Attachment L

Reserved for a later date

~~Quality Improvement Initiative Quarterly Report~~

REPEALED RESERVED

~~Quality Improvement Initiative Quarterly Report~~

AHCCCS

~~January - March 1998~~

~~May 1998~~

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~~APPENDIX A~~

~~ACTIVITY SUMMARY~~
~~JANUARY - MARCH 1998 QUARTER~~

~~The Fifth Annual Immunization Report was completed on February 3. The findings for the period from October 1, 1996 through September 30, 1997 indicate that all rates were over 75%, except for DTP which was 69%. The combined DTP, OPV and MMR rate was 65%, two percentage points higher than for 1995/96.~~

~~Through the combined efforts of ADHS/BHS and AHCCCS, the corrective action plan to improve the quality and quantity of behavioral health encounters has been very successful. Many of the missing encounters have been transmitted to AHCCCS. Efforts continue to remedy the remainder of encounter submission failures.~~

~~A determination was made that AHCCCS will not be able to produce the indicator on Frequency of Ongoing Prenatal Care at this time. A review of AHCCCS generated encounter data revealed two global codes, both of which cover multiple antepartum care visits and are not included in HEDIS 3.0 specifications. These facts impose a major obstacle to obtaining data on the frequency of prenatal visits through encounter data.~~

~~On February 19, 1998 three Acute and Long Term Care Utilization Reports and one Long Term Care Utilization Report were completed and forwarded to HCFA.~~
~~The four reports are:~~

- ~~Physician Services~~
- ~~Other Practitioner Services~~
- ~~Transportation Services~~
- ~~Hospice Services~~

~~Additionally, on March 30, 1998 three Acute and Long Term Care Utilization Reports and four Long Term Care Utilization Reports were completed and forwarded to HCFA.~~
~~The seven reports are:~~

- ~~Laboratory Services~~
- ~~Radiology Services~~
- ~~HCFA-416 EPSDT Utilization~~
- ~~Institutional Services~~
- ~~HCB Services~~
- ~~Therapy Services~~
- ~~Pharmacy LTC Services~~

~~Additional information on these subjects is provided in the following report.~~

~~QUALITY MANAGEMENT IN AHCCCS~~

~~Quality of care is a very important component of the AHCCCS program. In its 15 years of operation, AHCCCS has developed a mature quality management system which focuses on the performance of health plans and program contractors. Although this approach is effective, AHCCCS, in partnership with the Health Care Financing Administration (HCFA) and the AHCCCS health plans and program contractors, sought ways to incorporate other innovative elements into the quality management program which were tailored for a managed care environment. A proposal to implement a Quality Management Initiative was approved by HCFA in December 1994 as a multi-year project which will:~~

- ~~Develop clinical and long term care quality management indicators to measure health outcomes and quality of care.~~
- ~~Use financial indicators for financial performance and solvency standards.~~
- ~~Conduct Member Satisfaction surveys that assess access to care, availability of care and overall member satisfaction.~~
- ~~Assess provider satisfaction.~~

~~FOUNDATION OF THE AHCCCS QUALITY MANAGEMENT SYSTEM~~

~~Nationally, oversight of quality of care under the Medicaid program has been based on fee-for-service care and compliance with regulatory requirements designed to review claims after services were provided. As managed care developed under Medicaid, there were attempts to ensure quality of care through the mandatory use of independent entities, such as external quality review organizations, who conducted retrospective reviews of claims. This focus on claims is neither dynamic nor does it provide the feedback necessary to improve health care outcomes. AHCCCS attempted to overcome the limitations of the Medicaid requirements and built a quality management process that was more suitable for a statewide, managed care system. The quality management system relies on the following activities:~~

~~*Operational and Financial Reviews.* AHCCCS performs annual, on-site operational and financial reviews of all health plans and program contractors, and operational readiness reviews of all new health plans and program contractors. These reviews are conducted with AHCCCS staff from the Office of Managed Care, Office of the Medical Director, Office of Grievance and Appeals and the Office of Program Integrity in conjunction with staff from the health plan or program contractor under review. AHCCCS also monitors operational and financial reviews that the ADHS/Behavioral Health Services (ADHS/BHS) performs on the Regional Behavioral Health Authorities (RBHAs). In 1995, AHCCCS completed an operational and financial review on ADHS/BHS and will conduct a second review during contract year 1997/98. These operational reviews provide an excellent opportunity for AHCCCS to understand the operational practices of each health plan or program contractor and to recognize areas of noteworthy performance as well as any problem areas. If deficiencies are found during the review, AHCCCS issues a report and works with the health plan or program contractor to correct the issues. If areas of particular excellence are found, the results are shared with the other health plans or program contractors.~~

~~While conducting the operational reviews, the AHCCCS team conducts interviews with appropriate health plan personnel and reviews documentation in the following program areas:~~

- ~~Executive Management~~
- ~~Dental Services~~
- ~~Quality Management~~
- ~~Medical Direction~~
- ~~Early Periodic Screening Diagnosis and Treatment~~
- ~~Behavioral Health Services~~
- ~~Regional Offices~~
- ~~Provider Network Development~~
- ~~Member Services~~
- ~~Utilization Management~~
- ~~Maternal Health/Family Planning~~
- ~~Provider Services and Network Management~~
- ~~Grievance and Appeals~~
- ~~Accounting Systems~~

~~*Quality Management and Utilization Review*. Each health plan and program contractor must adhere to specific contractual requirements for quality management and utilization review activities. These requirements include maintaining a Quality Management/Utilization Committee chaired by the Medical Director who is responsible for oversight of the following activities: performing annual clinical studies; designating a registered nurse as the Quality Management Coordinator; and, conducting concurrent review of inpatient care. Health plans must submit clinical study proposals and methodologies to AHCCCS for approval. Examples of clinical studies performed by health plans are:~~

1. ~~Prenatal care services which identify women entering prenatal care in the first trimester.~~

2. ~~Asthma Guideline Compliance which determines the level of compliance by the primary care provider with the Asthma Treatment Guidelines established by the Health Plan Task Force on the Treatment of Obstructive Lung Disease.~~

3. ~~Mammography: Member Compliance and Provider Practices which evaluate the factors associated with compliance by members with mammography screening and recent physician practices related to notification and follow-up of mammograms.~~

~~*Practice Pattern Analysis Reports*. All health plans and program contractors, including the RBHAs, are required to submit quarterly Quality Management and Practice Pattern Analysis Reports and utilization review plans which provide detailed information on how the organization will concurrently and retrospectively determine the appropriateness of placements in institutionalized settings.~~

~~*Annual Immunization Study*. Beginning with FY 1992/93 AHCCCS has been conducting an annual immunization study which focuses on immunization completion rates for children in the first 24 months. The most recent Immunization Study was completed in January 1997. Over the four years of annual evaluations, the rates of immunizations have shown dramatic improvement. DTP improved by 17%; OPV by 18%; MMR by 14%; and HIB by 50%. The bench marks~~

~~developed from these annual studies have been incorporated into the Request for Proposal as an established goal that health plans must meet.~~

~~*Annual Medical Audits*. For the 1997 Medical Audit, AHCCCS contracted with HSAG to conduct a Diabetes Clinical Focused Quality of Care Study which provided baseline data on the management of diabetes for members of AHCCCS health plans. This data is used for quality improvement plans to improve timeliness and quality of care for diabetic members. The services provided were evaluated to assess compliance with 16 diabetic indicators which were grouped into three categories: 1) planning intervention strategies; 2) physical examination an laboratory screening/testing indicators; and 3) diabetes/health education indicators.~~

~~The audit identified that a high percentage of members with diabetes were receiving services such as referrals for retinal exams (93%) and medication education (79%). However, there were other services, such as lipid profiles and foot exams, which were being provided to only one-third or fewer of the diabetic members. In 1998, the health plans are individually required to submit a diabetes clinical study focusing on at least one of the 16 quality indicators. The health plans are to implement an intervention aimed at improving the quality of care provided to diabetic members. Subjects of Annual Medical Audits in previous years have included: Member Satisfaction of Maternity Services (1994); Mortality in the ALTCS Program (1995); and Pressure Ulcers (1996). The 1998 Medical Audit will be conducted on the Children's EPSDT Program.~~

~~*Annual Clinical Study Proposals*. Each health plan is required to submit two clinical study proposals annually. AHCCCS selected diabetes as the topic for one required study, the plans choose the second study area.~~

~~The health plan studies included such topics as:~~

- ~~Behavioral health referrals and the relationship between perinatal events and children's behavioral health symptoms~~
- ~~Participation in dental programs (choice of 3 health plans)~~
- ~~ER utilization of children with Otitis Media~~
- ~~Evaluation of effectiveness of asthma and migraine headache treatment guidelines~~
- ~~Cervical and breast cancer screening related studies (choice of 4 health plans)~~

~~Of the 16 diabetes quality indicators reported in the AHCCCS baseline study, the health plans each selected one indicator and developed an intervention to be implemented during the current contract year. The objective of the studies is to improve performance over the baseline findings. Normally, the study results would be due by the end of the year. However, health plans which are using claims data have been granted an extension to allow adequate time to collect data.~~

~~During next quarter, AHCCCS will offer a clinical study proposal development workshop for the health plans' quality management staff who are responsible for writing the clinical study proposals.~~

~~*External Quality Review Organization (EQRO)*. AHCCCS has a contract with HSAG, a Medicare EQRO, for external and concurrent reviews. HSAG performs external reviews for AHCCCS for the FFS population which includes the following individuals:~~

- ~~Those who received covered health care services in the prior quarter before eligibility.~~

- ~~Native Americans who elect to enroll with the Indian Health Services (IHS) but who are referred off-reservation by IHS for some services.~~

- ~~Undocumented persons who only receive emergency services.~~

~~HSAG also performs the following functions:~~

- ~~On-site concurrent reviews of fee-for-service for inappropriate admissions or levels of care, the appropriateness of the length of stay and the discharge needs of the member.~~
- ~~Retrospective reinsurance audits of the health plans and program contractors for expensive and complicated cases.~~
- ~~Annual external medical audit of the health plans.~~
- ~~Annual immunization audit of the health plans.~~
- ~~Consultative services to AHCCCS such as: physician review for those cases which raise quality of care issues, expert advice on the efficacy of experimental techniques or alternative methods of care and reviews of prior authorization denials.~~
- ~~Technical assistance and recommendations for improvements that are shared with the health plans and program contractors.~~
- ~~Investigation of outliers that are found when AHCCCS analyzes health plan/program contractor utilization data to identify any pattern of underutilization or overutilization of services.~~
- ~~Special reviews, at the request of the health plans.~~
- ~~Testimony as an expert witness in grievance hearings, when necessary.~~
- ~~Case file reviews during the operational reviews.~~
- ~~Development of practice guidelines for the health plans.~~

~~*Health Plan Quality and Utilization Management Plans.* Quality management plans (QMPs), and any modifications to those plans, must be submitted to AHCCCS for prior approval and must adhere to the following standards:~~

- ~~Systematic monitoring, evaluation, and improvement in the quality and appropriateness of care to members through quality of care studies and related activities.~~

- ~~Accountability and participation by the health plan management and the governing body in the monitoring, evaluation and improvement of care.~~

- ~~An identifiable, structured Quality Assessment and Improvement Committee responsible for performing quality management functions within the health plan.~~

- ~~Designated senior executive who is responsible for the implementation of the QMP. The organization's Medical Director must have substantial involvement in the quality assessment and improvement activities.~~

- ~~Sufficient material resources, and staff with the appropriate education, experience, or training to effectively carry out the QMP functions. The Quality Management Coordinator shall be a Registered Nurse, with a current Arizona license, or physician, physician assistant, or certified nurse practitioner.~~

- ~~Process to inform health plan physicians and other providers about the QMP.~~

- ~~Process to determine whether professional practitioners, who are licensed by the state and who are under contract with the health plan, are qualified to perform their services.~~

- ~~Description of member rights and how responsibilities are defined, implemented and monitored.~~

- ~~Description of service availability and accessibility.~~

- ~~Standards for medical records.~~

- ~~Systems to ensure that utilization of services is monitored and evaluated.~~

- ~~Systems which promote continuity of care.~~

- ~~Systems which document quality of care for all services, service areas and treatment modalities. Documentation includes studies, reports, protocols, standards, worksheets, minutes and corrective action plans.~~

- ~~Processes to coordinate other performance monitoring activities, including utilization management, risk management, resolution and monitoring of member complaints and grievances.~~

~~Each acute care health plan submitted a revised QM/UM plan for the current contract year as well as evaluations for the previous year's QM/UM performance. The revised QM/UM plans are in compliance with the RFP requirements and the criteria identified in the Office of Managed Care policies and procedures. The areas where the health plans experienced the greatest variability was in their evaluation of the previous year's activities and the completeness of Work Plans for the current year. Several health plans provided detailed accounts of quality studies which they had undertaken, with detailed results, and intervention strategies planned for the current year. However, a few plans provided only basic discussion of studies and results. In some cases, AHCCCS had to request additional information to clarify the evaluations. AHCCCS has provided feedback to the health plans to help them strengthen their Work Plans in the future.~~

~~*Program Contractor Quality and Utilization Management Plans.* Program contractors must adhere to the same quality management and utilization management requirements as discussed above for the health plans, with the exception of the service availability standard which is different under long term care.~~

~~*Quality Management and Independent Quality Audit of the RBHAs.* ADHS/BHS submits an annual statewide Quality Management/Utilization Management plan for behavioral health services to AHCCCS and provides a quarterly status report and an annual system evaluation. ADHS/BHS also commissions an independent quality audit of the RBHAs on an annual basis and reports findings and recommendations to AHCCCS.~~

~~*Periodic Member Surveys*. AHCCCS has conducted several member surveys. In 1995, AHCCCS surveyed 1,500 women to determine their perception about, and satisfaction with, all aspects of maternity care received while enrolled in a health plan. Overall, 85% of survey respondents were very satisfied with AHCCCS, almost 87% were very satisfied with the health plans, over 90% were very satisfied with the AHCCCS doctors and close to 84% were very satisfied with the hospitals. In 1996, AHCCCS completed a member telephone survey of more than 14,000 individuals who rated the ambulatory care provided by health plans. The results from the Member Satisfaction Survey are discussed in greater detail later in this report.~~

~~*Baseline Medical Pilot Study*. Two health plans participated in a medical record review and claims data review to identify all HIV/AIDS members to determine the best data sources to identify this population and to identify treatment protocols and subsequent outcomes. The study covered the period from October 1995 to September 1996. Preliminary results of the study were that:~~

- ~~Administrative data inaccurately identified members with HIV/AIDS. Twenty-seven percent of members initially identified by administrative data as having HIV/AIDS, did not have this diagnosis validated by medical records and 15% of members initially identified as having HIV/AIDS by medical records had no claims data to support that diagnosis.~~

- ~~Staging of disease data were not consistently documented at time of enrollment. In the event the PCP did not stage the illness, RNs used an approved set of criteria to determine what stage of the illness the member was in, based on available medical record data.~~

- ~~Treatment protocols were not consistently documented in the medical records~~

~~During the upcoming months the pilot study will include:~~

- ~~Performing additional analysis based on recommendations from AHCCCS' HIV/AIDS experts.~~
- ~~Identifying pertinent quality indicators in the care and management of HIV/AIDS members.~~
- ~~Developing a subsequent study incorporating the refined quality indicators.~~

~~*Fee-For-Service Quality and Utilization Management Policies*. AHCCCS has some members who receive their services on a fee-for-service basis. Therefore, utilization management must be in place for these populations in addition to utilization management requirements for health plans and program contractors. The fee-for-service quality utilization management practices which AHCCCS conducts are the same as for health plans and program contractors. Utilization management assesses care, services, procedures and facilities, including medical necessity, appropriateness of care, cost-effectiveness of the admissions to institutional settings, levels of care, ancillary services, length of stay, discharge and referral, re-admissions, quality of care and revenue, diagnosis, and procedure coding.~~

~~The elements of the assessment for both the health plans/program contractors and fee-for-service are:~~

- ~~Prior authorization which determines in advance whether a service that requires prior approval will be covered based on the initial information received. Prior authorization may~~

~~be granted provisionally (as a temporary authorization) pending receipt of required documentation to substantiate compliance with AHCCCS criteria.~~

- ~~Concurrent review which is performed by HSAG at the onset of, and during the provision of, all acute inpatient hospital stays to assess the appropriate usage of ancillary resources, levels of care and service settings, according to professionally recognized standards of care. Concurrent review validates the necessity for continued stay and ensures quality of care. These reviews are performed at frequent intervals throughout the patient's illness and/or hospitalization.~~

- ~~Medical claims reviews which are conducted, as appropriate, on specified claims for each AHCCCS eligibility category to verify appropriateness and effectiveness of service utilization. Criteria for these medical claims reviews focus on factors including, but not limited to, diagnosis, utilization pattern, elective surgery and type of admission. Focused medical reviews are conducted on either a pre- or post-payment basis, and may be applied to a sample of claims, or all claims, depending on the reason for conducting the review.~~

- ~~Other medical reviews which are conducted prospectively on assessment of medical need before care is rendered, determination of the most appropriate health care setting and resource requirements, and verification of privilege status (e.g., approved admitting, treatment or surgical privileges of the admitting or treating physician).~~

~~QUALITY IMPROVEMENT INITIATIVE~~

~~With the support of HCFA, AHCCCS began a major Quality Improvement Initiative in 1995. The Initiative was designed to use encounter data and test new concepts of quality of care based on many of the measurements and recommendations from the Quality Assurance Reform Initiative (QARI) and Health Plan Employer Data and Information Set (HEDIS) 2.0, 2.5 and 3.0 Reports.~~

~~The following are the major components of the Initiative which are discussed in more detail in the remainder of the document:~~

~~Quality Indicators: AHCCCS, in collaboration with the health plans and program contractors, developed and refined appropriate quality indicators through an examination of how encounter data can be used to monitor quality.~~

~~Financial Indicators: AHCCCS refined measurements of health plan fiscal viability, management of care, timely payment of claims and documentation of medical expenses.~~

~~Member Satisfaction Survey: AHCCCS conducted a member survey of acute care members to provide information on access to care, communication between members and providers, and quality of care.~~

~~Provider Satisfaction Survey: AHCCCS conducted a focused survey of PCPs to determine their degree of satisfaction with the AHCCCS program. A broader study is planned for the future.~~

~~QUALITY INDICATORS~~

~~AHCCCS, the health plans and the program contractors formed a partnership to develop and define appropriate indicators to measure quality of care and to analyze how an encounter data reporting system can be used to monitor quality. In order to handle the complex process internally, an interdivisional project committee, directed by the AHCCCS Medical Director, was formed. Separate teams were established for each of the indicator sets and special teams were appointed for specification and development, testing, analysis and distribution. This activity was prioritized into three phases and included the development of indicators and baseline data in the following program areas:~~

- ~~Acute care (clinical).~~
- ~~Long term care for the elderly and physically disabled population and for persons with developmental disabilities.~~
- ~~Behavioral health care.~~

~~ACUTE CARE INDICATORS~~

~~AHCCCS began developing the acute care indicators for prenatal care, women's health, childhood immunizations and birth outcomes in late 1994. In consultation with the health plans, the indicators were compared with HEDIS 2.0 and 2.5 and modifications were made. AHCCCS participated in the National Committee for Quality Assurance (NCQA) user group, reviewed HEDIS drafts and shared expertise on the Review and Specifications Panel for HEDIS 3.0. Initially, 11 indicators were identified. A year after the project began, the Cesarean Section indicator and the Asthma indicator were eliminated and well-child visits for children older than 1 year were added to conform with more recent HEDIS drafts. The indicators for the initiative are provided in Appendix A.~~

~~On September 30, 1996, quality indicator reports were distributed to the health plans for the Phase 1 indicators, which are mammography, dental services, cervical screening and low birth rate based on 1994-1995 data. Health plan representatives validated the AHCCCS data to identify any discrepancies between AHCCCS data and health plan data. After validating the quality indicator reports, health plans were satisfied that the data was an accurate representation of their experience. The reports, which were submitted to HCFA on October 4, 1996, are the baselines against which health plans will be measured in the future. Quality indicator reports covering the 1995-96 period for these same four indicators were completed in May 1997 and were used to evaluate health plans in the 1997 RFP process.~~

~~There are two tasks that remain in Phase 1 of the acute care quality indicators project:~~

1. ~~Gather data and complete report for the 1997 Annual Childhood Immunization Survey. This report is due to be completed at the end of January 1998.~~

2. ~~Gather 1996-1997 data for Phase 1 acute indicators and prepare a final report.~~

~~A brief explanation of several of the indicators is provided below. Appendix A provides a list of all the indicators, including the five which are not described below. All but three of the acute care indicators are due to HCFA in October 1998. Of the three indicators which are not due in October, The Childhood Immunizations was submitted in early February 1998, the Diabetes Management Audit is due at the end of 1999 (also, see the 1997 Annual Medical Audit on Diabetes which was submitted to HCFA earlier this year and is discussed further on page 4 of this). The Adolescent Well Care indicators is on hold and is scheduled for review in 2001.~~

~~***Annual Immunization Assessment:*** The fifth annual immunization survey covered the contract year from October 1, 1996 through September 30, 1997 and focused on immunization completion rates among children who reached 24 months of age during the study period. Results of this assessment were released on February 3, 1998. All immunization rates were over 75% except DTP which was 69%. The highest immunization rate was 84% for HBV. The combined DTP, OPV and MMR immunization completion rate was 65%, an increase of two percentage points over last year's rates. Results summarizing missed opportunities, identified DTP as the antigen which could have the most significant impact on improvement in overall AHCCCS immunization rates. Immunization awareness in Arizona has increased, and providers have made a concerted effort to improve the immunization status of AHCCCS members. Much of the observed annual increase in immunizations has been due to the established relationship between AHCCCS, the health plans, program contractors and the providers.~~

~~AHCCCS included the immunization goals in the Request for Proposals (RFP) for the 1998 contract year. As stated in the RFP, the AHCCCS long range goal is to reach or exceed the Healthy People 2000 goal of 90% immunization for two year old members. The annual immunization audit helps to ensure that these goals are being reached. If the health plan has not achieved at least the statewide average immunization rates by the end of the contract year, the health plan must submit a corrective action plan to AHCCCS.~~

~~***Initiation of Prenatal Care Visits:*** This indicator measures the percent of enrolled women who had a live birth during the reporting year, who were enrolled less then 44 weeks but more than 6 weeks and had their first prenatal visit within six weeks of enrollment. The first baseline report will cover all live births for enrolled women from October 1, 1996 through September 30, 1997 and is expected to be completed in October 1998.~~

~~***Prenatal Care Visits in the First Trimester:*** This indicator measures the trimester in which the pregnant member began receiving prenatal care through a health plan and the number of prenatal visits made by the member. Several reviews of the data have been done to examine the compliance of providers with the reporting requirement of trimester of entry into prenatal care (T1, T2 or T3). The reviews indicate that providers are appropriately reporting the trimester of entry as required by AHCCCS policy. The first baseline report will cover all live births for enrolled women from October 1, 1996 through September 30, 1997 and is expected to be completed in October 1998.~~

~~***Frequency of Ongoing Prenatal Care:*** This indicator will measure the percent of pregnant women who received the expected number or more than the expected number of prenatal visits during their pregnancy and those who received less than 21%, 21% to 40%, 41% to 60%, 61 to 80% of the expected number of prenatal visits. This report was expected to be completed in October 1998. However, a review of AHCCCS-generated encounter data revealed two global codes, both of which cover multiple antepartum care visits and are not included in the HEDIS 3.0 specifications. This makes it impossible for AHCCCS to collect the number of individual visits through encounter data. Because of these various obstacles, AHCCCS will not be producing this indicator at this time.~~

~~***Well Child 0-15 Months Indicator:*** The purpose of the reports is to analyze the utilization of preventive visits in this age group. The first report on the Well Child Indicator for 0-15 months was submitted on October 1, 1997 and will be considered a baseline for measuring future reports. The data show that the aggregate utilization rate for all acute care health plans is 55.66%. The rate for Maricopa County is 53.32%, for Pima County it is 62.56% and the overall rate for rural~~

~~counties is 40.60%. The next report on this indicator is scheduled for submission in October 1998.~~

~~***Well Child 3, 4, 5 and 6 Years Old:*** Gathering of data for the Well Child Indicator for 3, 4, 5, and 6 Year Olds has been delayed because AHCCCS wanted to follow the HEDIS 3.0 specifications for annual well child visits for children in this age group. Beginning October 1, 1997 the AHCCCS EPSDT periodicity schedule mandates one annual well child visit for children in this age group instead of the previous specification for one well child visit every other year. The report that will be generated for this indicator will evaluate Health Plan performance following implementation of the this change. The initial report is expected in October 1998.~~

~~***Adolescent Well Care:*** AHCCCS implemented a new periodicity schedule on October 1, 1997 which does not recommend an annual well adolescent visit. Focus for the next three years will be on measuring and improving EPSDT visits for the younger age groups. AHCCCS will move incrementally toward measuring adolescent visits.~~

~~***Acute Care Utilization Reports:*** The Physician Services, Other Practitioner Services and Transportation Utilization reports covering the period from October 1, 1995 through September 30, 1996 were submitted to HCFA on February 19, 1998, and Lab services, Radiology services, and the HCFA 416 EPSDT Utilization reports were submitted on March 30, 1998. The Pharmacy Acute report which was not due to be completed until mid-October, was completed five months early. There are four utilization reports which are still being worked on and will be completed in May.~~

~~The following are some of the findings from the reports. All information is for 1995/96 except Pharmacy (acute) which is for 1996/97.~~

~~ANNUALIZED NUMBER OF SERVICES PER 1,000 MEMBER MONTHS~~					
~~*Physician Services*~~		~~*Transportation Services*~~ ~~(emergency and non emergency)~~		~~*Radiology Services*~~	
~~Health plans~~	~~8,453~~	~~Health plans~~	~~80~~	~~Health plans~~	~~888~~
~~FFS~~	~~6,267~~	~~FFS~~	~~113~~	~~FFS~~	~~951~~
~~DD~~	~~7,425~~	~~DD~~	~~771~~	~~DD~~	~~786~~
~~LTC~~	~~15,760~~	~~LTC~~	~~7,966~~	~~LTC~~	~~2,866~~

~~*EPSDT Services*~~

- ~~Total number of individuals eligible for services: 432,129~~
- ~~Number of eligibles receiving at least one initial or periodic service: 151,912~~
- ~~Participant ratio for infants (under 1 year): 80%~~

~~*Pharmacy (acute) 1996/97*~~

- ~~The five top therapeutic drug class rankings were the same as in 1995/96~~
- ~~Central nervous system (CNS) agents were the most frequently prescribed therapeutic drug.~~

- ~~In 1996/97, anti-infectives represented 14.3% of total costs and an average cost per prescription of $14.82. In 1995/96, anti-infectives represented 22% of total costs and had an average cost of $17.35.~~

~~ALTCS ELDERLY AND PHYSICALLY DISABLED INDICATORS~~

~~AHCCCS is collecting data on all the indicators for ALTCS-EPD, with the exception of Psychotherapeutic Agents, which is currently on hold. The following information outlines the current status of the ALTCS-EPD quality indicators which were developed in collaboration with program contractors:~~

~~***Pressure Ulcer:*** The Sacral/Coccygeal Pressure Ulcer Indicator, which measures the rate of improvement of sacral-coccygeal pressure ulcers over a six month period, was the subject of the 1995/1996 Medical Audit which was completed in February 1997. The primary purpose of the audit was to establish a baseline for the indicator by examining the prevalence of pressure ulcers in the ALTCS population by stage classification and site. The audit was an important foundation piece for the Sacral/Coccygeal Pressure Ulcer Indicator. At the end of the six month report period, the results of the indicator showed that 56.1% of the pressure ulcers had healed, mainly due to the fact that Stage II ulcers were reduced by 33.4%. AHCCCS has begun collecting data for the Sacral/Coccygeal Pressure Ulcer Indicator for 1997/1998. The indicator will identify the how many members had pressure ulcers on October 1, 1997 and what the status of the pressure ulcers were on March 31, 1998.~~

~~***Influenza Immunization:*** The first report on this indicator covered the period from September 1, 1996 through December 31, 1996. The report identified that 86.8% of the sample population residing in nursing facilities had received an influenza vaccination. The Healthy People 2000 influenza immunization goal for people over 65 is 80%. The next report, which will cover the period 9/97 through 12/97 is scheduled for completion by August 15, 1998.~~

~~***Changes in Activities of Daily Living (ADL):*** This indicator was reported on in October 1997 for calendar year 1995 and identified that approximately 50% of the sample ALTCS-EPD population had a decline in ADL capabilities. The decline in ADL capabilities was most evident in two groups: members residing in nursing homes who are 81 years of age or older, and all ALTCS-EPD members diagnosed with dementia. This indicator will be reported for calendar year 1996 in November 1998.~~

~~***Hospital and Emergency Room Utilization:*** This indicator was reported on in October 1997 and showed that ALTCS-EPD members who had more than one ER visit during contract year 1993/94, had an average of 4.4 visits and of the 1,414 hospital admissions for the sample population, approximately half originated in an emergency room. The Hospital and ER Indicator was also reported for the DD population and that information is provided later in this document. The next report is due in November 1998 and will cover both 1994/95 and 1995/96.~~

~~***Fall Related Fractures:*** This indicator, which was submitted in November, provided data on ALTCS-EPD members who had a fracture secondary to a fall within the assessment period in 1997. In the sample population, 71 members had at least one fracture resulting from a fall. As expected, females had a higher percentage of fractures than males and actually appear to be about twice as likely to fracture a bone when they fall. The next report period for this indicator will be 1997/98 and is due in November 1998.~~

~~***Psychotherapeutic Drugs:*** This indicator is on hold and is scheduled for review in 2001.~~

~~***Long Term Care Utilization Reports:*** The utilization report on Hospice was submitted on February 19 and the four remaining long term care reports: Institutional Care, HCBS, Therapy, and Pharmacy were completed on March 30.~~

~~The following are some of the findings from the reports. All information is for 1995/96.~~

~~*Institutional Services*~~

~~The annualized number of institutional services for EPD per 1,000 member months was:~~

- ~~Urban 360,637~~
- ~~Rural 359,625~~

~~The annualized number of institutional services for DD LTC per 1,000 member months was 269,737.~~

~~*Home and Community Based Services (HCBS)*~~

~~THE ANNUALIZED NUMBER OF HCB SERVICES, BY GROUP, PER 1,000 MEMBER MONTHS~~		
~~EPD~~	~~DD~~	~~FFS/LTC~~
~~898,642~~ ~~[Urban 1,007,321~~ ~~Rural 528,465]~~	~~738,008~~	~~77,796~~

~~*Pharmacy (LTC)*~~

~~THE NUMBER OF PRESCRIPTIONS, BY SETTING, PER MEMBER MONTH~~					
~~EPD~~		~~DD~~		~~FFS/LTC~~	
~~Institutional~~ ~~HCBS~~ ~~Other~~	~~4.47~~ ~~4.43~~ ~~1.81~~	~~Institutional~~ ~~HCBS~~ ~~Other~~	~~3.58~~ ~~.35~~ ~~.21~~	~~Institutional~~ ~~HCBS~~ ~~Other~~	~~3.18~~ ~~.34~~ ~~.42~~

~~ALTCS DEVELOPMENTALLY DISABLED INDICATORS~~

~~AHCCCS and the DES/Division of Developmental Disabilities (DES/DDD) identified seven indicators for the developmentally disabled (DD) population. All of the indicators are summarized in Appendix A.~~

~~***Hospital and ER Utilization:*** Since there is no comparable population, FY 1995 and 1996 data will be compared with the information in the first report which is for FY 1994. The report data on the sample DD population shows that of those members with more than one visit, the average number of visits per member was 3.8, and of the hospital admissions for this population, 33.5%~~

~~originated in an emergency room. The first report on this indicator was completed in October 1997 and the next report is due in November 1998.~~

~~***DD Health/Safety in Group Homes:*** This Indicator was completed in October. The Health/Safety Indicator was based on data collected from January 1995 through June 1997 and indicated that an average of 1.43 health/safety noncompliances were cited during the 372 inspections in 1995. However, for the 238 inspections completed during the first six months of 1997, the average of noncompliances cited per inspection had dropped to 0.28 per inspection. In the four program areas which had a noncompliance percentage that was over 10% in 1995, all had improved over the period of the evaluation, so that none of these areas had a percentage above 3% in 1997. Further reporting on this indicator has been discontinued.~~

~~***DD Program Monitoring in Group Homes:*** The Monitoring Indicator, which was completed in October was based on data collected from July 1995 through June 1997. An average of 4.73 noncompliances per review were cited during the first six month evaluation period (July 1, 1995 - December 31, 1995). However, during the last six month evaluation (January 1, 1997 - June 30, 1997), the average noncompliances per review had dropped to 2.14. There were 14 programmatic rules with a frequency of noncompliance at or above 10% during the first review period. All of these had improved by the final review period, with half (7) dropping below a 10% noncompliance rate. Further reporting on this indicator has been discontinued.~~

~~National Core Indicators Project~~

~~Recently, Arizona was chosen as one of seven states to pilot the National Core Indicators Project (CIP) which is being developed in collaboration with the Human Services Research Institute (HSRI) and the National Association of State Directors of Developmental Disabilities Services, Inc. The DES/DDD will represent Arizona in this program. Because of the time the program will demand from DES/DDD staff, AHCCCS is requesting that the collection and reporting of data for the majority of the quality indicators for ALTCS DD members be suspended for approximately two years.~~

~~AHCCCS has suspended activities for most of the indicators, but will continue collecting DD indicator data for: Hospital and ER Utilization, Childhood Immunizations and Members Receiving Dental Services. Reporting for Childhood Immunizations and Dental Services for DD members will be included in the acute indicator reports.~~

~~For the CIP, DES/DDD has compiled data from a family survey which was distributed to 1,000 Arizona families with a DD member. The responses from 378 DD families was input into a computer program provided to DES/DDD by HSRI and the results were submitted to HSRI for analysis. A consumer survey, involving 600 face-to-face interviews is still being conducted through the Governor's Council on Developmental and a provider survey was mailed out from which responses were compiled by DES/DDD and submitted to HSRI.~~

~~All of the information from the surveys will be analyzed by HSRI and the findings will be reviewed by the pilot states and HSRI to determine what are the best indicators. This information will be used to prepare a refined survey for use by all states. After considerable refining of the tool, which DES/DDD believes will take a couple of years, Arizona hopes to have DD indicators which can be used to compare quality of care from district to district, and perhaps from provider to provider. HSRI plans to have a tool which can be used to compare quality of care from state to state.~~

~~BEHAVIORAL HEALTH INDICATORS~~

~~In 1995, AHCCCS, in collaboration with the ADHS/Division of Behavioral Health Services (ADHS/BHS), health plan representatives, and other interested participants, began conceptualizing and designing encounter-based quality indicators for the behavioral health program. Of seven potential indicators, three were chosen as the most accessible and meaningful, and most likely to provide data which could be used to shape policy and clinical care guidelines. These indicators are:~~

- ~~Ambulatory Follow-up to Inpatient Care~~
- ~~Inpatient Readmission Rate~~
- ~~Laboratory Follow-up to Selected Medications~~

~~ADHS/BHS Corrective Action Plan for Encounters~~

~~ADHS/BHS and AHCCCS met twice to monitor the effectiveness of corrective actions which ADHS/BHS has taken to improve the quality and quantity of data submitted as encounters for behavioral health services. Many of the missing encounters, those which were pended at the ADHS/BHS level of editing, have been successfully transmitted to AHCCCS as a result of these efforts. ADHS/BHS and AHCCCS will continue to meet regularly to examine the remainder of encounter submission failures in order remedy this situation, but are greatly encouraged by the success they have experienced. As a result of these efforts, both the quality indicators and utilization reports should provide a more realistic picture of the behavioral health services delivery system.~~

~~***Ambulatory Follow-up to Inpatient Care and Inpatient Readmission Rate:*** These two quality indicators were developed, run and reported to HCFA in July 1997 for the period 1994-1995. Analysis of the results was not possible as the review of the data revealed sizable encounter omission errors. A corrective action plan was required of ADHS/BHS regarding encounter submissions and AHCCCS also required that ADHS/BHS re-run the quality indicators from the ADHS internal claims data information for this same period.~~

~~AHCCCS is currently performing data analysis of UBs (Universal Bill type submitted for hospital services) to prepare for reporting of data on the two hospital service based indicators scheduled for reporting in July 1998.~~

~~***Laboratory Follow-up to Selected Medications:*** This indicator has been postponed due to encounter omission errors and because, in the process of developing technical specifications for this indicator, it was determined that encounters for two of the laboratory tests used could not be collected solely from the ADHS enrolled member's RBHA service provider. Therefore, the indicator specifications must be redesigned to include identification of health plan PCP involvement in monitoring the laboratory values of shared members. During 1994-95, only the health plans were capitated for these tests so that performing this indicator for that year would not provide a measure of ADHS and RBHA performance to be compared to later years. Measures of this indicator will begin with 1995-1996 data. The target date for submission of reports on this indicator is July 1999, for data from 1995-1996 and 1996-1997.~~

~~***Behavioral Health Utilization Reports:*** The utilization reports have been developed and were fashioned, where possible, to match HEDIS reporting guidelines for utilization data. Technical~~

~~specifications for the first three reports are nearing completion and are scheduled to be reported by August 1998, for data from 1994-1995 and 1995-1996. The service level activity report was previously run on 1994-1995 data, however, it will be run again for that year as well as 1995-1996 to validate encounter omission corrective actions and to provide a basis for comparative analysis.~~

~~**BEHAVIORAL HEALTH UTILIZATION REPORTS**~~	
~~**UTILIZATION REPORT**~~	~~**SUMMARY DESCRIPTION**~~
~~1. Inpatient Services~~	~~1. Number of inpatient hospitalizations for ADHS enrolled members reported per RBHA and statewide, by age grouping and mental health category.~~
~~2. Partial Care Services~~	~~2. Number of ADHS enrolled members who received basic or intensive partial care services, reported per RBHA and statewide by age grouping and mental health category.~~
~~3. Ambulatory Services~~	~~3. Number of ADHS enrolled members who received ambulatory mental health services, reported per RBHA and statewide by age grouping and mental health category.~~
~~4. Service Level Activity~~	~~4. Number of ADHS enrolled members receiving services by activity level and by mental health category reported by RBHA and statewide.~~

~~FINANCIAL INDICATORS~~

~~Financial indicators were identified as another performance assessment tool. Currently, AHCCCS requires health plans and program contractors to comply with, and report on, a variety of financial standards. Four specific financial indicators were developed by AHCCCS and the health plans in order to evaluate the performance of the health plans. Financial indicators will be calculated using 1997 audited information which will be final in April 1998.~~

~~**Indicator**~~	~~**Determines:**~~
~~1. Operating income/loss.~~	~~If a health plan can remain fiscally viable given current capitation rates.~~
~~2. Medical expense ratio.~~	~~How well a health plan manages care.~~
~~3. Days outstanding received but unpaid claims (RBUC).~~	~~If claims are being paid in a timely fashion.~~
~~4. Change in reported but unpaid claims and incurred but not reported (IBNR) estimates.~~	~~How well a health plan is recording medical expenses.~~

~~MEMBER SATISFACTION SURVEY~~

~~AHCCCS completed a satisfaction survey of more than 14,000 acute care members by telephone between November 1995 and April 1996 . This survey provided valuable information on access to care, communication between members and providers and the perception of the member regarding quality of care. The purpose for conducting this standardized member survey was to obtain feedback from members to assist AHCCCS in oversight and contracting activities and to assist health plans in identifying areas of excellence and areas in need of improvement.~~

~~Overall, the results of the 1996 AHCCCS Member Satisfaction Survey were quite positive. The overall feedback from respondents for six areas show that at least 75% of respondents gave a rating of "good" or "very good" when asked to judge their health plan, overall quality of care, care from their PCP, specialty care, ability to obtain the care needed and children's dental care. The overall rating given to PCPs by 84% of the respondents was "good" or "very good" and when asked about obtaining appointments when sick, 86% of the respondents rated appointment availability as "good" or "very good". This consumer feedback will be used in combination with other types of information, such as studies of the clinical processes and outcomes, to ensure continued quality improvement.~~

~~PROVIDER SATISFACTION SURVEY~~

~~As a component of the Quality Improvement Initiative, AHCCCS conducted a small pilot provider satisfaction survey in the first quarter of 1997 as a precursor to the Provider Satisfaction Survey. AHCCCS, in cooperation with HSAG, designed a survey tool to interview 50 providers who were selected based on specialty and volume. The review was conducted in conjunction with the scheduled on-site operational reviews of health plans. The results of the pilot survey helped determine AHCCCS' decision to conduct the survey by mail and to use an independent contractor. Two consultants have been hired, and the design and sampling stage of the project has begun.~~

~~DECISION SUPPORT SYSTEM (DSS)~~

~~The objective of the DSS is to improve the processes for structuring, accessing, and analyzing AHCCCS PMMIS information. AHCCCS is currently developing a Request for Proposal (RFP) to obtain comprehensive proposals from qualified bidders to provide, install and implement an integrated DSS using PMMIS data. Once the DSS is implemented, operation and maintenance will be the responsibility of AHCCCS staff.~~

~~The purpose of the DSS will be to:~~

- ~~Provide AHCCCS staff with increased availability to information necessary to support the day-to-day administration, planning, and evaluation of the AHCCCS Program~~

- ~~Enhance data access and analysis capabilities at varying levels of end-user sophistication~~

- ~~Identify patterns of behavior attributable to eligibles and providers in order to better understand utilization issues and to use this information to design effective cost containment measures~~

- ~~Apply normative data to measure cost, utilization, and quality of care findings against relevant norms~~

- ~~Support the continuing rate setting activities of the AHCCCS Program.~~

~~The project was given conditional approval from the Arizona Government Information Technology Agency in December. Enhanced funding for the project has been discussed with HCFA, and an Advance Planning Document was submitted on March 16.~~

~~DENTAL CARE TASK FORCE~~

~~The AHCCCS Dental Care Task Force was created at the request of the Arizona Legislative Dental Care Study Committee to make recommendations on ways to increase: 1) the utilization of dental services by children in AHCCCS, and 2) the number of dental providers who serve AHCCCS members. The final report has been drafted and will be submitted to the Legislature in April.~~

~~During their research, the Task Force found that AHCCCS and the health plans have implemented a number of changes in recent months which should have a positive impact on dental utilization rates and the number of dental providers. For example, as of January 1998, ten of the twelve health plans are contracting directly with individual dentists. This change has resulted in twice as many dentists participating in AHCCCS.~~