
QE 12/10												
QE 3/11												
QE 6/11												
QE 9/11												
	$ 14,837,563,088	$ 625,653,922	$ 15,463,217,010	$ 7,802,572,612	$ 3,295,698,645	$ 2,827,076,767	$ 252,284,137	$ 314,171,140	$ 535,775	$ 542,776,030	$ 15,035,115,106	$ 428,101,904

Last Updated: 5/3/2007

Arizona Health Care Cost Containment System
Budget Neutrality Tracking Report
For the Period Ended March 31, 2007

III. SUMMARY BY DEMONSTRATION YEAR AND WAIVER PERIOD

	Federal Share of Budget Neutrality Limit	Federal Share of Waiver Costs on CMS-64	Annual Variance	As % of Annual Budget Neutrality Limit	Cumulative Federal Share of Budget Neutrality Limit	Cumulative Federal Share of Waiver Costs on CMS-64	Cumulative Federal Share Variance	As % of Cumulative Budget Neutrality Limit
DY 01	$ 2,349,649,604	$ 2,444,965,943	$ (95,316,339)	-4.06%				
DY 02	2,208,092,283	2,122,024,880	86,067,403	3.90%				
DY 03	2,599,219,186	2,495,643,323	103,575,863	3.98%				
DY 04	2,951,818,013	2,899,842,959	51,975,054	1.76%				
DY 05	3,104,474,014	3,099,849,156	4,624,858	0.15%	$ 13,213,253,100	$ 13,062,326,261	$ 150,926,839	1.14%
DY 06	2,249,963,910	1,972,788,845	277,175,065	12.32%	2,249,963,910	1,972,788,845	277,175,065	12.32%
	$ 15,463,217,010	$ 15,035,115,106	$ 428,101,904		$ 15,463,217,010	$ 15,035,115,106	$ 428,101,904	2.77%

Arizona Health Care Cost Containment System
Budget Neutrality Tracking Report
For the Period Ended March 31, 2007

IV. Schedule C as Adjusted for Manual Entries and Waiver PMPM Groupings

Schedule C

Total Computable

Waiver Name	01	02	03	04	05	06	07	08	09	10	Total
AC/MED	521,495,374	535,922,070	622,129,415	875,352,515	1,039,661,067	452,748,999					4,047,309,440
AFDC/SOBRA	1,941,368,557	1,652,041,532	1,896,887,083	2,186,095,249	2,336,861,472	1,136,208,472					11,149,462,365
SSI	854,871,739	659,693,247	830,781,763	966,584,336	978,665,898	451,522,278					4,742,119,261
ALTCS-DD	-	-	-	-	-	379,068,635					379,068,635
ALTCS-EPD	-	-	-	-	-	471,875,023					471,875,023
Family Planning Extension	-	-	-	-	-	586,545					586,545
DSH/CAHP	-	-	-	-	-	23,425,000					23,425,000
Residual DSH	245,233,394	122,242,958	141,792,150	141,392,735	138,354,399	-					789,015,636
Total	3,562,969,064	2,969,899,807	3,491,590,411	4,169,424,835	4,493,542,836	2,915,434,952					21,602,861,905

Federal Share

Waiver Name	01	02	03	04	05	06	07	08	09	10	Total
AC/MED	362,156,136	386,881,219	447,902,083	608,903,999	714,197,439	307,035,891					2,827,076,767
AFDC/SOBRA	1,334,882,416	1,182,760,291	1,361,001,468	1,526,660,857	1,620,511,137	776,756,443					7,802,572,612
SSI	586,338,925	470,174,981	591,370,372	668,908,703	672,470,803	306,434,861					3,295,698,645
ALTCS-DD	-	-	-	-	-	252,284,137					252,284,137
ALTCS-EPD	-	-	-	-	-	314,171,140					314,171,140
Family Planning Extension	-	-	-	-	-	535,775					535,775
DSH/CAHP	-	-	-	-	-	15,570,598					15,570,598
Residual DSH	161,588,466	82,208,389	95,369,400	95,369,400	92,669,777	-					527,205,432
Total	2,444,965,943	2,122,024,880	2,495,643,323	2,899,842,959	3,099,849,156	1,972,788,845					15,035,115,106

Adjustments to Schedule C

Total Computable

Waiver Name	01	02	03	04	05	06	07	08	09	10	Total
AC/MED	-	-	-	-	-	113,560					113,560
AFDC/SOBRA	-	-	-	-	-	815,960					815,960
SSI	-	-	-	-	-	82,025					82,025
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-					-
Family Planning Extension[2]	-	-	-	-	-	(586,545)					(586,545)
CAHP[3]	-	-	-	-	-	(425,000)					(425,000)
Total	-	-	-	-	-	-					-

Federal Share

Waiver Name	01	02	03	04	05	06	07	08	09	10	Total
AC/MED	-	-	-	-	-	75,484					75,484
AFDC/SOBRA	-	-	-	-	-	688,267					688,267
SSI	-	-	-	-	-	54,522					54,522
ALTCS-DD (Cost Sharing)[1]	-	-	-	-	-	-					-
Family Planning Extension[2]	-	-	-	-	-	(535,775)					(535,775)
CAHP[3]	-	-	-	-	-	(282,498)					(282,498)
Total	-	-	-	-	-	-					-

[1] The CMS 1115 Waiver, Special Term and Condition 46,e requires that premiums collected by the State shall be reported on Form CMS-64 Summary Sheet line 9,D. The State should include these premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.

[2] The Family Planning Extension (FPE) waiver expenditures are included in the AFDC\SOBRA rate development while the expenditures are required to be reported on separate Forms CMS-64.9 and CMS-64.9P Waiver. This adjustment transfers the FPE expenditures to the AFDC\SOBRA waiver category for budget neutrality comparison purposes.

[3] The Critical Access Hospital Payment (CAHP) waiver expenditures are included in the AFDC\SOBRA and SSI rate development while the expenditures are required to be reported on separate Forms CMS-64.9 and CMS-64.9P Waiver. This adjustment transfers the CAHP expenditures to the AFDC\SOBRA, SSI and AC/MED waiver categories for budget neutrality comparison purposes. The CAHP expenditures are allocated to the waiver categories in the same proportion as the capitation payments made for the CAHP service period.

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Budget Neutrality Tracking Report
For the Period Ended March 31, 2007

Revised Schedule C

Total Computable

Waiver Name	01	02	03	04	05	06	07	08	09	10	Total
AC/MED	521,495,374	535,922,070	622,129,415	875,352,515	1,039,661,067	452,862,559					4,047,423,000
AFDC/SOBRA	1,941,368,557	1,652,041,532	1,896,887,083	2,186,095,249	2,336,861,472	1,137,024,432					11,150,278,325
SSI	854,871,739	659,693,247	830,781,763	966,584,336	978,665,898	451,604,303					4,742,201,286
ALTCS-DD	-	-	-	-	-	379,068,635					379,068,635
ALTCS-EPD	-	-	-	-	-	471,875,023					471,875,023
Family Planning Extension	-	-	-	-	-	-					-
DSH/CAHP	-	-	-	-	-	23,000,000					23,000,000
Residual DSH	245,233,394	122,242,958	141,792,150	141,392,735	138,354,399	-					789,015,636
Total	3,562,969,064	2,969,899,807	3,491,590,411	4,169,424,835	4,493,542,836	2,915,434,952					21,602,861,905

Federal Share

Waiver Name	01	02	03	04	05	06	07	08	09	10	Total
AC/MED	362,156,136	386,881,219	447,902,083	608,903,999	714,197,439	307,111,375					2,827,152,251
AFDC/SOBRA	1,334,882,416	1,182,760,291	1,361,001,468	1,526,660,857	1,620,511,137	777,444,710					7,803,260,879
SSI	586,338,925	470,174,981	591,370,372	668,908,703	672,470,803	306,489,383					3,295,753,167
ALTCS-DD	-	-	-	-	-	252,284,137					252,284,137
ALTCS-EPD	-	-	-	-	-	314,171,140					314,171,140
Family Planning Extension	-	-	-	-	-	-					-
DSH/CAHP	-	-	-	-	-	15,288,100					15,288,100
Residual DSH	161,588,466	82,208,389	95,369,400	95,369,400	92,669,777	-					527,205,432
Total	2,444,965,943	2,122,024,880	2,495,643,323	2,899,842,959	3,099,849,156	1,972,788,845					15,035,115,106

Calculation of Effective FMAP:

AFDC/SOBRA						
Federal	1,334,882,416	1,182,760,291	1,361,001,468	1,526,660,857	1,620,511,137	777,444,710
Total	1,941,368,557	1,652,041,532	1,896,887,083	2,186,095,249	2,336,861,472	1,137,024,432
Effective FMAP	0.687598659	0.715938594	0.717492085	0.698350567	0.693456226	0.683753742
SSI						
Federal	586,338,925	470,174,981	591,370,372	668,908,703	672,470,803	306,489,383
Total	854,871,739	659,693,247	830,781,763	966,584,336	978,665,898	451,604,303
Effective FMAP	0.685879411	0.71271759	0.711823969	0.692033461	0.687130107	0.678667986
ALTCS-DD						
Federal						252,284,137
Total						379,068,635
Effective FMAP						0.665536828
ALTCS-EPD						
Federal						314,171,140
Total						471,875,023
Effective FMAP						0.665793112

Arizona Health Care Cost Containment System
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For the Period Ended March 31, 2007

V. Budget Neutrality Member Months and Cost Sharing Premium Collections

Budget Neutrality Member Months:	AFDC/SOBRA	SSI	ALTCS-DD	ALTCS-EPD
Quarter Ended June 30, 2001	1,174,019	266,245		
Quarter Ended September 30, 2001	1,308,868	275,436		
Quarter Ended December 31, 2001	1,435,198	284,729		
Quarter Ended March 31, 2002	1,525,590	291,396		
Quarter Ended June 30, 2002	1,595,531	297,904		
Quarter Ended September 30, 2002	1,684,942	304,542		
Quarter Ended December 31, 2002	1,774,572	310,929		
Quarter Ended March 31, 2003	1,844,530	317,950		
Quarter Ended June 30, 2003	1,939,464	325,714		
Quarter Ended September 30, 2003	2,028,576	333,505		
Quarter Ended December 31, 2003	2,041,476	343,693		
Quarter Ended March 31, 2004	2,016,948	347,531		
Quarter Ended June 30, 2004	2,015,187	354,479		
Quarter Ended September 30, 2004	2,094,777	361,292		
Quarter Ended December 31, 2004	2,200,055	371,115		
Quarter Ended March 31, 2005	2,179,769	376,970		
Quarter Ended June 30, 2005	2,207,612	381,638		
Quarter Ended September 30, 2005	2,210,537	383,236		
Quarter Ended December 31, 2005	2,207,788	384,439		
Quarter Ended March 31, 2006	2,170,673	384,013		
Quarter Ended June 30, 2006	2,164,981	380,391		
Quarter Ended September 30, 2006	2,152,525	379,354		
Quarter Ended December 31, 2006	2,150,197	377,334	55,552	74,500
Quarter Ended March 31, 2007	2,135,069	374,417	56,194	73,516

	ALTCS Developmentally Disabled	
Cost Sharing Premium Collections:	Total Computable	Federal Share
Quarter Ended December 31, 2006	$ -	$ -
Quarter Ended March 31, 2007	-	-

Arizona Health Care Cost Containment System
Budget Neutrality Tracking Report
For the Period Ended March 31, 2007

VI. Allocation of Disproportionate Share Hospital Payments

Federal Share

	FFY 2001 *	FFY 2002	FFY 2003	FFY 2004	FFY 2005	FFY 2006	FFY 2007	
Total Allotment	**75,946,612**	**86,014,710**	**82,215,000**	**95,369,400**	**95,369,400**	**95,369,400**	**95,369,400**	**625,653,922**
Reported in QE								
Jun-01	49,741,851	-	-	-	-	-	-	49,741,851
Sep-01	9,964,155	-	-	-	-	-	-	9,964,155
Dec-01	-	-	-	-	-	-	-	-
Mar-02	-	31,742,730	-	-	-	-	-	31,742,730
Jun-02	-	25,195,280	-	-	-	-	-	25,195,280
Sep-02	-	-	-	-	-	-	-	-
Dec-02	6,706,135	6,911,991	-	-	-	-	-	13,618,126
Mar-03	-	-	30,321,680	-	-	-	-	30,321,680
Jun-03	7,391,794	10,860,127	45,641,513	-	-	-	-	63,893,434
Sep-03	2,142,676	70,751	6,248,559	-	-	-	-	8,461,986
Dec-03	-	-	-	-	-	-	-	-
Mar-04	-	-	-	29,594,400	-	-	-	29,594,400
Jun-04	-	10,760,702	-	63,177,451	-	-	-	73,938,153
Sep-04	-	100,274	-	2,597,548	-	-	-	2,697,822
Dec-04	-	-	-	-	-	-	-	-
Mar-05	-	-	-	-	32,038,750	-	-	32,038,750
Jun-05	-	-	-	-	46,343,073	-	-	46,343,073
Sep-05	-	-	-	-	16,987,577	-	-	16,987,577
Dec-05	-	-	-	-	-	-	-	-
Mar-06	-	-	-	-	-	34,829,600	-	34,829,600
Jun-06	-	-	(3,363)	-	-	40,326,448	-	40,323,085
Sep-06	-	-	-	-	-	17,513,729	-	17,513,729
Dec-06	-	-	-	-	-	-	-	-
Mar-07	-	-	-	-	-	-	15,288,100	15,288,100
Jun-07								-
Sep-07								-
Dec-07								-
Mar-08								-
Jun-08								-
Sep-08								-
Total Reported to Date	75,946,611	85,641,855	82,208,389	95,369,399	95,369,400	92,669,777	15,288,100	542,493,531
Unused Allotment	**1**	**372,855**	**6,611**	**1**	**-**	**2,699,623**	**80,081,300**	**83,160,391**

* Total Allotment FFY 2001	83,835,000
Reported in QE 3/31/01	7,888,388
Balance of Allotment Limit Calculation	75,946,612

Arizona Health Care Cost Containment System

Attachment II to the Section 1115 Quarterly Report

Quality Assurance/Monitoring Activity

Demonstration/Quarter Reporting Period
Demonstration Year: 24
Federal Fiscal Quarter: 2/2007 (1/07 – 3/07)

Prepared by the Division of Health Care Management
May 2007

INTRODUCTION

This report describes Quality Assurance/Monitoring Activities of AHCCCS during the quarter, as required in STC 26 of the State's Section 1115 Waiver. The report also includes updates on implementation of the AHCCCS Quality Assessment and Performance Improvement Strategy, in accordance with Balanced Budget Act (BBA) requirements.

The AHCCCS Division of Health Care Management (DHCM) is responsible for directly overseeing the quality of health care services provided to members enrolled with managed care organizations (also known as Contractors), as well as the administrative and financial functions of these contracted health plans. The Division works collaboratively and in conjunction with other AHCCCS divisions and external organizations to fulfill the AHCCCS mission of:

Reaching across Arizona to provide
comprehensive, quality health care for those in need.

AHCCCS has long been respected as an innovator in the area of Medicaid managed care. It is AHCCCS' goal to remain a leader by its proactivity in the quality arena. The Agency's vision includes:

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

The following sections provide an update on the State's progress and activities under each of the components of the AHCCCS Quality Strategy.

QUALITY ASSESSMENT ACTIVITIES

Receiving stakeholder input

The success of AHCCCS can be attributed, in part, to concerted efforts by the Agency to foster partnerships with its sister agencies, Contractors, providers, and the community. During the quarter, AHCCCS continued these ongoing collaborations to improve the delivery of health services to Medicaid recipients and KidsCare members, including those with special needs, and to facilitate networking to address common issues and solve problems. Feedback obtained from sister agencies, providers and community organizations also is included in the agency's process for identifying priority areas for quality improvement and development of new initiatives.

Agency for Healthcare Research and Quality Learning Network for Quality-based Purchasing

The AHCCCS Chief Medical Officer and the Administrator for Clinical Quality Management (CQM) are participating in this national initiative, which is focusing on collaborative opportunities to develop quality-based pay-for-performance programs. Working with other states and employers in Community Purchasing Groups, AHCCCS is participating in the development of a pay-for-performance program that rewards evidence-based care resulting in quality outcomes to members, and discourages negative outcomes. AHCCCS also is working with medical associations in the state to seek input in the development process. Work has been completed, using the AHCCCS Data Decision Support System (ADDS), the Agency's data warehouse, to identify target populations. AHCCCS anticipates coordinating the Pay for Performance effort with the CHCS initiative regarding Return on Investment. This should ensure subject specific data that can be utilized to request legislative funding for the Pay for Performance Program. During the quarter, the AHCCCS Chief Medical Officer and the Administrator for Clinical Quality Management attended a meeting March 12-14 meeting in St. Louis to further this effort.

Arizona Department of Economic Security Division of Developmental Disabilities

Periodic meetings continue between different divisions within AHCCCS and the Arizona Department of Economic Security Division of Developmental Disabilities (DES/DDD). Agenda items during this reporting period included quality management and behavioral health issues, quality of care resolution processes, and early intervention services. AHCCCS also is providing technical assistance to DDD to improve performance measure rates.

Arizona Department of Health Services Children's Rehabilitative Services

DHCM continues to work with AHCCCS Contractors and the Children's Rehabilitative Services (CRS) program to address issues such as data sharing, provider education, timely referral and care coordination for children with special health care needs. CRS is currently under a Notice to Cure for issues related to how it handles quality of care concerns and delegated functions. AHCCCS is holding ongoing meetings with CRS Administration to monitor progress of corrective actions related to the Notice to Cure, as well as its Network Development Plan and CYE 2005 and 2006 OFRs. During the quarter, AHCCCS and CRSA representatives met on Feb. 27 to review progress on all corrective actions to date and accepted several CAP components. Implementation of CAP activities was evaluated in the CRSA CYE 2007 Operational and Financial Review (OFR) conducted March 12 through 16.

Arizona Department of Health Services Immunization Program
Ongoing collaboration with the Arizona Department of Health Services (ADHS) helps ensure efficient and effective administration and oversight of the federal Vaccines for Children (VFC) Program. This includes closely monitoring vaccine supplies and ensuring that Contractors have up-to-date information on availability of these vaccines, as well as assisting Contractors and providers as necessary to ensure that members are immunized. In addition, when ADHS takes actions regarding VFC providers (e.g., placing a provider on probation for failing to comply with vaccine management requirements), AHCCCS works with Contractors to ensure that members assigned to that provider continue to receive necessary immunizations.

In January, Arizona VFC staff gave vaccine and program updates at the quarterly Quality Management/Maternal and Child Health meeting with Acute-care Contractors. In addition, AHCCCS is working with Contractors and staff of the Arizona State Immunization Information System (ASIIS) to improve reporting by primary care practitioners to the state's immunization registry, which is operated by ADHS; this activity is discussed under Performance Improvement Projects.

Arizona Department of Health Services Office of Environmental Health
Ongoing collaboration with ADHS supports efforts to eliminate childhood lead poisoning in Arizona. The ADHS Office of Environmental Health (OEH) notifies MCH staff in the CQM unit when AHCCCS members have laboratory tests indicating elevated blood-lead levels. CQM then notifies the appropriate Contractor with this information for timely follow up and coordination of care. In addition, AHCCCS and several Contractors participate in the Arizona Childhood Lead Poisoning Elimination Coalition. This coalition is working on strategies to increase testing of children who are enrolled in AHCCCS or who live in areas with the highest risk of lead poisoning due to the prevalence of older housing, industries that use/produce lead, and the use of lead-containing pottery or folk medicines. During the quarter, AHCCCS notified Contractors of members identified through OEH as having elevated blood lead levels.

Arizona Department of Health Services Office of Nutrition and Chronic Disease Prevention
In response to the Governor's Call to Action on Childhood Obesity, AHCCCS is working with the ADHS Office of Nutrition, which has the lead on this statewide initiative. AHCCCS adapted the Chronic Care Model for planning and development of a comprehensive approach to reduce or prevent childhood obesity. Components include medical guidelines for better screening and treatment of children who are or are at risk of becoming obese and implementation of data systems to evaluate outcomes. During the quarter, AHCCCS worked on analyzing outcomes from each of the service sites and the program overall; a report on progress in addressing childhood obesity among AHCCCS members will be available shortly.

During the quarter, AHCCCS also worked closely with ADHS nutritionists to resolve member issues related to coverage of nutritional supplements not provided by WIC.

In addition, AHCCCS is collaborating with ADHS regarding tobacco education/prevention initiatives. A survey has been completed to determine awareness levels in the provider community related to tobacco education resources and services available through ADHS. An AHCCCS member interview survey also is in process. Members agreeing to be interviewed at specific service sites will be asked a series of questions to determine awareness of tobacco cessation programs and interest in quitting smoking. AHCCCS and ADHS anticipate working collaboratively with AHCCCS health plans to increase awareness of public health smoking cessation programs.

Arizona Early Intervention Program

The Arizona Early Intervention Program (AzEIP), Arizona's IDEA Part C program, is administered by DES. MCH staff in the CQM unit continues working with AzEIP to facilitate early intervention services for children under 3 years of age who are enrolled with AHCCCS Contractors. During the quarter, AHCCCS CQM/MCH staff attended meetings of the AzEIP State Interagency Team and the Interagency Coordinating Council. Also during the quarter, AHCCCS and AzEIP representatives continued work on a major initiative to create a more "seamless" system of providing early intervention services to AHCCCS-enrolled children, which utilizes AzEIP's expertise in this area, but ensures that AHCCCS or AHCCCS Contractors coordinate care and pay for all medically necessary services covered under Medicaid. AzEIP and AHCCCS MCH staff is working to refine the process for care coordination between the contracted health plans and AzEIP, to ensure early intervention services are provided without delay and covered by the appropriate state agency.

Meetings between AHCCCS, AzEIP and AHCCCS health plans continued during the quarter to ensure issues are addressed in a timely manner and communication remains open.

Arizona Managed Care Quality Enhancement Program

AHCCCS participates in this group comprised mostly on Medicare Advantage plans, which meets quarterly and is coordinated by Health Services Advisory Group, an Arizona Quality Improvement Organization. Topics at the January 2007 meeting included fall prevention and a presentation by CIGNA on its diabetes pay-for-performance project.

Arizona Medical Association and American Academy of Pediatrics

AHCCCS collaborates with the Arizona Medical Association (ArMA) and the Arizona chapter of the American Academy of Pediatrics (AAP) in a number of ways. The AAP has been instrumental in the implementation of the Parental Evaluation of Developmental Status (PEDS) tool recommended by the Governor's School Readiness Board. Online training via the AAP website is available to physicians who wish to use the tool, as well as dates and times for training sessions in Phoenix and Tucson. A workgroup that includes AHCCCS staff, AAP representatives and health plan staff meets monthly to address barriers, increase provider participation and identify potential outcomes measures. During the quarter, CQM staff attended ArMA Maternal and Child Health Committee and Adolescent Health Subcommittee meetings.

The Arizona Partnership for Immunization
This initiative is critical to achieving statewide goals for immunization of children, adolescents and adults. CQM staff attended The Arizona Partnership for Immunization (TAPI) Steering Committee and adult immunization subcommittee meetings during the quarter. AHCCCS Contractors also are members of TAPI.

Baby Arizona
CQM staff continue coordinating this streamlined eligibility process to ensure Medicaid-eligible women have access to early prenatal care. A network of community-based organizations continues to support the project by informing women of this avenue to service and referring them to care. Training sessions for provider offices that assist women in applying for AHCCCS were held during the quarter, and CQM continues to support provider participation in the project.

AHCCCS also has initiated the development of a stand-alone website for Baby Arizona that will allow all three agencies the opportunity to update participating provider lists. The website will link to all agency websites in order to reach more potential members. AHCCCS is considering developing an electronic application for coverage through Baby Arizona.

Contractor Administrator and Medical Director Meetings
On Jan. 17, the Division of Health Care Management hosted an ALTCS Program Contractor Administrators Meeting. Quality-related topics included an update on the Medicaid Transformation Grant Proposal, the AHCCCS Waiver, the Governor's Executive Order 2007-01: Ensuring Quality in Long Term Care, an E-Learning Initiative/Strategy, Consumer Directed Care, coverage of the Gardasil vaccine for human papilloma virus (HPV), review of agency data for episode treatment groups and utilization review reports, Comprehensive Care for the Elderly development and implementation, use of non-Medicare home health nursing for bowel care, grant updates, updates on HCBS services including spouses as paid caregivers, contract amendment items and dental hygienists affiliated practice.

On Jan. 19, the Division of Health Care Management hosted an Acute Care Administrators Meeting. Quality-related topics included an update on the Medicaid Transformation Grant Proposal, the AHCCCS Waiver, the Governor's Executive Order for Ensuring Quality in Long Term Care, an E-Learning Initiative/Strategy, Acute Care Performance Measures, coverage of Gardasil, dental hygienists affiliated practice, newborn hearing screening in hospitals, episode treatment groups and utilization review data, member and provider surveys, and contract amendments such as SSDI-temporary medical coverage for behavioral health services.

Healthy Children Work Group
At the direction of Governor Janet Napolitano, the State Healthy Child Collaborative (formerly the State School Readiness Board) is leading a collaborative effort to ensure that Arizona children begin school safe, healthy and ready to succeed. During the quarter, AHCCCS held meetings of a Healthy Children Work Group (formerly known as the School Readiness Activities Work Group), which includes representatives from AHCCCS Contractors and community stakeholders, such as Health Start programs and the Arizona chapter of the American Academy of Pediatrics (AAP). The group has implemented activities to increase the number of children receiving EPSDT visits, improve the quality of those visits, increase immunization rates and improve access to oral health services.

The work plan is progressing, with focus on developing a process to enhance member compliance with EPSDT visits through targeted member and provider outreach, above and beyond the educational efforts currently in place. In addition, AHCCCS is leading implementation of the Parental Evaluation of Developmental Status (PEDS) tool recommended by the Governor's SRB. In collaboration with AHCCCS, the state AAP chapter has made PEDS tool training available online through its website.

Healthy Mothers, Healthy Babies

CQM staff participate in the Maricopa County Healthy Mothers, Healthy Babies (HM,HB) Coalition, as well as a related project in the Maryvale area of west-central Phoenix, designed to promote early prenatal care and good birth outcomes. CQM staff are working with the state HMHB organization to assist in educating communities about AHCCCS-covered services for women and children and the Baby Arizona process for AHCCCS application and initiation of prenatal care. CQM staff also attended monthly coalition meetings during the quarter.

Work Group for Members who are Seriously Mentally Ill and have Medical Complexities

The purpose of this workgroup is to identify and meet the needs of members who have psychiatric conditions that inhibit their ability to manage their medical conditions/needs, subsequently creating a barrier to their successfully residing in the community. The workgroup consists of representatives of AHCCCS, Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), various Regional Behavioral Health Authorities (RBHAs) and AHCCCS health plans. The group is currently focusing on a small but complex population of members with stable psychiatric disorders who need medical intervention due to their diabetes and refusal to self medicate. This has resulted in collaborative meetings with DBHS and providers to work together to come up with a solution that will allow these members to live in the community and not at a higher level of care.

Developing and assessing the quality and appropriateness of care/services for members

AHCCCS develops measures and assesses the quality and appropriateness of care/services for its members, including those with special health care needs, using a variety of processes.

- Identifying priority areas for improvement

During the quarter, an AHCCCS team continued work on reviewing potential new performance measures for the ALTCS program, evaluating those most likely to yield improvement and affect health outcomes, functional status and/or member satisfaction. After an extensive search and review of measures currently in use across the nation, as well as an analysis of state/program data and trends, AHCCCS has narrowed down a list of potential measures. As part of this process, an objective ranking system was used to prioritize measures/areas for improvement, using criteria such as the prevalence of a particular condition or problem, resources needed to conduct measurements, ability to effect change, whether the area is a national or state priority, etc.

Also during the quarter, DHCM staff continued working with the ADHS/DBHS to identify priority areas for improvement and revise the contract with ADHS to incorporate those measures that are most meaningful to assessing the outcomes of behavioral health services provided to Medicaid and KidsCare members. AHCCCS and ADHS reviewed potential data sources for each measure and identified those that would provide reliable data while making effective use of existing resources. These contractual revisions will be effective with the contract that begins July 1, 2007, and are expected to improve ADHS' ability to monitor and report performance to AHCCCS.

- Establishing realistic outcome-based performance measures

The new ALTCS Performance Measures will be incorporated into contracts effective Oct. 1, 2008. After soliciting Contractor input and internal review and approval, DHCM will identify minimum standards and goals by which Contractor performance will be measured. To the extent possible, these minimum standards and goals will be based on national and/or state objectives and other benchmarks if applicable.

In addition, all Contractors must conduct Performance Improvement Projects (PIPs) that are expected to have a favorable impact on health outcomes and member satisfaction. Through the same process of identifying and prioritizing areas for improvement, AHCCCS has selected and is in the process of implementing two new performance improvement projects that will include either Acute Care or ALTCS Contractors. These projects are:

- **Appropriate Use of Medications for People with Asthma**. Acute-care plans will participate in this PIP, which will utilize HEDIS 2006 specifications for the baseline measurement. In addition, AHCCCS anticipates analyzing emergency room and hospital inpatient utilization to evaluate the effectiveness of this PIP.

- **Completion of Advance Directives.** ALTCS plans (including DDD) will participate in this PIP, which is intended to increase the proportion of long-term care members who have advance directives documented in medical charts and/or case management systems. This also may include documentation of an advance directive with an Arizona registry that is maintained by the Secretary of State.

During the quarter, AHCCCS worked on developing detailed methodologies to measure Contractor performance under these two projects. The methodologies will be sent to Contractors for review and comment in the next quarter, after internal review and revisions by AHCCCS.

Also during the quarter, AHCCCS continued working with Children's Rehabilitative Services Administration (CRSA) on two AHCCCS-approved PIPs that it has under way. One PIP is designed to identify and reduce the number of CRS recipients who are not utilizing needed services; the other is designed to improve the rate of initiation of transition planning for children in the program by their 15th birthdays, so they can make a smooth and supportive transition to adult-oriented services by the time they "age out" of the program. During the quarter, CRSA submitted an interim measurement on the PIP related to "non-utilizers," and AHCCCS provided feedback on this measurement and CRSA's interventions to improve performance.

- Identifying, collecting and assessing relevant data

During the quarter, DHCM conducted data collection for the ALTCS Performance Measure of Initiation of Home and Community Based Services. The purpose of this measure is to evaluate Contractor compliance with AHCCCS medical policy in initiating services to newly enrolled elderly and physically disabled (E/PD) members in the HCBS program within 30 days of enrollment with the Contractor. The measurement period for this study is October 1, 2005, through September 30, 2006.

After selecting a sample of members from the recipient universe of the Prepaid Medical Management Information System (PMMIS), the Data Analysis & Research Unit of DHCM collected information on services to those members from the Encounter universe. For those members for whom qualifying services were not identified in PMMIS, DHCM sent an electronic data collection file to each Contractor. According to specific instructions, Contractors collected additional information on services provided to these members, along with documentation of services received. If members or their authorized representatives refused all services, they provided this information on the sample file, along with appropriate documentation. These data are being analyzed in the third quarter of CYE 2007.

In addition, AHCCCS worked on updating its programming for collecting and analyzing Performance Measures according to HEDIS 2006 specifications through the ADDS data warehouse. Measures were run with the HEDIS revisions and data were validated against historical data, as well as individual recipient and service records in PMMIS, to ensure the reliability of the data. AHCCCS has eliminated virtually all deviations from HEDIS criteria to provide Performance Measure data that is comparable with national and regional benchmarks for both Medicaid and commercial health plans. This benchmarking will further drive improvement as Contractors are expected to compare favorably with national means.

- Providing incentives for excellence and imposing sanctions for poor performance

During the quarter, AHCCCS posted to its website the most recent results of the Acute Care Contractor Performance Measures, which were completed in December 2006 and submitted to CMS. Publishing individual Contractors' performance provides an incentive for health plans to improve their performance when necessary or to maintain a high level of performance compared with their peers.

A DHCM team also reviewed results by Acute Care Contractor and analyzed historical trends in Contractor performance for these measures. The Clinical Quality Management Unit has made recommendations for possible sanctions of Contractors that have not met Minimum Performance Standards for more than one year. Contractors will be required to develop Corrective Actions Plans to bring their performance to the AHCCCS minimum standards, and those Contractors that currently have CAPs in place will be required to evaluate each activity under the CAP to determine its effectiveness. Contractors will be expected to identify whether they will continue activities or recommend new interventions to improve performance.

CQM also began working on recommendations to be incorporated into Acute Care contracts in the future, in order to incentivize improvement and/or discourage poor performance.

As previously reported, the Agency also is participating in initiatives led by the Agency for Healthcare Research and Quality and the Center for Health Care Strategies, which are exploring innovative ways to reward quality.

- Sharing best practices

AHCCCS regularly shares best practices with and provides technical assistance to its Contractors. In addition, Contractors are encouraged to share evidence-based best practices with each other and their providers. An example of this is the sharing of successful interventions during AHCCCS Contractor quality management meetings.

During the quarter, the CQM Unit of DHCM hosted a quarterly meeting with Contractor Quality Management and Maternal and Child Health staff to update them on program issues and provide information and technical assistance to support best practices and high-quality care. Topics included the Women Infants and Children (WIC) Supplemental Nutrition Program, updates on the federal VFC program and utilizing the Arizona Immunization Information System (ASIIS) electronic registry, strategies to improve health by enhancing the integration of oral health and child health programs (presented by Dr. Robert Birdwell, the AHCCCS Dental Director), and a presentation on fetal alcohol syndrome. In addition, CQM provided resources and tools to Contractors on diabetes management, utilizing the Chronic Care Model for better outcomes among patient with chronic disease, and management of falls.

Including medical quality assessment and performance improvement requirements in the AHCCCS contracts

Contracts with health plans are reviewed to ensure that they include all federally required elements prior to renewal. During the quarter, DHCM reviewed contracts for renewal with the Arizona Department of Economic Security/Division of Developmental Disabilities, Arizona Department of Health Services/Division of Behavioral Health Services, and Arizona Department of Health Services/Children's Rehabilitative Services Administration, and made changes as necessary.

As mentioned, CQM began working on recommendations to be incorporated into Acute Care contracts in the future, in order to incentivize improvement and/or discourage poor performance. Strategies to drive improvement may take the form of raising minimum performance standards, requiring Contractors to dedicate additional resources and/or staff with specific qualifications to quality/performance improvement efforts, or including a contractual requirement to allow AHCCCS to direct Contractors to implement specific evidence-based interventions when necessary.

Regular monitoring and evaluating of Contractor compliance and performance

AHCCCS monitors and evaluates access to care, organizational structure and operations, clinical and non-clinical quality measurement and performance improvement outcomes through the following methods.

- Annual on-site Operational and Financial Reviews (OFRs)

During annual on-site reviews, AHCCCS conducts a review of each Contractor's compliance related to development and implementation of policies, performance related to quality measures, progress toward applicable plans of correction in place to improve quality of care, and service outcomes for members. During the quarter, six OFRs were conducted, including two Acute Care Contractors, three ALTCS Contractors and one Prepaid Inpatient Health Plan, as follows:

- **Pinal Gila Long Term Care** – Jan. 8 through 12, 2007. Among the findings in the Quality Management area were: The Contractor has a structure and process implemented for identifying quality of care complaints made throughout the system to refer them to Quality Management for investigation. The Contractor tracks and trends performance measures and monitors progress. Pinal/Gila Long Term Care Plan initiates performance improvement projects when areas of concern are identified. Review of organizational provider charts indicated that the Contractor's audited files did not meet standards identified in its own policy and procedures regarding credentialing and recredentialing.

  The QM Manager position has been vacant since December 1, 2006. The new Organizational Chart does not indicate a connection of oversight between the Medical Director and the QM Manager and Department. The vacant QM Manager position will be the only dedicated QM staff member since the four nurses have been removed from any direct QM function. Whether this new structure will adequately support the Contractor's QM activities, Performance Measures, and Performance Improvement Projects given the historic strong performance of the Contractor is of concern.

- **Arizona Physicians IPA** – Jan 22 through 26, 2007. Among the findings in the Quality Management area were: Most of the Contractor policies were found to contain AHCCCS requirements. However, implementation of the requirements was difficult to ascertain in several areas. Quality Management staffing issues could greatly impact the ability of the Contractor to resolve member concerns accurately and timely. The apparent lack of local Contractor involvement in the credentialing and recredentialing process is of concern. Although the Contractor has implemented interventions to improve performance rates, evidence of monitoring the effectiveness of the interventions was not generally found. The Contractor has partially implemented a process for evaluating the effectiveness of interventions/corrective actions its rate of Breast Cancer Screening.

- **Yavapai County Long Term Care** – Feb. 5 through 9, 2007. Among the findings in the Quality Management area were: The Contractor has implemented the structure and processes to ensure that quality of care complaints made throughout the system are referred to Quality Management for investigation, and is proactive about identifying quality issues and opportunities for improvement. The Contractor has not developed or implemented a Peer Review process that meets AHCCCS requirements. Delegated entities need to be monitored annually and any corrective action plan(s) and follow up need to be formally documented. The Contractor needs to improve its performance in the Diabetes Performance Measures to demonstrate achievement of the Minimum Performance Standard (MPS) in all measures, as well as sustained improvement. The Contractor has an opportunity to strengthen credentialing compliance by reporting and documenting organizational and provisional credentialing activities in its Quarterly Quality Improvement/Performance Improvement (QI/PI) Committee meeting minutes.

- **Health Choice Arizona** – Feb. 20 through 23, 2007. Among the findings in the Quality Management area were: The Contractor has a process for identifying, researching and resolving quality of care concerns. Most Contractor policies were found to be in compliance with AHCCCS requirements. The Contractor approves policies annually; however, the policy regarding policy development lacks specific language delineating annual review and revision with Executive Management and Medical Director review. Compliance with AHCCCS requirements would be further enhanced by including a complete listing of member rights in the Member Handbook or through other member communication vehicles. The Contractor could strengthen monitoring processes already in place through onsite validation of specific corrective actions. The Contractor is conducting telephone outreach to members aimed at improving performance measure rates. It is evaluating the effectiveness of this outreach, which began near the end of CYE 2006. It also has begun looking at the spectrum of interventions to try to evaluate effectiveness of these activities.

- **SCAN Long Term Care** – March 5 through 9, 2007. Among the findings in the Quality Management area were: The Contractor has a process in place that appropriately addresses complaint tracking and member resolution. However, the Contractor has not ensured a consistent process that documents that communication from the Contractor occurs to the originator of each concern. The Contractor is proactive about identifying quality issues and opportunities for improvement. The Contractor's process of conducting performance improvement projects should be formalized by adding discussion and decision making to the agenda of the quarterly QM/Peer Review meeting. The Contractor should add credentialing activities to the QM agenda to include license verification and liability insurance for all HCBS organizations.

- **Children's Rehabilitative Services Administration –** March 12 through 16, 2007. Among the findings in the Quality Management area were: The Contractor has made significant progress during the past year as part of the Notice to Cure process in developing a stable quality management program structure to ensure quality of care concerns from throughout the system are referred to Quality Management for investigation. However, several critical quality program functions such as Peer Review, annual audits of Regional Contractors, monitoring of the Regional Contractor's corrective action plans and intervention, and credentialing of Regional Contractors have not yet been implemented by the Contractor. Implementation of these processes will be necessary for the Contractor to become compliant with all AHCCCS requirements. The Contractor's lack of a health information system that allows for tracking, trending and analyzing accurate data is also a major area of concern. Currently, the Contractor is not meeting the Minimum Performance Standard for any of the three contractual performance measures. The Contractor has identified problems with internal data collection for these measures, and working to resolve them. The Contractor has made progress in conducting Performance Improvement Projects.

AHCCCS is requiring corrective action plans for standards for which the Contractors do not fully meet contract and BBA requirements in all areas reviewed.

- Review and analysis of periodic reports

A number of contract deliverables are used to monitor and evaluate Contractor compliance and performance. AHCCCS reviews these reports, provides feedback and approves them as appropriate. During the quarter, submissions included the following:

- **Annual Quality Management/Performance Improvement Plans**. AHCCCS ensures that each Contractor has an ongoing quality assessment and performance improvement program for the services it furnishes to its members, consistent with BBA regulations. Annually, Contractors submit their annual Quality Management/Performance Improvement (QM/PI) Plans and Evaluations of the previous year's activities, Utilization Management (UM) Plans and Evaluations, Performance Improvement Project (PIP) proposals and reports, annual Maternity Care Plans, annual EPSDT/Dental Plans, and related Work Plans. CQM coordinates this review with other units in the division.

  During the quarter, most health plans submitted their annual QA/PI plans for the contract year ending September 30, 2007 (one plan requested and received and extension). These plans were submitted on December 15, 2006. After thorough review, AHCCCS responded to Contractors with required changes and recommendations for improvement in these plans. As of the end of the quarter, more than half of Contractors' annual plans met AHCCCS and BBA minimum requirements and were approved.

- **Quarterly EPSDT/Oral Health Progress Reports**. AHCCCS requires Acute and ALTCS Contractors to submit quarterly reports demonstrating their efforts to inform families/caregivers of EPSDT services and ensure that members receive these services according to the AHCCCS Periodicity Schedule. AHCCCS has developed a template for Contractors to report data on member and provider outreach, as well as Contractor rates for various services, such as blood-lead and tuberculosis screening, PCP oral exams, and referrals. The template prompts Contractors to evaluate the effectiveness of activities, including care coordination, follow up and new or revised interventions to improve quality and access to care. The template also provides a vehicle for Contractors to report the results of their internal monitoring of contractual Performance Measures on a quarterly basis.

- **Contractor-selected PIP Final Reports**. In addition to the Performance Improvement Projects (PIPs) that AHCCCS selects, designs and requires all Contractors to participate in, Contractors also may select and conduct their own PIPs to improve unique areas based on internal trends and surveillance. When each PIP is completed — i.e., when the Contractor demonstrates statistically significant improvement and then sustains that level of performance for the next year — the Contractor submits a final report documenting all measurements under the PIP, its analysis of the data and barriers to improvement, interventions implemented to address those barriers and an evaluation of the overall success of the project. At the end of the quarter, AHCCCS received final reports a several self-selected PIPs that were completed by Contractors. These projects focused on such topics as Breast Cancer Screening, Lead Screening in Young Children, Pain Management, the Prior Authorization Process, Use of Appropriate Medications for People with Asthma, and Improving Beta-blocker Usage after Acute Myocardial Infarction. Review and responses from AHCCCS will be completed in the next quarter.

- <u>Review and analysis of program-specific Performance Measures and Performance Improvement Projects</u>

AHCCCS considers a Performance Improvement Project (PIP) as a planned process of data gathering, evaluation, and analysis to determine interventions or activities that are anticipated to have a positive outcome. PIPs are designed to improve the quality of care and service delivery and usually last at least four years. While Contractors may select and implement their own PIPs to address problems specific to their plans, AHCCCS mandates other program-wide PIPs in which Contractors must participate, and monitors performance until each health plan meet requirements for demonstrable and sustained improvement.

Another method by which AHCCCS monitors the quality and appropriateness of care provided to members is through Performance Measures. Contractors submit encounter data to AHCCCS, which measures each plan's performance and evaluates its compliance in meeting contractual performance standards for specific health care services. Under their contracts with AHCCCS, Contractors are required to improve their rates for Performance Measures and achieve specific goals for each. AHCCCS requires corrective action plans from Contractors that do not meet the Minimum Performance Standard, or that show a statistically significant decline in their rates. The following summarizes the status of current AHCCCS PIPs and Performance Measures during the quarter.

- Performance Improvement Projects

Oral Health Performance Improvement Project (All Contractors)
Utilizing HEDIS methodology, AHCCCS has measured annual dental visits among Acute-care and ALTCS members younger than 21 under this PIP. CQM has worked with Contractors to identify educational opportunities and resources as part of their interventions to improve performance.

All Acute-care Contractors and DDD showed demonstrable improvement in the first remeasurement of performance for this PIP. Because of small cell sizes by ALTCS Contractor, changes in that population must be analyzed as a whole, rather than by individual plan.

A second remeasurement of performance was completed in the fourth quarter of CYE 2006. The Division of Developmental Disabilities (DDD) and all but one Acute Care plan sustained improvement in the second remeasurement. The ALTCS program did not show significant improvement.

During the quarter, Contractors that have shown demonstrable and sustained improvement, thus completing the PIP, submitted final reports detailing interventions implemented under this PIP and an evaluation of the overall evaluation of the success of the PIP. AHCCCS will conduct a third remeasurement for this project in mid-2007 to determine whether additional Contractors have achieved or sustained improvement.

Childhood Immunization Performance Improvement Project (Acute-care Contractors and the Division of Developmental Disabilities)
Working with Contractors, AHCCCS has been focusing additional efforts on improving 2-year-old immunization rates over the last few years. An assessment of immunization levels completed in early 2004 was being utilized as the baseline measurement for this PIP. Since Contractors had already implemented corrective actions to improve childhood immunization rates, the first remeasurement of performance for this PIP was conducted in late 2004. AHCCCS retained Health Services Advisory Group (HSAG), a Quality Improvement Organization, to conduct the remeasurement, which showed significant overall improvement in immunization rates.

During the second remeasurement of performance, all but three Contractors sustained improvement or achieved a benchmark rate for the five-antigen vaccination series. The other three Contractors will continue the PIP, with a third remeasurement to be conducted in the fall of 2007.

During the quarter, Contractors submitted final reports or reported plans for revised or enhanced interventions to improve or sustain performance. AHCCCS will continue to monitor childhood immunization rates of all health plans, at least biennially, as a contractual Performance Measure.

Management of Comorbidities Performance Improvement Project (ALTCS Contractors)

The purpose of this project is to help prevent the onset of additional comorbid diseases and/or reduce the effects of coexisting diseases by improving case management and care coordination services for ALTCS members. It focuses specifically on members in home- and community-based settings, in order to improve the likelihood that these members may remain in the HCBS program and avoid institutionalization longer.

DHCM has calculated the percentage of sample members with acuity levels of I or II (with III being the highest level of acuity), based on a uniform assessment tool (UAT) utilized by Contractors. DHCM also analyzed the mean and median number of emergency department (ED) visits, hospital inpatient days and outpatient encounters for the baseline measurement. Over the course of this longitudinal study, AHCCCS will track the percent of members whose acuity levels change and whose placements change from HCBS to nursing facility, as well as trends in inpatient days, ED visits and outpatient encounters.

A parallel component of this PIP will test activities to improve coordination of care of dual-eligible (DE) members. Thus, a small sample of DE members was selected to be followed over the four-year period. This group will be evaluated to see what effect care coordination with Medicare Advantage health plans and their providers had on outcomes. Some ALTCS Contractors also have Special Needs Plans (SNPs), others are coordinating with SNPs and Medicare Advantage Plans to improve care of these members.

Data for the first remeasurement of performance has been analyzed by DHCM, which is working on a report of results.

Physician Reporting to the Arizona Statewide Immunization Information System (ASIIS)

This was implemented in CYE 2005, and is designed to increase the number of primary care practitioners contracted with AHCCCS acute-care health plans who report vaccination data to ASIIS, and to increase the total number of reported vaccinations administered to AHCCCS members.

AHCCCS has reported to each Contractor its baseline rate of PCPs who are reporting immunizations within 30 days of administering vaccinations. Interventions have been under way since CYE 2006, and AHCCCS will conduct the first remeasurement at the end of CYE 2007.

Behavioral Health PIPs

AHCCCS continues to work with the ADHS Division of Behavioral Health Services (DBHS) staff to refine their PIPs, in order to make them more focused on outcomes that demonstrate an increase in member satisfaction and/and member care. One of the DBHS PIPs is focused on assessments of children from birth through 5 years of age, and is designed to capture additional data on this population in order to develop more comprehensive assessment plans and improve positive outcomes, possibly avoiding further involvement in the mental health system. The other PIP addresses Child and Family Teams (CFTs), to better ensure that every child has a CFT in place. This has never been done on a statewide level and DBHS is developing fidelity measures with two outside consultants to ensure efficacy and positive outcomes.

- Performance Measures

Acute-care Performance Measures

As previously mentioned, AHCCCS updated its programming for collecting and analyzing Performance Measures according to HEDIS 2006 specifications through the ADDS data warehouse. The ADDS brings more efficiency in generating the measures, allowing quarterly monitoring of rates and improves flexibility in analyzing data, allowing AHCCCS staff to calculate rates by such stratifications as county, geographic service area, age, and race or ethnicity.

ALTCS Performance Measures

During the quarter, AHCCCS began collecting data for the measure of Initiation of Home and Community Base Services, as previously reported. This measurement will be completed in mid-2007.

Maintaining an information system that supports initial and ongoing operations and review of the established Quality Strategy

As previously mentioned, AHCCCS has implemented a data warehouse that provides greater flexibility and timeliness in monitoring a broad spectrum of data, including information that supports ongoing operations and review of quality management and performance improvement activities. During the quarter, enhancements were made to the ADDS function that generates Performance Measure data. The system will be used to support performance monitoring under future PIPs, as well as provide data through specific queries to guide new quality initiatives.

Reviewing, revising and beginning new projects in any given area of the Quality Strategy

Review and revision of the components of the Quality Strategy is an ongoing process for AHCCCS. During the quarter, AHCCCS began a full review of the Agency's Quality Strategy, utilizing the CMS Medicaid Quality Strategy Toolkit, to ensure that all required components are addressed and that the document is up to date. This review and revision will continue in the next quarter.

Children's Rehabilitative Services Administration
Quarterly Update
May 2007

This update is submitted in accordance with the Arizona Health Care Cost Containment System 1115 Waiver Special Terms and Conditions, STC #35. This document provides a summary of Children's Rehabilitation Services Administrations progress on their corrective action plan regarding the BBA requirements and Quality Management program. Generally, the Contractor has made progress on creating the necessary infrastructure such as hiring qualified staff and developing polices and procedures to adequately manage their contract. However, additional progress must be made in the actual implementation of contract requirements.

AHCCCS conducted an Operational and Financial Review at Children's Rehabilitative Services Administration during the week of March 12 -16, 2007. The summary of the findings are below:

General Administration and Corporate Compliance

The Contractor is currently required to complete the development of uniform policies and procedures for the training of employees and subcontracted clinics regarding AHCCCS contract requirements. Upon completion of development, the Contractor must implement training on the contract requirements. Findings in the March 2007 Operational and Financial Review indicate that the Contractor has made significant progress on completing policies and procedures, and has initiate training, but full implementation is not complete. Therefore, AHCCCS is not yet confident that CRSA subcontractors are in compliance with all BBA standards, as they have not all completed training on what those requirements are.

In addition to training, Contractor is required to improve over sight of contracted clinics, including strengthening and validating reports from the subcontracted clinics. The Contractor has mandated consistent reporting methodologies for its subcontractors and has performed audits to validate the reports. The subcontracted clinics are scheduled to be reviewed during May and June, 2007.

Delegated Agreements

The Contractor has made significant progress since the last OFR in developing oversight mechanisms to monitor the performance of its delegated entities. Historically, the Contractor has not demonstrated consistent monitoring of subcontractors, or follow up to assure implementation of corrective action plans when deficiencies were identified with a subcontractor. The Contractor started quarterly site reviews for the areas of Medical Management, Quality Management and Grievance in November 2006. Additionally, CRSA has submitted an Annual Administrative Tool

for the review of subcontractors to AHCCCS for approval. The subcontracted clinics are scheduled to be reviewed during May and June, 2007.

Cultural Competency

The Contractor has developed a comprehensive Cultural Competency Program which understands and accommodates the cultural challenges faced by CRS recipients. The Contractor has developed and utilizes a parent's council which participates in the creation of recipient materials which provides a unique and highly beneficial component to the program. This is considered a best practice among the AHCCCS Contractors. The Contractor should continue to implement its program by ensuring staff members and subcontractor's staff receive training on the culture of being a child with a CRS health condition, that they are proficient in interpretation and translation services, and that each subcontractor corrects deficiencies when identified. CRSA must monitor the use and effectiveness of their translation services in conjunction with the subcontracted clinics in order to assure that needs are being met.

Delivery Systems

The CRSA has updated its policies to comply with all standards in this area. However, CRSA must improve its documentation of oversight activities. Furthermore, CRSA must improve the monitoring and execution of subcontractor corrective action plans to ensure compliance with AHCCCS standards, particularly in the area of appointment standards. The documentation provided at the time of the OFR did not show any demonstrable improvement in the wait times for specialty appointments over previous years. The appointment standards remain out of compliance with standards. However, it is an improvement that CRSA is consistently monitoring appointment availability.

Recipient Services

CRSA has delegated recipient notifications and services to its regional clinic subcontractors. CRSA must continue to improve its process for overseeing, recording and analyzing subcontractor compliance. CRSA must also continue to improve its monitoring and oversight of the education and training of subcontractor staff to ensure compliance with recipient service standards in a formal manner. These standards are included in the CRSA subcontractor oversight tool for use on the audits to be conducted by CRSA during May and June, 2007.

Financial Management

CRSA has policies in place to monitor the subcontractor financial reporting on a quarterly and annual basis. In CYE 06, AHCCCS required a CAP to show evidence that CRSA reviews and conducts follow up on the reporting submitted by the subcontractors to ensure it is complete and accurate according to the financial reporting

guide and CRSA is in the implementation phase. CRSA has added this to their audit tool and will be implementing this process during May and June, 2007.

Claims Systems

CRSA has created an internal Administration-level position that will be responsible for overseeing the individual clinic claim processing compliance. Review results have shown that a lack of uniform practice amongst subcontractors has lead to a lack of understanding by CRSA of the inner workings of its individual subcontractors' claims processing units. CRSA must fill and utilize the new position to monitor the claims processing system to determine their efficacy and accuracy. Claims standards are included in the CRSA subcontractor oversight tool for use on the audits to be conducted by CRSA during May and June, 2007.

Third Party Liability

CRSA has policies in place to monitor the subcontractor TPL cost avoidance, post payment recovery and reporting activities on a quarterly and annual basis. CRSA is required to review and follow up on the cost avoidance and post payment recovery process to ensure that it meets the contractual requirements of both CRSA and AHCCCS. CRSA will be required during the next quarter to provide AHCCCS with documentation that they have the infrastructure in place to assure that their system is able to accept and utilize all TPL information provided by AHCCCS to CRSA.

Staffing of Quality Management Positions

CRSA has maintained the appropriate key staff to fulfill the obligations of the contract and manage the functions required in the QM area since the hiring of the last required staff on December 18, 2007.

Peer Review Processes

CRSA is under a Notice to Cure related to its Quality Management Program. CRSA has submitted a revised Peer Review Policy that meets the community standard for peer review, yet they have not implemented the process. Evidence of implementation was reviewed during the March 2007 OFR and there were no cases that had been presented. The Peer Review Committee must be chaired by the Medical Director or designee and the current CRSA policy remains out of compliance with this standard.

Quality of Care Health Information System

CRSA is under a Notice to Cure related to its Quality Management program. CRSA's health information system continues to not consistently collect, integrate, analyze or report data necessary to implement its Quality Management/Quality Improvement

(QM/QI) program. Although CRSA has identified problems with the system these have not been corrected at the time of the March 2007 OFR. CRSA has partially implemented a quality of care tracking database received from AHCCCS. CRSA continues to look at other systems to more fully meet the requirements of a QM/QI Program. CRSA does not have consistent processes to receive data from the four subcontractor sites. CRSA has not yet implemented processes to ensure data received from providers is accurate, complete, logical and consistent. CRSA has developed and started implementing some basic trend graphs, but there isn't evidence how this will be utilized in the monitoring and oversight process or for quality improvement purposes. Implementation was not demonstrated at the time of the OFR.

Monitoring and Oversight of Delegated Functions- Quality

CRSA's delegated agreements with the Regional Clinics have been updated to include the specified activities and reporting responsibilities designated to the subcontractor. CRSA does have a process for annual monitoring and oversight, but have not implemented this new process. CRSA has submitted a schedule for conducting the oversight to AHCCCSA and should have all initial monitoring activities completed by June, 2007. CRSA has begun to implement corrective actions when deficiencies are found.

Quality of Care Resolution Process

CRSA is under a Notice to Cure related to its Quality Management process. CRSA's health information system does not consistently collect, integrate, analyze or report data necessary to implement its Quality Management/Quality Improvement (QM/QI) program. CRSA has partially implemented a quality of care tracking database received from AHCCCS. CRSA continues to look at other systems to more fully meet the requirements of a QM/QI Program. CRSA has implemented processes to receive data from the four Regional Contractor sites. CRSA has not yet implemented processes to ensure data received from providers is accurate, complete, logical and consistent. CRSA has developed a work plan to address the quality of care resolution process concerns. During the OFR conducted in March, there was only one quality of care concern that should have been reported to an outside source. CRSA lacked a process for identifying these types of cases and assuring they are handled appropriately. CRSA will need to develop and implement a process that assures that the quality of care complaints are reviewed, tracked and acted upon in accordance with all state, contract and federal guidelines. CRSA received a score of 80% compliance with this standard during the OFR, significant improvement over prior performance, though still below acceptable performance.

Performance Measures and Performance Improvement Projects

AHCCCS has mandated specific Performance Measures and Performance Improvement Projects (PIP) for CRSA. CRSA submitted data to AHCCCS for analysis of contractual Performance Measure rates; however, the data had to be returned to CRSA to be cleaned. Data was submitted in January 2007 and was usable for analysis. CRSA submitted a policy and procedure for Performance Measures and has now been accepted. An interim remeasurement report was received and did show an interim improvement, but they have not met the minimum performance standards. CRSA submitted data collected for the mandated Performance Improvement Project for 2006.

Credentialing/Recredentialing

CRSA has developed processes for monitoring and oversight of the credentialing and recredentialing processes delegated to the four Regional Clinic sites. Three of the Regional sites are JCAHO accredited and therefore meet AHCCCS requirements for credentialing/recredentialing. A fourth Regional Clinic site lost JCAHO accreditation during 2005. CRSA has developed a policy and procedure to delegate credentialing/recredentialing, that meets AHCCCS requirements, to the hospital system in which the fourth Regional Clinic site is based. CRSA has developed policies and procedures to provide monitoring and oversight of the delegated credentialing/recredentialing process. CRSA has developed a work plan to implement the monitoring and oversight process for the fourth Regional Clinic site in January 2007. The oversight of this process had not been done by March 2007.

Medical Management

The Subcontracted Regional Clinics have not been adhering to standardized policies regarding clinical criteria for delegated functions. CRSA has now instituted a Medical Management Committee which has no been able to produce data for review of utilization patterns and trending. There have been reports reviewed at utilization management meetings, however, no improvement activities were identified based on a review of the information. CRSA must identify areas for improvement and implement improvement activities. Following implementation, CRSA must evaluate the effectiveness of interventions.

Training has not been developed or implemented regarding inter-rater reliability with all staff involved in the application of criteria. There are no consistent medical standards or criteria that have been adopted by the regional subcontractors. CRSA has determined that they will adopt Inter-Qual for inpatient and outpatient services, but has not implemented this across the subcontractors. There is no method of assuring that authorization decisions are made consistently and that accepted criteria is applied. CRSA remains deficient in:

- Standardization of the decision making process and application of medical criteria in making service determinations, including prior authorization, concurrent review, and retrospective review.
- Inter-rater reliability testing and results for all staff involved in medical decisions
- Action planning and interventions developed as a result of utilization data, focusing on over and under utilization of services.
- Documentation of the analysis of data, including trends and development of measurable outcomes

CRSA is awaiting Corrective Action Plans (CAPs) from all the clinics regarding the processes of prior authorization, concurrent review and retrospective claim review. CRSA will need to continue to monitor these delegated functions to assure compliance.

Grievance Systems

CRSA had issued a Notice to Cure to all of the four (4) Subcontracted Regional Clinics regarding compliance with the Notice of Action (adverse decision) letters and compliance with BBA standards. AHCCCS has continued to conduct a review every two (2) weeks of all of the Notice of Action letters generated by the Clinics, including the service request documentation, timeliness of the service requests and how CRSA is providing oversight of the delegated functions. The subcontracted Regional Clinics have demonstrated compliance, but actions are now being taken by CRSA to manage the delegated functions. CRSA is providing direct oversight and training to the Subcontracted Regional Clinics during this process. CRSA has implemented a monitoring and oversight tool and is providing feedback to the clinics directly. AHCCCS is now reviewing the monitoring and direction provided by CRSA to the clinics as part of the bi-monthly review with CRSA.