

**ARIZONA HEALTH CARE COST
CONTAINMENT SYSTEM**

**QUALITY ASSESSMENT AND
PERFORMANCE IMPROVEMENT
STRATEGY**

Revised as of October 2012

AHCCCS Quality Assessment & Performance Improvement Strategy

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PREFACE

In accordance with Code of Federal Regulations 42 CFR 438.200 et. seq., the federal regulation that is specific to Medicaid Managed Care, the Arizona Health Care Cost Containment System (AHCCCS) Quality Strategy was established in 2003. Since that time, it has been reviewed and revised as appropriate. The 2012 revision includes requirements under Section 401(c) (1) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The AHCCCS Quality Assessment & Performance Improvement Strategy (Quality Strategy) is a coordinated, comprehensive, and pro-active approach to drive quality throughout the AHCCCS system by utilizing creative initiatives, monitoring, assessment, and outcome-based performance improvement. It is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. In addition, it leads to identification and documentation of issues related to those standards, and encourages improvement through incentives, or where necessary, through corrective actions. The Quality Strategy document adheres to the recommended Centers for Medicare and Medicaid Services (CMS) format.

AHCCCS develops and approves the Quality Strategy through the identification of specific goals and objectives as demonstrated throughout this document. Over time, emphasis has shifted from process measures to a more comprehensive process and outcomes based measurement. The Quality Strategy provides a framework for the overall goal of improving and/or maintaining the members' health status as well as fostering the increased resilience and functional health status of members with chronic conditions. Members, the public, and stakeholders provide input and recommendations regarding the content and direction of the Quality Strategy. The Agency maintains the ultimate authority for overseeing the Quality Strategy management and direction.

The Quality Strategy incorporates the following components as required by pertinent federal regulations. AHCCCS must:

- Have a strategy for assessing and improving the quality of managed care services offered by all Contractors;
- Document the strategy in writing;
- Provide for the input of members and stakeholders in the development of the strategy, including making the strategy available for public comment before adopting it as final;
- Ensure compliance with standards established by AHCCCS, consistent with the regulations;
- Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy as often as AHCCCS considers appropriate;
- Provide to CMS a copy of the initial strategy, and, whenever significant changes are made, a copy of the revised strategy; and
- Provide to CMS regular reports on the implementation and effectiveness of the strategy.

The management responsibilities for the Quality Strategy are shared by several Divisions/Offices within the Agency. Internal and external collaborations/partnerships may be utilized to address specific initiatives and/or issues. AHCCCS oversees the Quality Strategy's overall effectiveness and the performance of its Contractors. AHCCCS is responsible for reporting Quality Strategy activities, findings, and actions to members, other stakeholders, Contractors, the Governor, legislators, and CMS. AHCCCS posts most reporting related to the Quality Strategy to its website to ensure transparency.

The Quality Strategy document is very closely aligned and interfaces with:

- The External Quality Review (EQR) report requirements as defined in 42 CFR 438.364 and Section 401(c)(1) of CHIPRA. There are three mandatory activities which include 1) the review of the Managed Care Organizations/Prepaid Inpatient Health Plans (MCO/PIHP) compliance with specified standards for quality program operations, 2) the validation of state-required performance measures, and 3) the validation of state required performance-improvement projects. AHCCCS is unique in the approach it uses for EQR activities. AHCCCS has, over the past 25 years, developed significant in-house resources, processes and expertise in monitoring its Managed Care Contractors, and thus performs most of the EQR functions. AHCCCS contracts with External Quality Review Organizations (EQROs) to review the AHCCCS staff quality monitoring activities. The EQRO is tasked with preparing an independent report that summarizes each AHCCCS Contractor's compliance, strengths, weaknesses, and implementation of corrective actions and identification of best practices for review and follow through by AHCCCS staff as warranted.

The EQR reports encompass specific details of the assessment, results and recommendations related to the goals and strategies found in this document. This information is used to assess the effectiveness of the currently stated goals and strategies and provide a roadmap for potential changes and new goals and strategies.

- Quality strategies and deliverables are detailed in The AHCCCS 1115 Waiver Report. Progress and updates for the quality strategy are reported in Attachment II, "Quality Assurance/Monitoring Activity" of the section 1115 Waiver quarterly report.

A comprehensive Quality Strategy is a key priority for AHCCCS. AHCCCS has and will continue to collaborate with its stakeholders to optimize the health outcomes of its members.

Links to documents related to the body of the Quality Strategy are as follows:

- AHCCCS 1115 Waiver 2011-2016
<http://www.azahcccs.gov/reporting/federal/waiver.aspx>
- AHCCCS Five Year Strategic Plans: 2011-2015; 2012-2016; 2013-2017
<http://www.azahcccs.gov/reporting/PoliciesPlans/strategicplan.aspx>
- AHCCCS Contracts
<http://www.azahcccs.gov/commercial/Purchasing/contracts.aspx>
- AHCCCS Reports
 - AHCCCS Performance Measure and Performance Improvement Project Reports
<http://www.azahcccs.gov/reporting/quality/performanceasures.aspx>
<http://www.azahcccs.gov/reporting/quality/PIPs.aspx>
 - External Quality Review Organization Reports
<http://www.azahcccs.gov/reporting/reports/EQR.aspx>
 - Quarterly Report to CMS
<http://www.azahcccs.gov/reporting/reports/quarterly.aspx>
- AHCCCS Manuals
 - AHCCCS Contractor Operations Manual (ACOM)
<http://www.azahcccs.gov/shared/ACOM.aspx?ID=contractormanuals>
 - AHCCCS Medical Policy Manual (AMPM)
<http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx>

SECTION I: INTRODUCTION

A. Quality Strategy Overview

1. Background

The Arizona Health Care Cost Containment System (AHCCCS) has operated under an 1115 Research and Demonstration Waiver since 1982, when it became the first statewide Medicaid managed care system in the nation. AHCCCS began its acute care program at that time. The Arizona Long Term Care System (ALTCS) was added in December of 1988 for persons with developmental disabilities. In January of 1989, ALTCS was expanded to include the Elderly and Physically Disabled (E/PD) populations. On October 1, 1990, AHCCCS began incorporating comprehensive behavioral health services, starting with coverage of seriously emotionally disabled children under the age of 18 years who required residential care. Over the next five years, behavioral health coverage was extended to all Medicaid-eligible persons.

Arizona extended coverage to children younger than 19 years of age under the State Children's Health Insurance Program (now Children's Health Insurance Program, or CHIP) on Nov. 1, 1998. The program, known in Arizona as KidsCare, provides a mechanism under which more children are covered for immunizations and other primary and preventive health services, as well as more acute medical and behavioral health services. Children enrolled under KidsCare receive services through the same Managed Care Contractors that provide services to children and adults enrolled under Medicaid and are eligible for the same package of health care benefits as Medicaid-eligible children.

Arizonans' approval of Proposition 204 added additional groups to the acute care population in 2001. The enrollment of new childless adults, however, is currently frozen. As of March 1, 2012, there are approximately 1.2 million AHCCCS members. Fourteen Managed Care Organizations (MCOs) and one Prepaid Inpatient Health Plan (PIHP) serve AHCCCS managed care members statewide. The one PIHP is limited to providing behavioral health services. Within the AHCCCS program, MCOs and PIHPs are called "Contractors."

2. Mission

The Quality Strategy supports the AHCCCS' Mission, "*Reaching across Arizona to provide comprehensive, quality health care for those in need.*" Inherent in carrying out this mission is AHCCCS' commitment to drive quality through the development of the Quality Strategy. The Agency establishes its goals, objectives and timetables for health care improvements. AHCCCS has had a formal Quality Initiative and Performance Improvement Plan since 1994. This commitment to quality was the foundation for fulfilling the quality strategy requirements initiated by the Centers for Medicare and Medicaid Services (CMS) in 2003.

3. Vision

The Quality Strategy also supports the AHCCCS Vision: “Shaping tomorrow’s managed health care from today’s experience, quality and innovation.” AHCCCS has long been respected as an innovator in the area of Medicaid managed care. Thoughtful quality strategies are intended to carry this reputation forward to meet ongoing challenges, and it is the Agency’s goal to continue proactive engagement in quality initiatives.

4. Process For Overall Quality Strategy Development, Review And Revision

AHCCCS has built its quality structure over time by means of its adherence to Federal requirements, continual review of applicable national standards and national and/or regional trends, collaboration with partners, and its own experiences. The Quality Strategy includes both the Medicaid and CHIP programs and encompasses AHCCCS acute and long-term care Contractors, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS), and Children's Rehabilitative Services (CRS). It also incorporates measures to improve the Agency’s internal processes involving enrollee information, monitoring and evaluation.

The Agency uses the steps described below when considering the addition of new clinical and non-clinical projects to enhance the well-being of its members. Using a workgroup process, AHCCCS first engages in a review of the current components of the Agency’s quality initiative, examining the various processes in place to develop, review and revise quality measures. Second, a review is completed of AHCCCS materials that illustrate the focus on quality, which is central to the Agency’s mission and vision. Finally, the Quality Strategy document is revised to include the overall strategic goals and objectives related to quality, the quality-improvement approach of the Agency, and the quality measurement initiatives and overview processes. AHCCCS also incorporates opportunities to improve care coordination by designing projects that include more than one aspect of a member’s health care needs.

The specific components of the overall AHCCCS Quality Strategy are as follows:

a. Facilitating Stakeholder Involvement

The success of AHCCCS can be attributed, in part, to concerted efforts by the Agency to foster collaborative partnerships with its sister agencies, Contractors (Administrators and Medical Directors), providers (physicians, other professionals, and paraprofessionals) and the community (advocacy groups, non-profit and for-profit groups). Venues for suggestions and feedback, such as public forums, member councils, and meetings with Contractors and providers, are regularly sponsored by AHCCCS. In order to provide for public involvement and commentary on changes resulting from the Balanced Budget Act BBA regulations, the Affordable Care Act implementation and State program/policy changes, AHCCCS includes the Contractors in discussions regarding strategies and implementation of new activities. Examples include:

1) Direct Care Worker (DCW) Training and Testing Program

In order to enhance quality of care for members, AHCCCS has instituted training and testing standards for DCWs who provide direct care services (i.e. Attendant Care, Personal Care and Homemaker services) to ALTCS members residing in their own home. All DCWs hired on or after October 1, 2012 are required to meet the new training and testing requirements to demonstrate proficiency related to the established competencies. AHCCCS adopted the “Principles of Caregiving” curriculum, created by the Arizona Direct Care Workforce Committee, as the only approved training modules and testing protocol for DCWs. The Committee was instituted in Arizona seven years ago with the aim of promoting a stable and competent direct care workforce to meet the growing need for support for the elderly and individuals with disabilities living at home. The Committee comprised of public and private partners (including AHCCCS staff, ALTCS Program Contractors and their respective contracted providers), created standardized competencies, training modules and a testing protocol for DCWs. In preparation for the program’s implementation date, AHCCCS continues to solicit input from a variety of stakeholders on the policy standards and practices that guide the program’s implementation.

2) Community First Choice (CFC)

CFC is a Home and Community Based Services (HCBS) option that is being considered for the ALTCS population. CFC development is guided by the Development and Implementation Council, which is primarily represented by ALTCS members. Other members include Contractor representatives, provider representatives and community stakeholders. The group is discussing a new attendant care model, Agency with Choice, which would be introduced under CFC. In July 2011 and December 2011, AHCCCS staff met with the ALTCS Contractor representatives to discuss operational issues that need to be considered when implementing CFC and Agency with Choice. During the past year, staff also consulted with a few provider agencies regarding challenges that they may face in implementing the Agency with Choice model. The Development and Implementation Council will continue to meet monthly or as needed through the development stages of the program and will then be involved in follow up discussions after CFC is implemented.

b. 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 using the following processes:

1) Identifying Priority Areas for Improvement

AHCCCS regularly establishes key clinical and non-clinical areas on which to focus future efforts. This is done through analyses of state and national trends and in consultation with other entities working to improve health care in Arizona, such as

the Medicare Quality Improvement Organization (QIO), community leaders, other state agencies, and AHCCCS Contractors.

2) Establishing Realistic Outcome-Based Performance Measures

AHCCCS establishes minimum performance standards, goals, and benchmarks based on national standards, such as the NCQA National Medicaid means, whenever possible. Contractors are expected to achieve the minimum performance standard for performance measures. Performance measure reports, such as that for immunizations, may compare the Contractors' results with each other and with Medicaid and commercial health plan national averages. The rationale for establishing these measures is for Contractors to develop methods to continuously increase the well-being of their respective populations through the removal of barriers to care and ongoing process improvement. AHCCCS participates in national efforts focused on developing Medicaid and CHIP Core Measures to allow comparability across States' programs.

Each Contractor is expected to conduct Performance Improvement Projects (PIPs) in clinical care and non-clinical areas that are expected to have a favorable impact on health outcomes and member satisfaction. Utilizing financial, population, and disease-specific data and input from the Contractors, AHCCCS selects an indicator of performance improvement to be measured across Contractors. For each mandated PIP, AHCCCS develops a methodology to measure performance in a standardized way across Contractors and manages data collection and analysis. In this way, AHCCCS ensures that the project is implemented by Contractors in a consistent manner and yields results that can be analyzed by individual Contractors, as well as by other stratifications and for the program overall. In addition, Contractors are required to review their data and quality measures to determine Contractor-specific Performance Improvement Projects.

3) Identifying, Collecting and Assessing Relevant Data

Methods may vary given the project. Data sources can include, but are not limited to: administrative data (e.g. member demographics, encounters), interview findings and survey results. The Agency and/or its Contractors may also use an External Quality Review Organization (EQRO) to assist in some or all phases of a project.

4) Providing Incentives for Excellence and Imposing Sanctions for Poor Performance

In 2003, AHCCCS began posting aggregate results of performance measures on the AHCCCS website. Web site postings have been expanded to include Contractors' individual performance measure rates. It is expected that the postings are viewed as incentives by Contractors to improve their performance rates. AHCCCS will continue to explore creative ways to provide incentives for performance improvement and positive outcomes.

Corrective Action Plans (CAPs) are required from Contractors not achieving minimum performance standards. This approach has resulted in a positive trend overall in performance measure rates and a positive impact for AHCCCS members. In order to make the CAP process more robust, AHCCCS requires Contractors to evaluate, at least annually, each corrective action and to determine whether it effectively improves performance. The Agency determines whether Contractors evaluate the effectiveness of these corrective actions during annual site visits.

AHCCCS provides various incentives and technical assistance, and may impose sanctions if improvement is not achieved. Sanctions include, but are not limited to, financial and enrollment-related measures. An example of an incentive is an increase in the auto-assignment algorithm for Contractors who demonstrate improved quality of care in specific performance measures. Contractor sanctions are also posted to the AHCCCS web site as a mechanism to improve performance and comply with transparency initiatives.

5) Sharing Best Practices

AHCCCS regularly shares best practices 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 quarterly AHCCCS Contractor Quality Management meetings.

c. Including Medical Quality Assessment and Performance Improvement Requirements in the AHCCCS Contracts

AHCCCS includes all federally required elements in the contracts and monitors them accordingly.

d. 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:

1) Annual On-Site Operational and Financial Reviews

AHCCCS conducts administrative Operational and Financial Reviews (OFRs) of each Contractor. During an OFR, Agency staff from the Division of Health Care Management (DHCM), the Office of Administrative and Legal Services (OALS), the Division of Business and Finance (DBF), and the Office of Inspector General observes the operations of Contractor personnel, interview key staff and review documentation.

AHCCCS utilizes the OFR process to meet the requirements of the Medicaid Managed Care Regulations (42 CFR 438.364), and to determine the extent to which

- each Contractor meets the AHCCCS contract requirements, AHCCCS policies, and additional federal and state requirements. AHCCCS also uses the OFR to increase its knowledge of each Contractor's operational and financial procedures, provide technical assistance and identify areas for improvement and areas of noteworthy performance and accomplishment. Additionally, the AHCCCS Administrative staff reviews the progress in implementing the recommendations made during prior OFRs, determines each Contractor's compliance with its own policies and procedures and evaluates its effectiveness.
- 2) Ongoing Review and Analysis of Plans, Evaluations, and Reports (refer to Section II for more detail), Including, but not Limited to:
 - a) Case Management Plan
 - b) Cultural Competency Evaluation
 - c) Enrollee Appeal and Provider Claim Dispute Report
 - d) Enrollee Grievance Report
 - e) Early and Periodic Screening Diagnosis and Treatment (EPSDT) Plan
 - f) Maternity Plan
 - g) Medical Management Plan and Evaluation
 - h) Member / Provider Council Plan
 - i) Network Development and Management Plan
 - j) Quality Management Plan and Evaluation
 - k) Quality Management Quarterly Reports
 - l) Credentialing Quarterly Reports
 - m) Service gap reports for Attendant Care, Personal Care, Housekeeping and Respite Care
 - 3) Review and Analysis of Program-Specific Performance Measures and Performance Improvement Projects

On a regular basis, AHCCCS reviews results by Contractor for the quality management performance measures. Results are compared with minimum performance standards specified in contract, and trends are identified. Results of measurements for performance improvement projects also are reviewed and analyzed by Contractor. Appropriate action, such as requiring Contractors to implement

corrective action plans and/or providing technical assistance to Contractors, is taken dependent on findings.

4) Meetings and Staffings

- a) AHCCCS holds semi-annual meetings with Contractors with representation from DHCM administration, operations, finance, quality management, medical management, and encounters to review Contractor performance and discuss identified trends. These meetings also provide for open discussion and serve as opportunities for AHCCCS to offer technical assistance in areas with which a Contractor may be struggling.
 - b) The DHCM, OALS and Division of Member Services meet quarterly to share and discuss the performance of the Managed Care Organizations. Areas of review include member services, claims, encounters, quality management, grievance and appeals, medical management, finance and overall operational performance. These meetings afford AHCCCS an opportunity to identify individual trends and trends that cross Contractors.
- e. Maintaining an Information System that Supports Initial and Ongoing Operations and Review of the Established Quality Strategy

AHCCCS uses a statewide, automated managed care data system to support the processing, reporting, research and project needs of the Agency and its Contractors.

AHCCCS performs extensive data validation of managed care data. Records of services provided, known as encounter data, are submitted to the Agency for all covered services including institutional, professional, dental, and medication/pharmacy services, in standard HIPAA and NCPDP formats, and are subject to extensive data standards and data quality editing. AHCCCS also performs annual validation studies on Contractor encounter data to ensure that the data has been reported in a timely manner, and is accurate and complete. In 2005, the Agency established a “data warehouse,” known as the AHCCCS Data Decision Support System (ADDS), which provides a timely and flexible way to monitor performance measure data. Utilization data may be reviewed by multiple characteristics such as diagnosis, service, age, gender or another characteristic type based on the area under consideration.

- f. 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. New projects and/or strategies may evolve from current ones. Success with improvements and outcomes is monitored over time for sustainability prior to retiring projects. The process repeats itself for the development of new studies, which are followed by interventions to improve the health and well-being of AHCCCS members.

g. Public Involvement

For the original document, as well as any subsequent substantive changes to the Quality Strategy, the Agency solicits input from the Director's State Medicaid Advisory Committee (SMAC). The Committee includes the Director of AHCCCS; representation from the American Indian community; AHCCCS members; senior, disabled, and child advocacy communities; nursing facility and home and community based services advocates; the medical community (physicians); the Arizona Department of Health Services (ADHS); and the Arizona Department of Economic Security (DES). SMAC holds open meetings that are regularly attended by citizens, in addition to council members.

h. Frequent Strategy Evaluation

In an effort to maintain a commitment to continuous improvement, the Quality Strategy document is reviewed annually and/or when a significant change occurs. Corresponding changes to Agency documents such as policy manuals and contracts are made as appropriate. A significant change is defined as any change to the Quality Strategy that may reasonably be foreseen to materially affect the delivery or measurement of the quality of health care services.

B. Quality Strategy Objectives

The AHCCCS quality strategy objectives (Continuous Quality Improvement and Performance Measures) are a component of the Agency's overall Five Year Strategic Plan. The AHCCCS Five Year Strategic Plan provides a high level view of the Agency's quality strategies which are further developed, implemented and reviewed for effectiveness regarding member health outcomes.

1. Quality Strategy Scope

Quality Strategies are formulated to include:

- a. AHCCCS Managed Care members in the acute, long-term care, Children's Rehabilitative Services and behavioral health programs.
- b. Aspects of care including: coordination, accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by AHCCCS.
- c. Aspects of Contractor performance relating to access to care, quality of care and service, including, but not limited to: disease management, preventive care, health promotion, patient care planning, network contracting (includes professional and paraprofessional workforce development), credentialing and grievance systems.
- d. Professional and institutional care in any setting, including inpatient and outpatient, in-home and alternative settings.
- e. Professional and paraprofessional providers and any other delegated or subcontracted provider types such as providers of transportation or durable medical equipment.
- f. Aspects of Contractors' internal administrative processes that are related to service and quality of care. This includes member services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information systems and quality improvement.

2. Quality Strategy Goals and Objectives

AHCCCS requires that the quality of health care and services it provides be transparent to its members, the community and its funders. AHCCCS has developed quality initiatives and strategies for evidence-based outcomes that:

- a. Reward quality of care, member safety and member satisfaction outcomes;
- b. Support best practices in disease management and chronic care;

- c. Provide feedback on quality and outcomes to Contractors and providers; and
- d. Provide comparative information to consumers.

AHCCCS has adopted the following tenets as part of its quality strategy goals:

- a. Enhance current performance measures and performance improvement projects and best practices activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS programs that serves as a roadmap for driving the improvement of member-centered outcomes. Objectives include the continued use of:
 - 1) Nationally recognized protocols, standards of care, and benchmarks; and
 - 2) The practice of collaborating with Contractors to reward providers based on clinical best practices and outcomes (as funding allows).
- b. Build upon prevention efforts and health maintenance/management to improve AHCCCS members' health status through targeted medical management by:
 - 1) Emphasizing disease and chronic care management,
 - 2) Improving functionality in activities of daily living,
 - 3) Planning patient care for the special needs population,
 - 4) Identifying and sharing best practices, and
 - 5) Exploring Centers of Excellence
- c. Develop collaborative strategies and initiatives with state agencies and other external partners. Objectives include continuing use of:
 - 1) Strategic partnerships to improve access to health care services and affordable health care coverage,
 - 2) Collaboration with Contractors and providers on best practices in disease prevention and health maintenance,
 - 3) Partnerships with sister agencies, Contractors and providers to educate Arizonans on health issues,
 - 4) Effective medical management of at risk and vulnerable populations, and
 - 5) Capacity building in rural and underserved areas to address both professional and paraprofessional shortages.

- d. Enhance customer service and improve information retrieval and reporting capability by establishing new and upgrading existing information technologies and thereby increasing responsiveness and productivity. Objectives include:
- 1) Continuing to work with state and federal partners to support the creation of a single health information exchange. AHCCCS participates in planning sessions hosted by Arizona Strategic Enterprise Technology (ASET) in conjunction with Health-e Arizona for the development and implementation of Arizona's Health Information Exchange (HIE). Through the federal stimulus package known as the Health Information Technology for Economic and Clinical Health ("HITECH") Act, funds are available for eligible providers (EPs) and hospitals (EHs) to receive incentive payments for adopting and using certified electronic health records (EHRs). EPs and EHs receive payments when they Adopt, Implement, or Upgrade (AIU) EHRs and are then eligible to receive payments for up to five years for meaningful use of their EHRs. Once providers have the EHRs, they will be better positioned to perform electronic reporting of quality measures, e-prescribing, patient education, and more timely assessments of patients.

The Agency recently received approval from CMS to proceed with planning efforts that will support the administration of the incentive program and the State Medicaid Health Information Technology (HIT) Plan. Arizona has successfully launched its portal for AIU attestation and first year payments are distributed monthly. The MU portal is being developed and on track to accept EP and EH attestations beginning in October 2012.

- 2) Continuing participation in "Arizona Health Query" Along with other major providers of health care in Arizona, AHCCCS is a partner in an unprecedented health data system that aggregates and analyzes essential, comprehensive health information for residents of Arizona. Arizona Health Query tracks individuals across systems over time.
- 3) Continuing enhancement of the AHCCCS data sharing warehouse system in order to enable the end-users quick access to AHCCCS data for a variety of quality and medical management studies.

The full AHCCCS Five Year Strategic Plan is available at
<http://www.azahcccs.gov/reporting/PoliciesPlans/strategicplan.aspx>

3. Quality Strategy Progress

Current analysis, progress and results of current and on going performance measures, performance improvement projects and initiatives may be found by accessing the "AHCCCS Reports" and "Initiative" sections noted in the Preface. Additionally, Section II, ASSESSMENT, describes AHCCCS quality activities including process and examples of results. AHCCCS strives for optimal member health outcomes and member satisfaction as demonstrated by the following examples.

a. Performance Measures

AHCCCS was among the first to utilize Healthcare Effectiveness Data and Information Set (HEDIS®) measures or HEDIS®-like measures for Medicaid managed care. Minimum Performance Standards are based on the most recent national National Committee for Quality Assurance (NCQA) HEDIS Medicaid means available. If the Medicaid mean for any measure is met, the Minimum Performance Standards (MPS) is based on a target to narrow the gap between the current AHCCCS statewide mean and a national goal such as Healthy People 2020.

Performance Measures are required for all member populations, but AHCCCS may analyze and report results by line of business/program, Geographic Services Area (GSA) or county, and/or applicable demographic factors to identify opportunities for improvement. For example, rates for several child and adolescent members are analyzed and reported separately for Medicaid and KidsCare members, and further stratified by race/ethnicity.

This system has helped achieve a high level of overall performance in several areas of preventive health, as measured by HEDIS® specifications. For example, the overall average of AHCCCS Contractors for annual dental visits by children and adolescents is in the top ten percent of Medicaid health plans nationally. Other measures in which the AHCCCS program outperforms the national average for Medicaid health plans are well-child visits in the first 15 months of life, appropriate medications for asthma and almost all KidsCare measures.

AHCCCS continues to explore new ways to drive further improvements in performance, including incentives for members, providers and potential Contractors. The Agency also continues to raise expectations for Contractor performance; for example, by increasing Minimum Performance Standards, enforcing corrective action plans, and implementing sanctions to ensure that members receive preventive health care services.

b. Performance Improvement Projects

The Agency has a well-developed process for identifying and conducting projects to improve performance in key areas of clinical care and non-clinical services that affect health outcomes and enrollee satisfaction. PIPs may be focused on specific populations or programs. To identify more specific opportunities for improvement, members may also be stratified by line of business/program, GSA or county, and/or applicable demographic factors.

In 2008, AHCCCS implemented a Performance Improvement Project (PIP) to improve the use of Advance Directives among ALTCS members, as documented in their health records. By documenting one's wishes for end-of-life care, it is assured that families and physicians are aware of the treatment that a member does or does not want when that person is no longer able to make those wishes known. Baseline data indicated that 41.8

percent of Elderly and Physically Disabled (E/PD) members had an advance directive. At the PIP's conclusion in 2011, data indicated a statistically significant increase to 64.7 percent of E/PD members having a documented Advance Directive. AHCCCS has also initiated PIPs to decrease the number of influenza vaccine refusals, reduce hospital readmissions, improve adolescent well care, use of electronic health records for the CRS population, and coordination of care between DBHS and Acute-care Contractors.

c. Spouse as Paid Caregiver

To continue expansion of the Home and Community Based Services (HCBS) network within ALTCS and allow more choice for ALTCS members, AHCCCS requested and received a waiver from CMS to allow members to select their spouse to be their paid caregiver. The Spouse as Paid Caregiver Policy became effective in October, 2007. In Contract Year 2011, approximately 969 members received paid services from their spouse. Allowing the spouse to be a paid caregiver has also expanded the availability of caregivers for other members by making non-spouse caregivers available to other HCBS members.

d. Self Directed Attendant Care (SDAC)

Consumers and advocates requested that AHCCCS develop a Self Directed Attendant Care Program to allow members to have more control and management of their needs. Led by an ALTCS Program Contractor, the development work teams have included members, providers, advocates and AHCCCS Contractors. Self Directed Attendant Care encourages members to make decisions that will more likely result in positive outcomes. Stakeholder input has been an integral part of the planning and development of Self Directed Attendant Care. The SDAC Program was implemented as of 8/1/2008. In Contract Year 2011, approximately 230 ALTCS members utilized this service.

e. Collaborative Oversight of Nursing Facilities

AHCCCS has worked with ALTCS Contractors to coordinate the monitoring and oversight of nursing facilities and Assisted Living Homes/Facilities throughout Arizona. This process has reduced the burden on these provider types by reducing the number of AHCCCS Contractors scheduling and conducting quality management reviews allowing them more time for member care and quality improvement activities. In addition, this process has freed time for Contractor resources to evaluate and improve monitoring and oversight of the home and community based program, much of which has far less state licensure oversight.

f. AHCCCS Data Decision Support System

In 2005, the Agency implemented a "data warehouse," known as the AHCCCS Data Decision Support System (ADDS), which provides a timely and flexible way to monitor performance measure data, run specialized queries and analyze utilization data by multiple characteristics including type of treatment, provider, diagnosis. When ADDS

was developed, the Agency incorporated HEDIS® measures, including many that had not been previously used, into the data warehouse. There are now more than 100 separate measures, ranging from Adolescent Well Care Visits to Use of Imaging Studies for Low Back Pain that can be selected to monitor and improve quality. Results for these measures can be analyzed by individual Contractor, geographic area, race/ethnicity, and specific beneficiary categories. This allows the Agency and its Contractors to target efforts where improvement is needed and likely to be most beneficial.

g. Health Information Technology

Congress passed the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program in the American Recovery and Reinvestment Act of 2009 (ARRA). The intent of the Incentive Program is focused on providing financial incentives to providers to transition to and meaningfully use E.H.R. systems. More recent CMS initiatives are aimed at expediting the health care system transition to meaningful use of certified electronic health records. In addition to the incentive payments, CMS will begin phasing in penalties for Medicare providers who fail to show meaningful use beginning in 2015.

AHCCCS has extensive experience in data collection and reporting, beginning with implementation in 1993 of clinical quality measures which closely mirrored the later released National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS). Over the last 15 years, AHCCCS has demonstrated significant improvements in quality measures of primary and preventive services, such as well-child visits and children's dental services, due to a systematic oversight process that includes close monitoring of contracted health plans, setting minimum contractual standards, requiring health plans to implement to implement corrective actions and possible financial sanctions when minimum standards are not met, and conducting quality improvement projects.

The health care system is also changing in relation to how it measures quality. What has been utilized as traditional data sources and methodologies are no longer enough. Data sources and processes to fully achieve the next level in clinical outcomes, service and satisfaction measures are being determined. Processes to drive the system to the next level are progressing including efforts focused on:

- Greater adoption by providers of certified HER technology
- Implementation of the Meaningful Use incentive payment program, including greater public health standards and connectivity requirements
- Participation in health information exchanges
- And greater health home, medical home and patient centered medical home models of care

AHCCCS supports the adoption of certified EHR Systems as a tool to improve efficiency and effectiveness of patient data collection, clinical decision support and to support the availability of accurate and reliable data for the purposes of outcomes measurement. A well designed and implemented EHR system can create administrative efficiencies,

improve care coordination for patients and may result in improved clinical outcomes and patient satisfaction. AHCCCS views the EHR Incentive Program as an opportunity to leverage processes currently underway. There should be a critical evaluation of the Meaningful Use Clinical Quality Measures as potential system quality and performance measures system wide. Linkages should also be made, whenever possible, to requirements necessary to meet the quality requirements under the Affordable Care Act (ACA), and to support CMS efforts to implement the quality Core Measure Sets. Other activities must also be aligned such as 5010 and ICD-10 which provide an opportunity to create additional efficiencies and may result in the ability to capture more detailed data, from claims/encounters or through EHR utilization.

Measure sets under development and being implemented by CMS support the need for adoption of electronic health records and electronic data exchange capabilities. This quality measure set transition is anticipated to result in efficiencies and the availability of data/information that sets the stage to transform care practices, improve individual patient outcomes and population health management including:

- improved health care outcomes
- improved patient satisfaction
- increased efficiencies
- reduced costs

AHCCCS is supportive of activities that facilitate and incentivize Medicaid and Medicare providers to adopt and meaningfully use EHRs to improve quality and efficiency of health care, with the ultimate goal of better health outcomes. Such a program that assists providers in this manner is particularly important to improving the delivery of health care in a state like Arizona, in which most areas are classified as frontier and rural, and providers serving these areas often have limited access to HIT resources.

In more than two decades of leading successful quality improvement efforts, AHCCCS has demonstrated that meaningful improvement within the context of rational resource use is only achievable when objectives and measures of improvement are limited and based on strong evidence to support better health outcomes. The number and complexity of the measures proposed will continue to challenge providers who qualify for incentive payments; many providers may have to expand their resources in efforts to meaningfully use information from EHRs with significant expectations remaining in the proposed rule. Any opportunity to further limit or align quality expectations across government programs should be considered. If eligible hospitals and eligible providers are able to achieve improvement in a limited number of measures, rather than being over burdened with reporting and improvement expectations, providers are more likely to adopt and meaningfully use EHRs in their practices and facilities.

Widespread, meaningful use of EHRs by primary care practitioners (PCPs) is vital to improving the health care system; however, the ability to capture and share clinical information between primary care providers and others involved in a patient's care is critical to coordinating care, reducing duplication of services and achieving the best possible health outcomes.

CMS continues to have the ability to align meaningful use measures with other developing measure sets, such as the CHIP Core Measures, CMS comprehensive well care measures, measures for Medicare and Duals. Rather than continuing the fractured approach to quality measurement of the health care system, AHCCCS is encouraged to see more alignment of Meaningful Use measures with those established measures focused on measuring access, availability and outcomes of the health care system. Adding more measures and more complexity will not drive as much improvement in the health care system as focusing and aligning efforts in specific areas where there are opportunities to achieve quality improvement and cost savings. Including too many measures may act as a disincentive and result in fewer providers participating in the program.

SECTION II: ASSESSMENT

The following are key areas related to assessment which the Balanced Budget Act of 1997 (BBA) regulations designate as required components of the Agency's overall Quality Strategy. The subject of each segment is followed by its relevant federal citation as a reference.

A. Quality and Appropriateness of Care

1. State Assessment of Quality and Appropriateness of Care/Services for Routine and Special Health Care Needs Members [42 CFR 438.204(b)(1) & 438.208(c)(1)(i)]

AHCCCS monitors quality and appropriateness of care/services for routine and special health care needs members through annual Operational & Financial Reviews of Contractors and the review of required Contractor deliverables set forth in contract, program specific performance measures, and performance improvement projects.

Members with special health care needs are those members who have serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally. A member will be considered as having special health care needs if the medical condition simultaneously meets the following criteria:

- a. Lasts or is expected to last one year or longer, and
- b. Requires ongoing care not generally provided by a primary care provider.

AHCCCS has determined that the following populations meet this definition:

- a. Acute care:
 - 1) Members who are recipients of services provided through the Children's Rehabilitative Services (CRS) program,
 - 2) Members who are recipients of services provided through the Arizona Department of Health Services Division of Behavioral Health contracted Regional Behavioral Health Authorities (RBHAs), and
 - 3) Members diagnosed with HIV/AIDS.
- b. Arizona Long Term Care System (ALTCS):
 - 1) Members enrolled in the ALTCS program who are elderly and/or physically disabled, and
 - 2) Members enrolled in the ALTCS program who are developmentally disabled.

Contractors may also choose to identify any members with special health care needs, challenging members or any other members who they determine meet the definition.

As previously noted, AHCCCS utilizes a variety of modalities to implement quality-based projects and initiatives, monitor and support ongoing activities, as well as provide technical expertise. The following are examples of activities in each of the assessment areas.

a. Operational and Financial Reviews (OFR)

AHCCCS conducts administrative Operational and Financial Reviews (OFRs) of each Contractor. During an OFR, Agency staff from the Division of Health Care Management (DHCM), the Office of Administrative and Legal Services, the Division of Business and Finance, and the Office of Inspector General interview key staff and review documentation.

AHCCCS utilizes the OFR process to meet the requirements of the Medicaid Managed Care Regulations (42 CFR 438.364), and to determine the extent to which each Contractor meets the AHCCCS contract requirements, AHCCCS policies, and additional federal and state regulations. AHCCCS also uses the OFR to increase its knowledge of each Contractor's operational and financial procedures, provide technical assistance and identify areas for improvement and areas of noteworthy performance and accomplishment. Additionally, AHCCCS staff reviews the progress in implementing the recommendations made during prior OFRs and determines each Contractor's compliance with its own policies and procedures as well as evaluates its effectiveness.

To maintain compliance with BBA requirements and AHCCCS contract standards, AHCCCS reviews the following areas at least every three years:

- 1) Behavioral Health
- 2) Case Management
- 3) Claims System
- 4) Corporate Compliance
- 5) Cultural Competency
- 6) Delegated Agreements
- 7) Delivery System
- 8) General Administration
- 9) Grievance System

10) Maternal and Child Health

11) Medical Management

12) Quality Management

13) Reinsurance

14) Third Party Liability

AHCCCS has chosen to review some areas more frequently, sometimes annually. A variety of factors could initiate an increase in frequency (e.g. new requirements, compliance concerns, specific areas of interest).

b. Contractor Periodic Reporting Requirements (Deliverables)

Required contract deliverables include, but are not limited to:

1) Case Management Plan (annually)

2) Cultural Competency Evaluation (annually)

3) Enrollee Appeal and Provider Claim Dispute Report (quarterly)

4) Enrollee Grievance Report (quarterly)

5) Early Periodic Screening Diagnosis and Treatment (EPSDT) Plan (including dental) (annually)

6) EPSDT Progress Report (including dental) (quarterly)

7) Maternity Plan (annually)

8) Medical Management Plan and Evaluation (annually)

9) Member / Provider Council Plan (annually)

10) Network Development and Management Plan (annually)

11) Quality Management Plan and Evaluation (annually)

12) Quality Management Reports (quarterly)

13) Service Gaps for Attendant Care, Personal Care, Housekeeping and Respite Care (Biannually)

AHCCCS reviews, provides feedback and technical assistance, and approves the various plans as appropriate. For example, annually, Contractors submit their 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. Clinical Quality Management (CQM) coordinates this review with other units in the division. On December 15th of each year, DHCM receives annual plans from most Contractors, and, with other units, reviews them to ensure compliance with AHCCCS and BBA requirements. Quarterly Reports are reviewed and analyzed with follow-up action taken as appropriate.

c. Performance Measures

Historically, the Agency used the HEDIS[®] to develop, collect and report data for most Performance measures; most results reported were indicators of members' use of services, rather than absolute rates for how successfully AHCCCS and/or its Contractors provided care. AHCCCS is currently taking advantage of a unique opportunity to transition its Performance Measure requirements for all lines of business to align with clinical, outcome, and satisfaction measures that are being implemented by CMS. Although HEDIS[®] measures are reasonable indicators of health care accessibility, availability and quality, thoughts on what is important to measure and how to measure have evolved and become more sophisticated. Focus has shifted from the importance of access to an office visit to the actual content of the visit: treatment of specific conditions, evidence based care, care coordination, care outcomes and patient safety.

Transitioning the AHCCCS Performance Measure sets will also support the health care communities' need for adoption of electronic health records (EHRs) and electronic data exchange capabilities. The health care system is changing in relation to how it measures quality. Traditional data sources such as claims, encounters and medical chart reviews are no longer enough. The CMS Core Measures include methodologies that utilize data sources and data collection processes that are not yet fully developed or implemented but are progressing at a rapid rate. With this in mind, the transition is anticipated to result in greater availability of data/information that will allow for:

- increased efficiencies,
- improved health care outcomes, including patient-specific outcomes,
- improved patient satisfaction,
- greater population health management capabilities and
- reduced costs.

This transition will be an incremental approach in order to provide needed flexibility for the methodologies as not all expected technologies/data sources (EHRs, the Health Information Exchange (HIE), ICD-10, etc.) are currently operational. Each methodology will outline current measurement practices as well as expected practices once the data sources are in place.

Each measure will continue to have a Minimum Performance Standard (MPS) and goal. If a MPS is not achieved, Contractors are required to develop and submit a corrective action plans with interventions that will assist them in meeting the MPS Performance measure requirements are explicit in contract. Contracts and amendments are located on the AHCCCS website.

AHCCCS utilizes several methods to encourage improvements in performance measure rates. In 2003, the Agency began posting aggregate results of performance measures on the AHCCCS website. Website postings include Contractors' individual performance measure rates. These postings provide an incentive for Contractors to improve their rates. AHCCCS also utilizes corrective action plans and/or sanctions to improve rates when MPS' are not met. Contractors not meeting the MPS for a specific performance measure must develop and implement interventions focused on improving the rate at which members receive recommended services and must evaluate the effectiveness of corrective actions at least annually. This approach has resulted in a positive trend overall in performance measure rates.

d. Performance Improvement Projects

AHCCCS Performance Improvement Projects (PIPs) are going through a revision process similar to that of the Performance Measures; please see above for additional details. AHCCCS considers a PIP to be a planned process of data gathering, evaluation, and analysis to design and implement interventions or activities that are anticipated to have a positive outcome. PIPs are designed to improve the quality of care and service delivery and include:

- 1) Identifying areas for improvement,
- 2) Gathering baseline data from administrative data and other sources,
- 3) Designing and implementing interventions,
- 4) Measuring the impact of the intervention, and
- 5) Maintaining/sustaining that improvement.

The Agency may require its Contractors to submit a PIP proposal with its Quality Management Plan. For self-selected PIPs, Contractors are required to submit annual PIP milestone reports as well as final reports. The improvement strategy must include, at a minimum, identification of the team that will address the problem, a root cause analysis, identification of interventions that will be implemented, and a proposed timeline.

AHCCCS also mandates a number of Agency-specified PIPs. Contractors are required to participate; PIPs may vary by contract type. For example, the required PIP for Acute-care Contractors may not be the same as that for long-term care Contractors. Current PIPs underway include reducing influenza immunization refusal rates, reducing avoidable

hospital readmission rates, improving adolescent well care visit rates, improving coordinator of care efforts between the Regional Behavioral Health Authorities (RBHAs) and Acute-care Contractors, improving the use of advance directives, and increasing the use of electronic health records for the CRS population.

Under a dental PIP that concluded in 2008, the rate of dental visits among Medicaid and Children's Health Insurance Plan (CHIP)-eligible children enrolled with Acute-care Contractors improved significantly, from a baseline of 52.2 percent to 65.4 percent in a five-year period. The rate of members enrolled with the Division of Developmental Disabilities also showed significant improvement, from 30.9 percent to 39.9 percent, under the PIP. AHCCCS provides significant monitoring and oversight of performance measures and engages in relationships with external entities for partnering opportunities. As a result of these activities, Arizona was named a Best Practice State for Oral Health in Medicaid for 2010.

After baseline rates for each Contractor are established and interventions to improve performance have been implemented, the Agency and/or the Contractors will remeasure performance for at least two years to achieve the BBA required "sustained improvement." PIPs take a minimum of four years to complete; if a Contractor's performance improves as a result of interventions, the PIP can be closed after the second remeasurement.

2. Arrangement for Annual External Performance Review [42 CFR 438.204(d)]

The Agency conducts most of the activities of the Quality Strategy in-house. There are a limited number of Performance Improvement Projects and performance measurement processes conducted directly by an External Quality Review Organization (EQRO). For purposes of BBA compliance, AHCCCS contracts with EQROs to review the quality monitoring activities of AHCCCS and write an independent report regarding each AHCCCS Contractor. These reports identify areas of strength and areas requiring improvement by the Contractor. EQR reports are a driving force in assessing the effectiveness of the Quality Strategy document.

3. State Procedures for Identifying Race, Ethnicity, and Primary Language of Each Member [42 CFR 438.204(b)(2)]

AHCCCS receives the member's race and ethnicity, and primary language information from the eligibility source, which collects this information at the time of application. This information is systematically updated on the AHCCCS member record file and transmitted daily to the Contractor on the member enrollment roster. Changes to this information are also updated and transmitted to the Contractor.

Contractors are responsible for providing any updated information to AHCCCS that differs from the initial documentation provided for each member. AHCCCS updates the member information as appropriate. This information is included on the data exchange file received from the Social Security Administration. If any information is missing, the system will

default to unknown or unspecified. AHCCCS continues to evaluate this area and establish other procedures as necessary.

AHCCCS has identified seven race and ethnicity categories as follows:

- a. Asian/Pacific Islander
- b. Black
- c. Cuban/Haitian
- d. Caucasian/White
- e. Hispanic
- f. Native American
- g. Unknown/Unspecified
- h. Other

If the member does not provide or does not wish to provide this information, he will be designated as unknown/unspecified.

Currently there are codes for 40 languages that can be captured electronically. AHCCCS periodically assesses the language data to determine any need to expand the possible language categories. To date, the prevalent languages in the AHCCCS population are English and Spanish.

B.(1) Managed Care Organization/Prepaid Inpatient Health Plan (MCO/PIHP) Requirements

AHCCCS MCOs and PIHPs are required as specified in contract, Section D and Attachment H, as well as in the AHCCCS Member Information Policy, to provide members with information including, but not limited to, the following: covered services, how to obtain services, how to choose a provider, their rights with respect to grievances and state fair hearings, prior authorization, advance directives, what constitutes an emergency, language and cultural competency requirements, and the member's financial responsibilities.

1. State Standards at Least as Stringent as Those in Sub-Part D for: Access to Care, Structure and Operations, and Quality Measurement and Improvement [42 CFR 438.204(g)]

The contracts between AHCCCS and its MCOs and PIHPs define the standards for access, structure and operations, and quality measurement and improvement. The AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractors Operations Manual (ACOM), as well as other AHCCCS policies and manuals, are incorporated by reference as part of the MCO/PIHP contracts and provide more detailed standards information and requirements.

2. Enrollee Information (Medicaid 42 CFR 438.218 & 438.10) (SCHIP 42 CFR 457.110)

42 CFR 438.10 and 42 CFR 457.110 set forth the requirements for both AHCCCS and its Contractors regarding the dissemination of information to enrollees. In addition to the information specified in Section II (A) (3) of this text, AHCCCS processes also ensure that:

- a. The application for AHCCCS Health Insurance (AHI) complies with all BBA requirements concerning potential enrollees. When an application form other than the AHI application is used, a supplementary stand-alone document is included with the application. The stand-alone document complies with all of the BBA and pre-enrollment requirements, and is given or mailed to the applicants at the time of their application.
- b. The eligibility staff has access to the provider listing by Contractor for their Geographic Service Area (GSA) and will share the Contractor's websites with the applicant.
- c. Vital documents are available in Spanish. Spanish is currently the only prevalent non-English language in Arizona. Bilingual staff is available in key areas, and AHCCCS has a contract with *Language Line Services* to facilitate oral interpretation of other languages. When necessary, additional communication accommodations are provided for applicants who have visual, auditory, and/or other impairments.

AHCCCS also provides links to the AHCCCS Contractors' web sites. This enables applicants to view the Contractor networks from the AHCCCS Web site.

3. Information System that Supports Initial and Ongoing Operations and Review of Established Quality Strategy [42 CFR 438.204(f)]

AHCCCS has mechanisms in place to ensure that its Contractors maintain information systems that collect, analyze, integrate, and report data, and can achieve the objectives of the AHCCCS program. Contractors are required to maintain claims processing and management information mechanisms sufficient to support provider payments and data reporting between themselves and AHCCCS. Contractors must also collect service-specific procedures and diagnosis data, encounters, and maintain detailed records of remittances to providers. AHCCCS assesses data accuracy and completeness.

AHCCCS uses a statewide, automated managed care data system to meet the processing and reporting needs of the MCOs and PIHPs. The system is known as the Prepaid Medical Management Information System (PMMIS). It is composed of eleven core subsystems, five reporting and quality oversight subsystems, and a security subsystem. PMMIS has extensive information retrieval and reporting capabilities to satisfy the data needs of the Agency, CMS, other state and federal agencies, counties, Contractors, providers and members. The system processes Contractor encounters for all AHCCCS members and supports the monitoring of service utilization, quality of care, and program expenditures. PMMIS is a mature system that has been modified over time to accommodate the growing and changing needs of the AHCCCS program.

In 2005, the Agency implemented a “data warehouse,” known as the AHCCCS Data Decision Support System (ADDS), which utilizes data loaded from the PMMIS to provide a timely and flexible way to collect and analyze a variety of data overall and by individual Contractor. These data include performance measures, utilization data (including the ability to conduct analyses by type of treatment or provider), recipient enrollment and demographic information, and specialized queries. When ADDS was developed, the Agency incorporated HEDIS® measures, including many that had not been previously used by AHCCCS, into the data warehouse. There are now more than 100 separate measures, ranging from Adolescent Well Care Visits to Use of Imaging Studies for Low Back Pain that can be selected to monitor and improve quality. Results for these measures can be analyzed by individual Contractor, geographic area, race/ethnicity, and specific beneficiary categories. This allows the Agency and its Contractors to target efforts where improvement is needed and likely to be most beneficial. ADDS data for performance measures is compared with performance measure data reported by Contractors to identify trends and potential completeness or reliability discrepancies.

B.(2) MCO/PIHP Contractual Compliance

1. State Standards at Least as Stringent as Those in Sub-part D for: Access to Care, Structure and Operations, and Quality Measurement and Improvement [42 CFR 438.204(g)]

The contracts between AHCCCS and its MCOs and PIHPs describe the Agency's standards for access, structure and operations, and quality measurement and improvement. Refer to the contracts link and review Section D. The AHCCCS Medical Policy Manual (AMPM), and the AHCCCS Contractors Operations Manual, as well as other AHCCCS policies and manuals, are incorporated by reference as part of the MCO/PIHP contracts and provide more detailed information on standards requirements.

2. State Verification that Sub-Part D Provisions of the BBA Regulations Are Included in Medicaid Contract Provisions [42 CFR 438.204(a)]

AHCCCS incorporates into its MCO (Health Plans & Program Contractors) and PIHP (ADHS/DBHS & CRS) contracts the Sub-Part D provisions, which include standards for:

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

3. Regular State Monitoring and Evaluation of MCO and PIHP Compliance [42 CFR 438.204(b)(3) & 438.416]

AHCCCS monitors and evaluates Contractor compliance through Operational and Financial Reviews (OFR), the review and analysis of periodic reports as required in the contract, program specific Performance Measures, and Performance Improvement Projects. In addition to the information provided in Section II (A) (1), the following is a description of the broad spectrum of the OFR. In order to ensure a Contractor's operational and financial program compliance with its AHCCCS contract, the Agency's review team:

- a. Determines if the Contractor satisfactorily meets AHCCCS requirements as specified in contract, policy and federal/state regulations,
- b. Reviews the Contractor's progress toward implementing the recommendations made during the previous review,
- c. Reviews outcomes of interventions for Performance Measures and Performance Improvement Projects,
- d. Reviews records of appeals for timeliness and appropriateness,

- e. Determines if the Contractor is in compliance with its own policies and procedures, and evaluates the effectiveness of those policies and procedures,
- f. Provides technical assistance,
- g. Identifies areas which could be improved, as well as identifying areas of noteworthy performance and accomplishment,
- h. Conducts interviews or group conferences with members of the Contractor's administrative staff, and
- i. Examines the Contractors' records, books, reports, and information systems, and/or those of any management company as necessary.

As a condition of its 1115 Waiver, AHCCCS performs extensive data validation. Known as encounter data, records of services provided are submitted to the Agency for all covered services including institutional, professional, dental, and medication/pharmacy services, with each having its own format. AHCCCS also performs annual validation studies on Contractor data to ensure that the data has been reported in a timely manner, is accurate, and complete. Since sanctions may be imposed on the Contractor, based on the results of the data validation studies, the Agency provides technical assistance and training to the Contractors to support the Contractor's ability to meet AHCCCS requirements. OFR and data validation results are reported to CMS in accordance with the 1115 Waiver Terms and Conditions.

Through its collaboration with the CMS, AHCCCS maintains a "checklist for managed care contract approval." This checklist provides detailed explanations of standards and indicates where standards are located in the contract.

4. For MCOs, Intermediate Sanctions that Meet the Requirements of Sub-Part I [42 CFR 438.204(e)]

AHCCCS may impose monetary sanctions, and/or suspend, deny, refuse to renew, or terminate a contract or any related subcontracts in accordance with Arizona Administrative Code, R9-22-606, and the terms of the contract and applicable Federal or State regulations. Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for the sanction, and either the length of suspension or the amount of capitation prepayment to be withheld. The Contractor may appeal the decision to impose a sanction in accordance with 9 A.A.C. 34. Intermediate sanctions may be imposed for, but are not limited to the following actions:

- a. Substantial failure to provide medically necessary services that the Contractor is required to provide, under the terms of its AHCCCS contract, to its enrolled members,
- b. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver,
- c. Discrimination among members on the basis of their health status or need for health care services,

- d. Misrepresentation or falsification of information furnished to CMS or AHCCCS,
- e. Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider,
- f. Failure to comply with the requirement for physician incentive plan as delineated in contract,
- g. Distribution directly, or indirectly, through any agent or independent contractor, of marketing materials that have not been approved by AHCCCS or that contain false or materially misleading information,
- h. Failure to meet AHCCCS Financial Viability Standards,
- i. Material deficiencies in the Contractor's provider network,
- j. Failure to meet quality of care and quality management requirements,
- k. Failure to meet AHCCCS encounter standards,
- l. Violation of other applicable state or federal laws or regulations,
- m. Failure to fund accumulated deficit in a timely manner,
- n. Failure to increase the Performance Bond in a timely manner, and
- o. Failure to comply with any other contract provisions.

AHCCCS may impose the following types of intermediate sanctions:

- a. Civil monetary penalties,
- b. Appointment of temporary management for a Contractor as provided in 42 CFR 438.706 and A.R.S. §36-2903,
- c. Allowing members the right to terminate enrollment without cause and notifying the affected members of their right to dis-enroll,
- d. Suspension of all new enrollment, including auto assignments, after the effective date of the sanction,
- e. Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur, and
- f. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

Cure Notice Process:

Prior to the imposition of a sanction for non-compliance, AHCCCS may provide a written cure notice to the Contractor regarding the details of the non-compliance. The cure notice will specify the period of time during which the Contractor must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, the Contractor has complied with the cure notice requirements, the Agency may take no further action. If, however, the Contractor has not complied with the cure notice requirements, AHCCCS will proceed with the imposition of sanctions.

AHCCCS' Sanctions Policy 408, in the AHCCCS Contractors Operations Manual, describes Contractor requirements in accordance with 42 CFR 438, Subpart I. The Policy cites the types of sanctions and subsequent monetary penalties or other actions that may result if a Contractor fails to adhere to the provisions of the Medicaid Managed Care program or contractual requirements.

C. Evolution of Health Information Technology

1. Information System that Supports Initial and Ongoing Operations and Review of Established Quality Strategy [42 CFR 438.204(f)]

AHCCCS has mechanisms in place to ensure that its Contractors maintain information systems that collect, analyze, integrate, and report data, and can achieve the strategy objectives of the AHCCCS program. Contractors are required to have available claims processing and management information sufficient to support provider payments and data reporting between themselves and AHCCCS. Contractors must also collect service-specific procedures and diagnosis data, encounters, and maintain detailed records of remittances to providers. AHCCCS assesses Contractors' data accuracy and completeness.

PMMIS - AHCCCS uses an integrated information infrastructure to satisfy the processing and reporting needs of the MCOs and PIHPs. The system is known as the Prepaid Medical Management Information System (PMMIS). It is composed of eleven core subsystems, five reporting and quality oversight subsystems, and a security subsystem. PMMIS provides extensive information, retrieval, and reporting capabilities to satisfy the data needs of the Agency, CMS, other state and federal agencies, counties, Contractors, providers and members. The system processes Contractor encounters for all AHCCCS members and supports the monitoring of service utilization, quality of care, and program expenditures. PMMIS is a mature system that has been modified over time to accommodate the growing and changing needs of the AHCCCS program.

ADDS - The AHCCCS Data Decision Support System (ADDS) provides data for performance measures, utilization data (including the ability to conduct analysis by type of treatment or provider), recipient enrollment and demographic information, and specialized queries. When ADDS was developed, the Agency incorporated HEDIS® measures, including many that had not been previously used by AHCCCS, into the data warehouse. There are now more than 100 separate measures, ranging from Adolescent Well Care Visits to Use of Imaging Studies for Low Back Pain that can be selected to monitor and improve quality. Results for these measures can be analyzed by individual Contractor, geographic area, race/ethnicity, and specific beneficiary

categories. This allows the Agency and its Contractors to target efforts where improvement is needed and likely to be most beneficial. ADDS data for performance measures is compared with performance measure data reported by Contractors to identify trends and potential gaps in completeness or reliability.

Health Information Exchange start up by the Health Information Network of Arizona (HINAz)

Since 2010, the Health Information Exchange (HIE) environment in Arizona has been managed by the private sector, although the state government is an invested stakeholder. Arizona's HIE, formerly called the Arizona Medical Information Exchange or AMIE project, is being developed and managed by the Health Information Network of Arizona (HINAz). In the past year, HINAz has created a new board of directors, established new bylaws and governance structure, and developed new legal policies and participation agreements. HINAz underwent a technology assessment to identify a vendor that could act as their technology partner to implement HIE and created a sustainable business plan by establishing a subscription fee schedule for Phase I of their HIE operations.

HINAz announced in September, 2011 that they would be launching their "robust" health information exchange over the course of the next few months. Since then, the organization has successfully signed twenty different health care organizations/health care systems including AHCCCS. It is expected that data sharing will begin in fall 2012.

HINAz will use a phased implementation approach. Phase 1 is for a limited set of participants to test that the technology performs accurately, is consistent and replicable. Phase 2 is open to all entities eligible to patient information. Phase 1 is expected to last between 6 and 9 months; there are currently four hospitals testing the data sharing system. The data that will be involved will be medications history from Sure-scripts and utilization data from each hospital. The following information will be included:

- Admissions, Discharges and Transfer (ADT) information
- Lab and Radiology reports
- Discharge information from EDs, including in-patient and observation services
- SonoraQuest Labs will be providing at least two years of lab reports and Electronic Health Record (EHR) data that has been collected such as problem lists, allergies, etc.

For AHCCCS, there are three main reasons to participate in a state level health information exchange:

- AHCCCS members are located statewide and information about their health care needs to come from their providers which are in every county of the state.
- As the Medicaid EHR Incentive program administrator, AHCCCS needs to ensure that its biggest trading partners are engaged in adoption of certified technology that can improve care coordination efforts and meet current and future levels of information exchange requirements that will be found in Stages 2 and 3 of Meaningful Use. The priority for

AHCCCS is to ensure that any interested Medicaid provider can meet information exchange requirements found in Meaningful Use.

- Health care providers have indicated that they are only interested in participating in one Health Information Exchange as it alleviates duplication of efforts and administrative costs. Commercial and Medicaid health plans, hospitals, laboratories, Federally Qualified Health Centers (FQHCs) and other health care organizations are willing to provide governance and oversight to a state level information exchange. By having AHCCCS join and be a part of the state level governance, AHCCCS is supporting the business strategy adopted by the providers.

SECTION III: IMPROVEMENT/INTERVENTION

AHCCCS has numerous process improvement and intervention strategies in place to achieve the goals and objectives noted in the “Quality Strategy Objectives” portion of Section I B. The general and specific methodologies used by AHCCCS are thoroughly explained in Sections I and II. Specific activities and progress are described in the AHCCCS Reports noted in the Preface.

AHCCCS has several projects under development as well as under consideration pending baseline reporting of targeted information. The following are key projects and interventions under development:

A. Health Information Technology (HIT)

In addition to the information provided in Section II, HIT is expected to:

1. Improve quality of care oversight and quality transparency through the provision of timely performance information.
2. Improve care coordination for chronic diseases, and foster better coordination between behavioral health and physical health services.
3. Enhance opportunities for better self-management of chronic illnesses by beneficiaries and their families through access to personal health information and online wellness materials.
4. Improve care coordination through a medical home model including but not limited to members with special health care needs, chronic health conditions or those challenged with navigation of the health care system.

B. Pay for Performance

1. AHCCCS participates in a Center For Health Care Strategies (CHCS) grant that focuses on developing pay for performance programs in Medicaid.
2. Pay for performance programs under consideration focus on diabetes care, asthma, and care provided in nursing homes.
3. Funding for the pay for performance programs is on hold due to state budget constraints.

C. Return on Investment

1. AHCCCS is involved in a CHCS grant focused on return on investment. AHCCCS has linked this project to the CHCS pay for performance grant.
2. AHCCCS will be utilizing a CHCS developed tool to calculate what the return on investment would be for implementing interventions to improve quality of care outcomes.

3. Outcomes from this project will be utilized to evaluate the value of investing in pay for performance programs related to other initiatives.

D. Increased Contractual Performance Standards

AHCCCS realigned the reporting of targeted information to the contractual Performance Standards that would better align minimum performance levels and benchmarks with the most current HEDIS® means and percentiles for Medicaid managed care organizations, as reported by the National Committee for Quality Assurance. This mechanism is designed to ensure that; overall, measures of quality meet or exceed national averages for Medicaid and CHIP enrollees.

SECTION IV: STRATEGY EFFECTIVENESS

In general the effectiveness of the strategies described in this document can be evaluated by the data that is collected and analyzed on an ongoing basis; trends; and comparisons with goals and benchmarks that are established and reviewed on a continuum. Examples of these data include results of performance measures and performance improvement projects, as well as other data reported by Contractors, such as quality of care concerns. The frequency of the evaluations and the reporting requirements are noted in Section II of this document and in Contract. The Quality Strategy is considered a companion document to the External Quality Review Organization (EQRO) reports.

The EQRO reports encompass specific details of the assessment, results and recommendations related to the goals and strategies found in this document. This information is used to assess the effectiveness of the currently stated goals and strategies and provides a roadmap for potential changes and new goals/strategies. To review this information for the acute and long term care MCOs and the PIHPs, refer to the AHCCCS website as noted in the preface.

Strategy effectiveness, progress and updates for the Quality Assessment and Performance Improvement Strategy are also reported in Attachment II, “Quality Assurance/Monitoring Activity,” of the Section 1115 Quarterly Report. 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 report may be found on the AHCCCS website as noted in the preface.

SECTION V: CONCLUSION

Improving and/or maintaining members' health status as well as increasing the potential for resilience and functional health status for members with chronic conditions is at the core of the Quality Strategy. AHCCCS uses a variety of modalities to drive quality through the system to achieve improvements and successes. AHCCCS' culture of quality is sustained by the combination of oversight and collaboration provided in the form of:

1. OFRs, which identify accomplishments and areas of improvement. The OFR is an effective vehicle for discovering best practices that can be shared with all Contractors. Corrective Action Plans (CAPs) are developed as necessary. CAPS function as a tool to follow up where improvement is needed;
2. Performance Measures, such as standards for children's dental care and timely prenatal care, which demonstrate an overall improvement and for which corrective measures are in place as necessary;
3. Performance Improvement Projects, such as the project to improve the use of Advance Directives among ALTCS members, as documented in their health records. By documenting one's wishes for end-of-life care, it is assured that families and physicians are aware of the treatment that a member does or does not want when that person is no longer able to make those wishes known.
4. Consumer inspired projects such as the Spouse as Paid Caregiver program and the Self-Directed Attendant Care Program that continue to expand the ALTCS HCBS network and provide more choices for ALTCS members;
5. Collaborative projects, such as the coordination of the oversight of nursing/Assisted Living Home facilities, which has reduced the burden on nursing/Assisted Living Home facilities and freed time for Contractor resources to evaluate and improve monitoring and oversight of the home and community based program, much of which has far less state licensure oversight;
6. Federal initiatives, such as that led by the Agency for Healthcare Research and Quality (AHRQ), which is focusing on collaborative opportunities to develop quality-based pay-for-performance programs and value based purchasing. 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;
7. Federal/State Systems based initiative that will enhance member self-management and provide more immediate access to member information for physicians, and
8. A continual flow of information and synergy with all stakeholders as noted in this document.

Although AHCCCS has experienced significant quality improvements and successes as demonstrated by the Reports noted in the Preface, the Agency and its Contractors continuously strive for:

1. Improved performance by Contractors as a result of incentives such as comparative reporting and financial advantages;
2. Informed, health literate members who understand the value of preventive care; and, for those members with chronic diseases, the ability to maintain or increase their health;
3. A physician community that is increasingly vested in the prevention of disease;
4. Systematic research and sharing of best practices and lessons learned both locally and nationally;
5. A significant reduction in the costs associated with treating disease and adverse health outcomes;
6. Broader participation in collaborative community efforts to improve the health status of Arizonans;
7. Identification of centers of excellence; and
8. Provision of technical assistance programs with subject matter experts.

AHCCCS has long been respected as an innovator in the area of Medicaid managed care. It is our commitment to quality and our desire to continue that history of innovation and continuous improvement that has helped Arizona remain in the forefront. Despite the challenges, AHCCCS is committed to increasing its pro-active role as a “quality of care improver,” while maintaining its traditional role as the monitor of quality of care. AHCCCS looks forward to continued partnerships and collaborations in meeting this challenge.