A REPORT
TO THE
ARIZONA LEGISLATURE

Performance Audit Division

Performance Audit

Arizona Health Care Cost Containment System

Quality of Care

SEPTEMBER • 2002
REPORT NO. 02 – 08

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

The **Auditor General** is appointed by the Joint Legislative Audit Committee, a bipartisan committee composed of five senators and five representatives. Her mission is to provide independent and impartial information and specific recommendations to improve the operations of state and local government entities. To this end, she provides financial audits and accounting services to the State and political subdivisions, investigates possible misuse of public monies, and conducts performance audits of school districts, state agencies, and the programs they administer.

The Joint Legislative Audit Committee

Representative **Roberta L. Voss,** Chair

Representative **Robert Blendu**
Representative **Gabrielle Giffords**
Representative **Barbara Leff**
Representative **James Sedillo**
Representative **James Weiers** *(ex-officio)*

Senator **Ken Bennett,** Vice Chair

Senator **Herb Guenther**
Senator **Dean Martin**
Senator **Peter Rios**
Senator **Tom Smith**
Senator **Randall Gnant** *(ex-officio)*

Audit Staff

Dale Chapman, Manager and Contact Person

Michele Diamond, Team leader
Mary Edmonds

Andrea Leder

Copies of the Auditor General's reports are free.
You may request them by contacting us at:

Office of the Auditor General
2910 N. 44th Street, Suite 410 • Phoenix, AZ 85018 • (602) 553-0333

Additionally, many of our reports can be found in electronic format at:
www.auditorgen.state.az.us

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

WILLIAM THOMSON
DEPUTY AUDITOR GENERAL

September 16, 2002

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Ms. Phyllis Biedess, Director
Arizona Health Care Cost Containment System

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Arizona Health Care Cost Containment System's processes for monitoring the quality of care provided to its members. This audit, part of a Sunset review of the agency, was conducted pursuant to an August 9, 2001, resolution of the Joint Legislative Audit Committee and under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §41-1279 and 41-2951 et seq. I am also transmitting with this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

This is the fourth in a series of five reports to be issued on the Arizona Health Care Cost Containment System.

As outlined in its response, AHCCCS agrees with all of the findings and recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on September 17, 2002.

Sincerely,

Debbie Davenport
Auditor General

Enclosure

2910 NORTH 44th STREET • SUITE 410 • PHOENIX, ARIZONA 85018 • (602) 553-0333 • FAX (602) 553-0051

FACT SHEET

Arizona Health Care Cost Containment System
Office of Medical Management

Services:

The Office of Medical Management (OMM) performs the following primary services to monitor quality of care:

1. Participates in the annual Operational and Financial Reviews of AHCCCS health plans;
2. Monitors the investigation and resolution of quality-of-care complaints that AHCCCS receives;
3. Develops and tracks performance indicators;
4. Tracks utilization of services;
5. Pre-authorizes high-cost services, such as transplants and treatment for severe head injuries;
6. Oversees contracted pharmaceutical services; and
7. Establishes AHCCCS clinical policies.

Facilities and Equipment:

OMM performs its duties at the state-owned building located at 701 East Jefferson Street, in Phoenix.

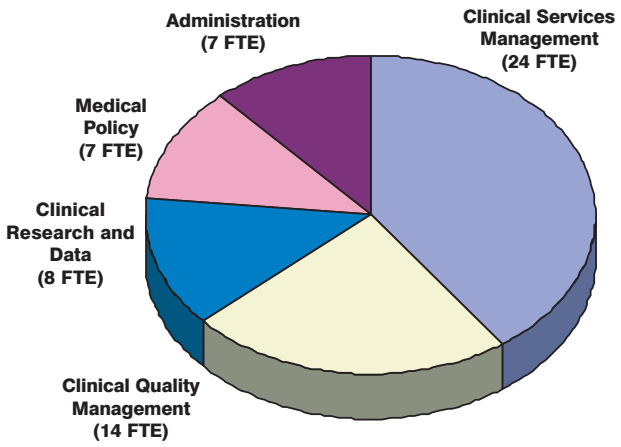
OMM owns standard equipment, such as computers, printers, copy machines, and fax machines. It also has one vehicle assigned to it.

Mission:

To establish and implement all clinical policies and services to ensure comprehensive quality healthcare is delivered to eligible Arizonans in a cost-effective manner.

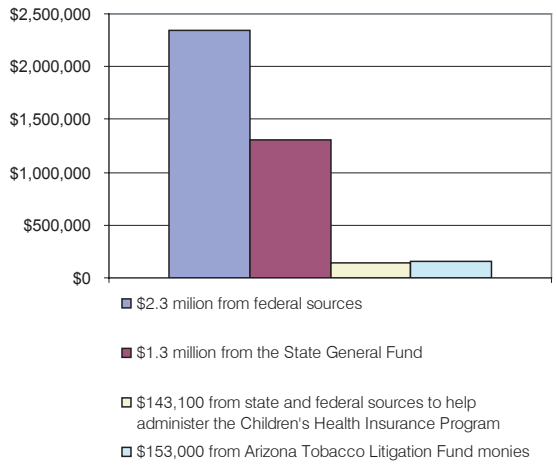
OMM staffing:

60 FTE (fiscal year 2002)



OMM funding sources:

$3.9 million (fiscal year 2002)



Office goals:

AHCCCS has established the following seven goals for the Office. AHCCCS established the first two goals to report healthcare information annually to the Legislature, while the remaining goals are internal to the Office.

1. To improve the health status for children.
2. To improve the health status of AHCCCS-enrolled women and senior citizens.
3. To continue refinement of OMM internal processes.
4. To improve internal visibility and coordination within AHCCCS.
5. To improve our partnership with contracted health plans by becoming a resource of expertise and innovation in the clinical aspects of managed healthcare.
6. To increase the frequency and improve the effectiveness of OMM interaction with the medical community.
7. To strengthen our quality management initiatives.

Adequacy of performance measures:

OMM has established 17 clinical performance indicators or performance measures that track the quality of care provided to its members. As indicated in Finding 4 (see pages 29 through 34), AHCCCS collects and tracks data for these indicators, which include measures that track the percentage of children with access to a primary care provider, the percentage of 2-year-old children who have received immunizations, the percentage of well-child visits, women receiving cervical and breast cancer screening, and the percentage of nursing home residents who receive flu and pneumococcal immunizations.

However, AHCCCS has not established performance measures for OMM's internal goals and should consider doing so. Specifically, AHCCCS should consider establishing output, efficiency, quality, and outcome measures. In fact, OMM collects, tracks, and analyzes the data needed to support and report many of these suggested performance measures. For example:

- AHCCCS could adopt output measures that would report the number of medical policies revised or implemented, or the number of health plan requests for assistance fulfilled.
- AHCCCS could adopt quality measures that would emphasize OMM's reliability or responsiveness to the customer or stakeholder, such as health plan satisfaction with medical policies and OMM assistance in interpreting medical policies.
- AHCCCS could also adopt efficiency measures that would reflect the cost or timeliness of services provided by OMM. These measures might track how timely OMM responds to health plan or internal requests for assistance, or whether complaints OMM receives are resolved in a timely manner.

SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Health Care Cost Containment System's (AHCCCS) processes for monitoring the quality of care provided to participants in the State's major healthcare program. AHCCCS administers Arizona's Medicaid program and is also the healthcare program for low-income Arizonans who do not qualify for Medicaid. This audit, part of a Sunset review of the agency, was conducted pursuant to an August 9, 2001, resolution of the Joint Legislative Audit Committee and under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-1279 and 41-2951 et seq. It is the fourth in a series of five audits of AHCCCS. Other audits in the series cover the Division of Member Services, AHCCCS' rate-setting processes, AHCCCS' medical services contracting practices, and an evaluation of the agency using the criteria in Arizona's sunset law.

Monitoring the quality of care and services provided within a managed care system is important to ensure that members receive needed services. A U.S. General Accounting Office report found that managed care can create an incentive to under-serve or even deny beneficiaries access to needed care, since plans can profit from not delivering services.[1] Another study has found that monitoring quality of care may be especially important for programs serving the Medicaid population because they contain many disadvantaged and vulnerable individuals.[2] Because of this importance, monitoring the quality of care is one of AHCCCS' primary functions. AHCCCS uses four main tools for monitoring quality of care:

- Operational and Financial Reviews—These annual onsite reviews assess health plans' compliance with AHCCCS standards and contract requirements in several categories, including quality of care. These reviews are one of AHCCCS' primary ways to ensure that plans provide high-quality, accessible health services.

- Quality-of-Care Complaints—These complaints typically involve concerns with the medical care members have received and can be used to identify systemic problems and make improvements.

1 U.S. General Accounting Office, *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort*, May 1997. (GAO/HEHS-97-86).

2 Hadley, James P. and Wolf, Linda F. "Monitoring and Evaluating the Delivery of Services Under Managed Care." *Health Care Financing Review*, Washington, Summer 1996.

- **Clinical performance indicators**—AHCCCS has established 17 clinical performance indicators to determine how well the overall healthcare system is delivering services, such as cancer screening or immunizations, for specific populations within its membership.

- **Quality management plans**—AHCCCS annually reviews each health plan's quality management plan to assess the systems they have established to monitor and improve quality of care. The quality management plan includes an evaluation of the plan's quality management programs and documents health plan policies and procedures for conducting quality management activities.

In addition to establishing these and other mechanisms to monitor the quality of care, AHCCCS has been recognized for its performance. According to a Nelson A. Rockefeller Institute of Government study, which assessed Medicaid managed care in five states, Arizona "has perhaps the longest running, best-established managed care program in the country…(AHCCCS) has been extensively evaluated and has received uniformly high marks both for management and program outcomes."[1] Additionally, a U.S. General Accounting Office report notes that AHCCCS requires its health plans to provide data documenting the patient care provided and to conduct various patient outcome studies and also indicates that "Arizona's AHCCCS program can serve as a model for other Medicaid programs."[2]

AHCCCS should strengthen its health plan reviews (see pages 9 through 15)

AHCCCS can strengthen its annual operational and financial reviews (OFR) by focusing more heavily on plans' actual performance in providing quality care. Auditors found that reviews were primarily evaluating whether plans had policies or processes in place, rather than whether the policies or processes produced acceptable results. For example, AHCCCS requires its health plans to provide medically necessary transportation in a timely manner. AHCCCS members are provided with both emergency and non-emergency transportation if needed. AHCCCS reviews whether a health plan has a system in place to monitor wait times. However, it does not review what the actual transportation wait times were, or whether the transportation was provided on a timely basis. To conduct the additional work needed to assess performance outcomes, AHCCCS may need to reduce or prioritize the various standards it evaluates, as it currently evaluates up to 111 standards during some reviews.

1 James W. Fossett and Associates, Malcolm Goggin, John S. Hall, Jocelyn Johnston, Christopher Plein, Richard Roper, and Carol Weissert, *Managing Accountability in Medicaid Managed Care: The Politics of Public Management*, The Nelson A. Rockefeller Institute of Government, Albany, New York, 1999.

2 U. S. General Accounting Office, *Arizona Medicaid:Competition Among Managed Care Plans Lowers Program Costs,* October 1995. (GAO/HEHS-96-2).

Furthermore, limited followup on identified problems has allowed some problems to continue. When auditors compared recommendations from reviews conducted in 1999 with reviews conducted 2 years later, they found that problems continued, even though health plans submitted corrective action plans as AHCCCS required. AHCCCS expects its reviews to act as a check on how thoroughly plans adopt needed changes, but auditors found that subsequent reviews did not always cover all the areas in which problems had been identified. These problems point to a need to strengthen follow-up efforts by verifying that corrective actions have occurred, either through a review of applicable documentation or a follow-up visit.

AHCCCS needs to ensure member complaints are appropriately resolved (see pages 17 through 21)

AHCCCS needs to ensure that all quality-of-care complaints are appropriately resolved. Currently, AHCCCS refers the complaints it receives to its health plans for investigation and resolution. When auditors reviewed a sample of such complaints, they found that, for nearly half of the complaints requiring corrective action, the files contained no indication that any corrective action had been taken. AHCCCS needs to take additional steps to ensure that the complaints it refers to health plans are appropriately resolved.

These problems are exacerbated because AHCCCS continues to refer complaints to health plans with deficient complaint-handling practices. In its federal fiscal year 2000 and 2001 operational and financial reviews, AHCCCS identified four health plans with inadequate complaint processes. AHCCCS referred at least 83 complaints to these four health plans for investigation and resolution after it identified the deficiencies and before it accepted the health plans' corrective actions. When it identifies deficient complaint-handling practices, AHCCCS should take the appropriate action against the health plan to ensure the deficient practices are addressed. Until corrective action is taken, AHCCCS should investigate and resolve those complaints it receives rather than referring these matters to the health plan. AHCCCS should also increase its monitoring of how these health plans handle the complaints they receive directly.

AHCCCS needs to do more to address concerns with care for the developmentally disabled (see pages 23 through 27)

AHCCCS needs to do more to ensure that quality-of-care concerns for its ALTCS developmentally disabled members are addressed. Statute currently requires AHCCCS to contract with the Department of Economic Security's Division of Developmental Disabilities (DDD) to provide services to the State's developmentally disabled population. However, AHCCCS has two long-standing concerns with DDD's

provision of services to its members. One is complaint handling, an area in which DDD has not met standards since 1996. For example, DDD had not met AHCCCS requirements to develop a comprehensive, centralized complaint system to track all member problems and complaints. Additionally, in its 2001 OFR of DDD, AHCCCS identified problems with DDD's complaint handling, specifically noting that some complaints lacked evidence of adequate research and documentation. In response to AHCCCS' concerns and requirements, DDD has implemented a complaint-processing system to capture complaint data statewide. However, while this system currently captures complaint data on the most severe, high-risk incidents, it does not yet capture all complaint data. DDD plans on adding other incidents to this system in the future and is working with AHCCCS to ensure the remainder of the system development meets AHCCCS requirements. As a result, AHCCCS should continue working with DDD to implement a complaint-tracking system that meets standards and expand its review of DDD's complaint handling.

The second area of concern is the provision of home modification services, such as wheelchair ramps. AHCCCS has not ensured that DDD has provided services on a timely basis, hindering members' ability to function independently in the community. Auditors found continuing evidence of delays, with DDD failing to meet deadlines for nearly two-thirds of the 85 modifications reported as approved between January and May 2002. Although AHCCCS took action in 2000 to address the delays in providing these services, it has taken limited action to address the current delays. Therefore, AHCCCS should determine the reasons for these continuing delays as soon as possible, and if necessary, use its various options such as a notice to cure or financial sanctions to ensure these services are provided in a timely manner.

Clinical performance indicators provide useful information (see pages 29 through 34)

AHCCCS uses clinical performance indicators to track how well the system is delivering services such as immunizations, cancer screenings, and well-child checkups. These indicators serve several purposes, including assessing health plan performance and moving the AHCCCS population toward national health goals. For example, for the most recent 3 years in which data are available, AHCCCS health plans have continued to improve in the areas of immunizations in 2-year-olds, annual dental visits for children, and adolescent well-care visits. In contrast, health plans' performance on children's access to primary care and influenza immunizations in nursing facilities has declined.

While such indicators are useful, minor changes could enhance their impact. Because the indicators provide valuable information about how well health plans are delivering services, AHCCCS should use the indicator results as part of its annual reviews when assessing health plan performance. In addition, AHCCCS should expand its followup for health plans that do not meet the established indicator standards beyond requiring and reviewing corrective action plans. AHCCCS should request additional documentation that demonstrates that the health plan has implemented corrective actions and in some cases, conduct site visits to ensure that actions were implemented.

TABLE OF CONTENTS

continued

TABLE OF CONTENTS

concluded

INTRODUCTION & BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Health Care Cost Containment System's (AHCCCS) methods to monitor quality of care. This audit, part of a Sunset review of the agency, was conducted pursuant to an August 9, 2001, resolution of the Joint Legislative Audit Committee and under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S) §§41-1279 and 41-2951 et seq. This is the fourth in a series of five audits of AHCCCS. The first two audits covered the Division of Member Services and AHCCCS' rate-setting processes. The remaining two audits in this series will cover AHCCCS' medical services contracting practices and provide information on the agency using the criteria in Arizona's sunset law.

Overview of AHCCCS' managed care system

AHCCCS administers Arizona's managed care Medicaid program and the State's healthcare program for low-income Arizonans who do not qualify for Medicaid. While Arizona became the last state to implement a Medicaid program, it was the first state to have a managed care Medicaid program. AHCCCS began in 1982 by offering acute care such as physician services, hospitalization, pharmacy, and laboratory benefits to its members, and began adding long-term care services such as nursing facility care and home- and community-based services in 1988. AHCCCS contracts with health plans to provide medical services for its members. These health plans then obtain services for AHCCCS members from physicians, hospitals, laboratories, and other healthcare providers. AHCCCS pays the health plans a fixed amount in advance each month, called a capitation payment, for each enrolled member, regardless of the number or level of services provided. From these capitation payments, the health plans pay the providers for covered services provided to AHCCCS members. AHCCCS currently contracts with nine plans to provide acute care services in various locations throughout the State and eight other plans to provide long-term care (see Table 1, page 2).

Arizona was the first state to implement a managed care system.

Monitoring quality of care an important function

Monitoring the quality of care and services provided within a managed care system is one of the most critical functions that state Medicaid agencies can perform, as it

Table 1 Enrollment and Counties Served by Health Plans
As of July 2002

Health Plan	Enrollment	Counties Served
Acute Care		
Arizona Physicians IPA	215,617	All but Gila and Pinal
Mercy Care Plan	172,463	All but Apache, La Paz, Mojave, Navajo
Phoenix Health Plan/Community Connection	65,707	Gila, Maricopa, and Pinal
CIGNA Community Choice	60,540	Maricopa
Health Choice Arizona	57,336	Maricopa, Pima
Maricopa Managed Care	39,545	Maricopa
University Family Care	20,776	Pima
Pima Health Plan	13,922	Pima
Family Health Plan of North Eastern Arizona (NEAZ)	12,642	Apache, La Paz, Mohave, and Navajo
Total [1]	658,548	
Long-Term Care		
Department of Economic Security—Division of Developmental Disabilities	13,402	All
Maricopa Long Term Care	7,635	Maricopa
Pima Long Term Care	3,507	Pima, Santa Cruz
Evercare Select	2,952	Apache, Coconino, La Paz, Maricopa, Mohave, Navajo, Yuma
Mercy Care Plan	2,828	Maricopa
Yavapai County Long Term Care	1,043	Yavapai
Pinal/Gila Long Term Care	1,005	Gila, Pinal
Cochise Health Systems	850	Cochise, Graham, Greenlee
Total [2]	33,222	

[1] Excludes 5,401 members served by Department of Economic Security Comprehensive Medical and Dental program and the 88,994 members served by the Indian Health Services and Arizona Health Care Cost Containment System (AHCCCS), fee-for-service.

[2] Excludes the 1,440 Native Americans served by tribal contractors.

Source: Auditor General staff summary of information on AHCCCS Web site, July 2002.

helps ensure that members receive needed services. According to the U.S. General Accounting Office, managed care can create an incentive to under-serve or even deny beneficiaries access to needed care since plans can profit from not delivering services.[1] According to the Health Care Financing Review, quality monitoring is "… perhaps one of the most important activities to pursue as the number of beneficiaries in managed care systems increases…with the economic incentives inherent in managed care systems, there is the potential for access and quality of care to be adversely affected. Considering that a significant number of disadvantaged and vulnerable individuals make up the Medicaid population, the need for effective monitoring and evaluation of the access and quality of care provided to this population is particularly apparent."[2] AHCCCS relies primarily on its Office of Medical

AHCCCS conducts an annual onsite review of all health plans.

1 U.S. General Accounting Office. *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort,* May 1997. (GAO/HEHS-97-86)

2 Hadley, James P. and Linda F. Wolf. "Monitoring and Evaluating the Delivery of Services Under Managed Care." *Health Care Financing Review*, Washington, Summer 1996.

Management (OMM) to ensure quality of care for its members. As a result, OMM is generally responsible for evaluating health plan practices for improving quality and monitoring the care members received.[1] AHCCCS uses four primary mechanisms to accomplish this.

- Operational and financial reviews—AHCCCS conducts annual onsite Operational and Financial Reviews (OFR) of 17 acute and ALTCS health plans to assess compliance with AHCCCS standards and contract requirements in several categories: quality of care, grievance and appeals, delivery of services, and financial management.[2] While OMM participates in these reviews, AHCCCS' Office of Managed Care coordinates the OFR and is also responsible for reviewing many of the standards. (See Auditor General Report No. 02-XX for more information about the Office of Managed Care.) Through the OFR, AHCCCS attempts to maintain a comprehensive understanding of health plan activities, ensure service delivery and, in the event of deficiencies, provide technical assistance to resolve the problem and ensure that it will not reoccur.

- Quality-of-care complaints—AHCCCS also monitors the care members receive through quality-of-care complaints. Quality-of-care complaints typically involve concerns with the medical care members have received, such as substandard nursing care or difficulty in obtaining medications and services, and can be used to identify systemic problems and make improvements. Members can send their complaints to their provider, their health plan, or directly to AHCCCS.

- Clinical performance indicators—AHCCCS has established 17 clinical performance indicators to determine how well the overall healthcare system is delivering services for specific populations within its membership. For example, AHCCCS tracks the percentage of its elderly population who receive flu shots and the percentage of pregnant women receiving prenatal care. By tracking this information AHCCCS can determine if its population is meeting state and national healthcare benchmarks. Also, AHCCCS can identify poor performance for specific indicators and require corrective actions to improve performance at individual health plans or across several health plans. AHCCCS has established performance standards for each of these indicators and has incorporated them into the acute care health plans' contracts. For a complete list of the clinical performance indicators, see Table 4, page 31.

- Quality management plans—AHCCCS annually reviews each health plan's quality management plans to assess the systems the health plans have established to monitor and improve quality of care. The quality management plan includes an annual evaluation health plans conduct to measure the effectiveness of their quality management programs. This evaluation

1 OMM also tracks the utilization of services, preauthorizes high-cost services such as transplants and treatment for severe head injuries, and oversees contract pharmaceutical services.

2 While AHCCCS contracts with 18 health plans, it does not conduct OFRs of the Department of Economic Security's Comprehensive Medical and Dental Program.

summarizes quality management activities performed throughout the year, trends identified as a result of these activities, and action taken for improvement. The quality management plan also includes written measurable objectives the health plans have developed to improve their quality management programs. Further, the quality management plan documents various health plan policies and procedures that address quality management activities, such as complaint tracking and trending and coordination of member care.

AHCCCS also conducts a number of other activities to monitor quality of care. Specifically, AHCCCS conducts periodic member and provider satisfaction surveys to obtain feedback on its healthcare system and members' assessments of their treatment for various illnesses, such as diabetes and asthma, to determine the impact of efforts to improve the care members receive.

OMM staffing and budget

For fiscal year 2002, OMM was authorized 60 FTE and allocated over $3.9 million in total funding. As illustrated in Table 2 (see page 5), of this amount, approximately $1.3 million was from the General Fund and over $2.3 million came from Title XIX federal matching funds. The remainder came from the Children's Health Insurance Program Fund and the Arizona Tobacco Litigation Fund.

Audit scope and methodology

This audit focused on AHCCCS' methods to monitor the quality of care provided to its members. Specifically, auditors reviewed AHCCCS' Operational and Financial Review process, its quality-of-care complaint-handling process, its efforts to address concerns with its DDD long-term care contract, and the clinical performance indicators AHCCCS has established and tracks.

This report contains findings and recommendations in four areas, as follows:

- AHCCCS should increase the impact of its Operational and Financial Reviews by focusing on health plan performance outcomes, in addition to its review of plan policies and procedures.

- AHCCCS needs to ensure that the quality-of-care complaints it receives are appropriately resolved.

Table 2 Office of Medical Management
Schedule of Revenues and Expenditures
Years Ended June 30, 2000, 2001, and 2002
(in Thousands—Unaudited)

	2000	2001	2002
Revenues:			
Appropriations:			
State General Fund	$1,209.1	$1,302.8	$1,286.3
Children's Health Insurance Program Fund [1]	71.1	131.9	143.1
Federal	1,878.9	2,049.4	2,353.4
Tobacco settlement litigation monies [2]		4.1	153.0
Total revenues	$3,159.1	$3,488.2	$3,935.8
Expenditures:			
Personal services	$1,782.6	$2,089.6	$2,535.7
Employee-related	349.1	412.2	507.9
Professional and outside services	892.5	837.7	728.3
Travel, in-state	11.6	10.6	15.0
Travel, out-of-state	5.5	7.9	6.0
Other operating	108.6	123.4	139.8
Equipment	9.2	6.8	3.1
Total expenditures	$3,159.1	$3,488.2	$3,935.8

1 Consists of monies allocated to the Division for its role in administering the children's health insurance program. Monies are appropriated from the Children's Health Insurance Program Fund and consist of tobacco taxes and federal matching monies for providing health insurance coverage to uninsured children whose families meet certain income requirements.

2 Consists of the portion of monies obtained from a settlement with the tobacco companies allocated to the Division and used for its role in administering the Proposition 204 program.

Source: Auditor General staff analysis of financial information provided by the Arizona Health Care Cost Containment System for the years ended June 30, 2000, 2001, and 2002.

- AHCCCS needs to do more to ensure that complaints from its ALTCS developmentally disabled clients are appropriately handled and that home modification services are provided to this population in a timely manner.

- While AHCCCS has established and tracks the performance of 17 clinical performance indicators that reflect the services provided and the general health of its member population, minor adjustments to these indicators could enhance their impact.

Auditors used a number of research methods to study the issues addressed in this report, including interviewing AHCCCS staff, reviewing the AHCCCS 2000 member satisfaction survey design and results, conducting a literature review, and attending two AHCCCS quarterly meetings with acute health plans and two quarterly meetings

with ALTCS health plans, during which quality improvement issues were reviewed. Auditors also reviewed statutes, rules, and policies and procedures. In addition, auditors used the following methods:

- To assess the Operational and Financial Review as a tool to ensure quality, auditors analyzed a subset of OFR standards selected to reflect those areas members were most likely to view as important aspects of health service quality based on an auditor review of literature and AHCCCS member surveys. This subset was reviewed and amended with input from AHCCCS management. The subset included 28 of 111 acute standards evaluated in 2001, 16 of 31 ALTCS standards evaluated in 2001, and 18 of 43 ALTCS standards evaluated in 2000. Auditors reviewed AHCCCS findings and recommendations regarding health plans' performance on these standards and assessed AHCCCS' evaluation methods by reviewing the 2001 or 2000 OFR for 17 health plans. For 4 health plans, auditors also reviewed AHCCCS OFR working papers. Further, auditors reviewed the 1999 OFR recommendations made for 7 health plans and compared these recommendations to 2001 OFR results. Finally, auditors observed AHCCCS employees conducting the quality management and delivery systems portion of an OFR for an acute health plan and interviewed staff at two other large health plans.

- To assess whether AHCCCS handles quality-of-care complaints appropriately, auditors reviewed a sample of 40 quality-of-care complaints AHCCCS received in federal fiscal year 2001, involving two acute and two ALTCS health plans. Auditors also reviewed the health plans' files for these 40 complaints, and the quality complaint investigation and resolution policies and procedures for the four health plans in the sample, and interviewed these health plans' staffs on their complaint-handling processes.

- To assess AHCCCS' ability to ensure the quality of care provided to its developmentally disabled members, auditors reviewed the two notices to cure regarding AHCCCS concerns with the Arizona Department of Economic Security Division of Developmental Disabilities (DDD) complaint-handling system and provision of home modification services.[1] Auditors attended the April and May 2002 meetings held by AHCCCS and DDD to discuss progress on the complaint-handling notice to cure and reviewed the minutes from the 20 previous meetings that took place between March 2001 and March 2002. Further, auditors reviewed the 5 DDD-prepared monthly home modification tracking reports from January 2002 to May 2002 and 12 DDD home modification files selected from the January 2002 to April 2002 reports. Further, auditors

[1] If a health plan does not comply with its contract, AHCCCS may issue a notice to cure, which alerts the health plan of the deficiency, describes what the health plan must do to be in compliance, and provides a deadline for completing these tasks.

reviewed the 6 DDD OFRs conducted between 1996 and 2001; interviewed DDD central office and District 1 staff; and reviewed 10 complaints one District 1 local office received during federal fiscal year 2002.

- To assess the clinical performance indicators, auditors reviewed AHCCCS clinical performance indicator reports from 1998 through 2002; reviewed corrective action plans from four health plans that did not meet AHCCCS contract standards; reviewed the 2002 Health Plan Employer Data and Information Set standards; and researched state and federal health benchmark standards, including those of the Arizona Department of Health Services.

This audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the director and staff of the Arizona Health Care Cost Containment System, the Office of Medical Management, and the Office of Managed Care for their cooperation and assistance throughout this audit.

FINDING 1

AHCCCS should strengthen its health plan reviews

AHCCCS' annual onsite reviews can be strengthened by increasing the focus of these reviews on health plan performance outcomes in providing quality care. These reviews are one of AHCCCS' key evaluation tools for ensuring that health plans provide high-quality, accessible health services. However, because these reviews primarily focus on whether plans have a policy or process in place, rather than on what the process accomplishes, problems in service delivery may be overlooked. Additionally, AHCCCS' followup on identified problems is limited, allowing some problems to continue. To increase the value of its reviews, AHCCCS should increase its focus on health plan performance outcomes and strengthen its efforts to ensure that health plans have corrected deficiencies.

Annual reviews used to monitor quality of care

AHCCCS has established a comprehensive evaluation mechanism, called an Operational and Financial Review (OFR), to annually review its health plans' operations. In its state Medicaid Plan, AHCCCS identifies the OFR as a key mechanism to ensure the quality and effective delivery of health services through its health plans. These reviews assess the health plan's compliance with contractual and AHCCCS requirements as well as the quality and availability of health services. The OFR's important components include:

- Assessment by a qualified team—AHCCCS assembles highly qualified teams, typically comprising 10 to 20 AHCCCS personnel, including doctors, nurses, and accountants, and other analysts who will spend up to 1 week onsite at the health plan conducting the review. Typical review activities include interviews, observing processes, policy and procedure reviews, and some file reviews.

An OFR evaluates the quality of services provided to members.

- **Assessments of compliance with numerous standards**—For each of its reviews, AHCCCS evaluates health plan compliance with numerous standards. Specifically, for the year ending September 30, 2001, AHCCCS evaluated each acute health care plan on 111 different standards grouped into 9 categories, while it reviewed four ALTCS health plans on 31 standards grouped into 6 categories. Table 3 (see page 11), provides further information on these review categories and examples of standards. During the 5-year contract period (1-year contract with four 1-year renewal options), AHCCCS will conduct both full and targeted annual reviews. For full reviews, which normally occur during the first and last year of the contract, AHCCCS reviews all of the standards for each of its health plans. For targeted reviews, AHCCCS focuses on review categories or standards of particular current importance, or those that tend to be problematic for individual health plans.

- **Action plans when problems are reported**—Following the onsite review, AHCCCS prepares an individual report of its findings and recommendations for each health plan. For each standard reviewed, AHCCCS determines a score of full, substantial, partial, or noncompliance and reports it along with any recommendations for improvement. In most cases, when it makes recommendations for improvement, AHCCCS requires the health plan to submit a corrective action plan detailing how it will address the problems identified. Additionally, AHCCCS sends the complete report to each health plan, while executive summaries are sent to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Reviews can better monitor quality

Although AHCCCS has established a comprehensive set of standards, its assessment methods often focus on ensuring that a policy or process is in place, and not on how effectively the health plan is providing services or whether the process is being implemented effectively. To better assess whether members receive the care and services that health plans are required to provide, AHCCCS should place more emphasis on performance. To free up staff time for such assessments, AHCCCS may need to narrow its current set of standards, placing priority on those standards that matter most for health plan performance and quality of care.

Reviews do not always assess plan performance.

AHCCCS often evaluates policy rather than performance—Auditors analyzed 28 acute and 16 ALTCS quality-of-care standards and found that for approximately 40 percent of the standards, AHCCCS' evaluation was based on whether the health plan had a process or policy in place, not on whether the desired outcome was achieved.[1] This emphasis on policy and procedure may cause AHCCCS to miss problems that exist within the system. For example:

[1] See Audit Scope and Methodology (pages 4 through 7), for auditors' methods to select standards.

Table 3 Operational and Financial Review Standards
Federal Year Ended September 30, 2001

Category	Number of Standards	Examples
Standards for Acute Care Health Plans		
Delivery System	17	Meets minimum network standards for primary care physicians
Member Services	13	Has adequate number of customer service representatives to answer telephone calls promptly
Quality Management	18	Resolves quality-of-care complaints within established time frame
Maternal/Child Health	9	Ensures members receive timely prenatal care
Member Rights and Responsibilities	6	Explains service denial reasons in common language
Grievances and Appeals	9	Has provider manual that contains grievance process
Utilization Management	21	Makes prior authorization decisions in a timely manner
Financial Management	13	Meets required financial viability criteria
Health Service Reporting	5	Has policies and procedures addressing encounter data submission
Standards for Long-Term Care Health Plans		
Delivery System	4	Meets service area minimum network standards for attendant care workers
Member Services and Case Management	2	Ensures case managers have appropriate qualifications and meet caseload standards
Quality Management	3	Aggregates and analyzes member quality- of-care and complaint data and uses the results to improve care
Behavioral Health	4	Ensures contractors train case managers and providers to screen for behavioral health needs
Administration and Management	8	Appropriately notifies members when services are denied, terminated, reduced, or suspended
Financial Management	10	Has adequate procedures for timely and accurate claims payment or denial

Source: Auditor General staff summary of Arizona Health Care Cost Containment System's 2001 operational and financial reviews of health plans.

- **Wait times for medically necessary transportation**—This standard evaluates whether health plans provide members with medically necessary transportation in a timely manner. Sixteen of the 17 health plans received ratings of at least substantial compliance for this standard because they had a system to monitor

wait times. However, none of the 17 OFRs included information regarding the actual transportation wait times, or whether the transportation was provided on a timely basis. At the same time, member complaint records or satisfaction surveys indicated that transportation wait times were a source of member dissatisfaction for six of nine acute health plans.

- **Members receiving prenatal care**—This standard evaluates whether "the health plan ensures that pregnant members obtain initial prenatal care appointments within prescribed time frames…" However, data on the percentage of women receiving prenatal care within prescribed time frames is not considered for AHCCCS health plan compliance scores, even through AHCCCS collects and reports this information for a clinical performance indicator. Instead, health plans are evaluated on whether they have established goals, interventions, and other procedures to monitor and increase the number of members receiving prenatal care. Eight of nine acute health plans received ratings of full or substantial compliance for this standard.

- **Timely response to member calls**—This standard evaluates whether the health plan has a sufficient number of member service representatives to promptly handle member telephone calls. Each health plan sets its own standards for call wait times. AHCCCS assesses this standard by whether: 1) the plan has established standards for wait times and abandonment rates, 2) the plan monitors hold times and abandonment rates, and 3) the plan takes action when standards are not met. Because AHCCCS assesses the health plan's system to handle member calls, health plans can receive ratings of full or substantial compliance regardless of whether calls are answered according to plan standards. Seven of the nine acute health plans received ratings of full or substantial compliance for this standard.

Timeliness of response to member calls is not reported.

In 1997, the U.S General Accounting Office evaluated the mechanisms used to monitor the adequacy and accessibility of healthcare services in four managed care states.[1] While GAO acknowledged the difficulty in assessing quality of care in managed care systems, it found fault with current compliance standards used in these managed care organizations to assess quality of care. Specifically, it found that plan compliance with contract requirements does not necessarily ensure that beneficiaries receive the care they need.

OFR evaluation methods should emphasize performance—AHCCCS should place more emphasis on performance when evaluating health plans, which it can do by revising its assessment methods to more often focus on health plan performance outcomes and member quality of care. AHCCCS management has indicated that it agrees with the change in emphasis and, during the course of this audit, changed its assessment methods for several important service quality

1 U.S. General Accounting Office. *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort,* May 1997. (GAO/HEHS-97-86). The four states reviewed were Arizona, Pennsylvania, Tennessee, and Wisconsin.

standards for its 2002 reviews. For example, in February 2002, AHCCCS began to evaluate health plan data to determine if AHCCCS standards for transportation wait times are met, in addition to determining whether plans have a system in place to monitor wait times.

Standards may need to be prioritized—Since assessing performance outcomes may require increased AHCCCS resources, AHCCCS may need to prioritize and/or reduce the current number of standards it measures. Generally, AHCCCS reviews 17 health plans annually and assesses compliance with up to 111 standards for its acute plans and 31 standards for its ALTCS plans. According to AHCCCS officials, it has adequate staff to conduct these reviews. However, a change to a more performance-oriented review could require more in-depth work and analysis and potentially more resources. Therefore, AHCCCS may want a limited set of core OFR standards, measured across all health plans, with the remainder of the review focusing on health plan-specific or system-wide areas of concern. Auditors' review identified a number of sources AHCCCS can consider to identify focus areas for the OFR each year.

AHCCCS should prioritize or reduce the number of standards.

- Member complaints—Both the health plans and AHCCCS compile data on the number and nature of member complaints. Topics of member concern that appear with high frequency at either AHCCCS or the health plans could become focus areas for future reviews. For example, AHCCCS and its health plans received many complaints regarding prescription drugs in 2001. With this information, AHCCCS could focus on health plan and provider practices for issuing prescriptions.

- Member and provider surveys—AHCCCS and the health plans conduct member and provider surveys. While AHCCCS does not conduct surveys every year, individual health plans frequently conduct member and provider surveys on a variety of topic areas. AHCCCS could review these surveys for specific areas of concern or current priorities in healthcare and delivery, and address these areas in its OFR.

- Prior-year OFRs—Prior-year OFR finding areas and recommendations can provide health plan-specific topics for future reviews. For example, 2001 OFRs identified that six of nine acute care health plans did not ensure that required interpreter services were available to non-English-speaking members. At the same time, the AHCCCS member satisfaction survey conducted in 2000 identified that the ability to communicate with the health provider is a critical component of member satisfaction with healthcare. AHCCCS has included a review of interpreter availability in the 2002 OFR.

- Clinical performance indicator results—AHCCCS collects and tracks data for 17 different clinical performance indicators. While indicator results are not routinely

reported in the OFR, the clinical performance indicator data provides valuable information on how well health plans are delivering services. The indicators include access to care for adults, adolescents, and babies; immunization rates; and cancer screening efforts for women. AHCCCS could use this information to identify focus areas for specific health plans. (See Finding 4, pages 29 through 34 for more information on AHCCCS clinical performance indicators.)

AHCCCS should strengthen monitoring

AHCCCS should also strengthen its monitoring efforts to ensure health plan deficiencies are corrected. Typically, when AHCCCS identifies deficiencies as part of an OFR, it requires the health plan to develop a corrective action plan, but AHCCCS does not always verify that the corrective action was implemented. This lack of followup has allowed some problems to continue.

AHCCCS does not ensure corrective actions are taken—AHCCCS does not verify whether health plans have implemented corrective actions. Although AHCCCS obtains corrective action plans and other documentation, such as revised policies and procedures, the existence of such plans may not ensure that corrective action has occurred. According to AHCCCS management, in addition to requiring corrective action plans, followup is ensured by the fact that subsequent OFRs will review those areas in which the health plan was previously deficient. However, AHCCCS did not reassess some important 1999 deficiencies in its 2000 OFR of acute health plans. For example, based on the 1999 OFRs, many acute health plans needed to implement corrective actions in categories such as quality management and delivery systems. However, these categories were not reviewed in the 2000 OFR.

1999 deficiencies still existed in 2001 OFRs.

Finally, when auditors reviewed the 1999 OFR recommendations made for seven health plans and compared them to 2001 OFR results, they found that some problems continued despite the fact that health plans had submitted corrective action plans to AHCCCS. For example,

- In its 1999 OFR of one acute health plan, AHCCCS identified deficiencies with the health plan's credentialing of dentists and the implementation of a system to track whether members receive behavioral health services. The health plan submitted corrective action plans that detailed how it would resolve these issues. Nonetheless, AHCCCS did not review dentist credentialing files in the 2001 OFR, but identified deficiencies with the health plan's physician credentialing, as well as its system for tracking members who receive behavioral health services. AHCCCS ultimately issued a notice to cure to this health plan in November 2001, for this and other quality management deficiencies.

- In the 1999 OFR of another health plan, AHCCCS identified that the plan did not meet standards for the required number of dentists in several communities. Additionally, the plan was not tracking whether members received behavioral health services. The health plan submitted a corrective action plan specifying actions it would take to address these concerns. However, in its 2001 OFR, AHCCCS again found that the plan did not meet standards for the number of dentists in several communities and for tracking behavioral health services.

One plan did not have the required number of dentists in several communities.

AHCCCS should verify health plans' corrective actions—When OFR results show that the health plan needs to correct deficiencies that substantially impact member health or service quality, AHCCCS should verify that corrective actions have occurred. In its 1997 report, the U.S General Accounting Office found that the success of healthcare quality oversight depends on whether the state's monitoring efforts are independent and systematic, and go beyond plan-reported, paper-based indications of compliance. AHCCCS does not meet this standard. AHCCCS should verify corrections have been made though either: 1) documentation that provides evidence of implementation or, 2) through a follow-up visit to the contractor. For example, some of the areas identified for corrective action in the 2001 OFRs that may warrant AHCCCS' more timely and thorough followup include:

- One acute and one ALTCS health plan do not have adequate systems to monitor and resolve member complaints;

- Six of nine acute health plans are not ensuring that required interpreter services are available to members; and

- An ALTCS health plan is not conducting the required quality oversight of its group homes, behavioral health facilities, and other home- and community-based services.

Recommendations

1. AHCCCS should modify its annual operational and financial reviews of health plans to focus more on evaluating health plan performance outcomes.

2. If AHCCCS increases its focus on health plan performance outcomes in its OFRs, which may require increased resources, AHCCCS should prioritize and consider reducing the overall number of OFR standards that it evaluates during each operational and financial review.

3. AHCCCS should enhance its follow-up efforts to ensure that health plans resolve the problems identified in the operational and financial reviews, including obtaining evidentiary documentation and conducting more frequent follow-up visits when necessary to verify that corrective actions have occurred.

FINDING 2

AHCCCS needs to ensure member complaints are appropriately resolved

AHCCCS needs to ensure that all complaints it receives regarding quality of care are appropriately resolved. Currently, AHCCCS refers the complaints it receives to its health plans for investigation and resolution. When auditors reviewed a sample of such complaints, they found that, for nearly half of the complaints requiring corrective action, the files contained no indication that any corrective action had been taken. AHCCCS should follow up on complaints it refers to health plans to ensure they are appropriately resolved. AHCCCS also continues to refer complaints even in those cases where plans appear to have deficient complaint-handling practices. Where it has identified deficient complaint-handling practices, AHCCCS should work with the health plan to develop an acceptable complaint-handling system and in the meantime, investigate and resolve complaints it receives, rather than referring these matters to the health plans.

Complaints identify member concerns

AHCCCS refers complaints to health plans for investigation and resolution.

Complaints serve as one mechanism to identify member concerns and make improvements. According to the Center for Health Care Strategies, Inc., complaints highlight how well customer satisfaction is being addressed and can provide early warnings of potential systemic problems.[1] Within the AHCCCS system, complaints pertaining to the quality of care a member received, such as substandard nursing care or difficulty getting medications and services, can be sent either to the health plan or directly to AHCCCS. However, when AHCCCS receives quality-of-care complaints, it refers them to the appropriate health plan for investigation and resolution. AHCCCS requires health plans to investigate complaints it receives since it views the investigation and resolution of member complaints as a health plan function. AHCCCS states that it is confident relying on health plans to investigate and resolve these complaints because it ensures the

1 Verdier, James, and others. *Using Data Strategically In Medicaid Managed Care*. Center for Health Care Strategies, Inc., Chapter 4: Other Data Sources and Uses, 2002. [electronic version]

adequacy of the plans' complaint-handling processes through the annual OFR. While the health plans will independently investigate complaints, AHCCCS' policy is to require updates on the progress of investigations, provide direction on these investigations, and require health plans to report on the complaint's disposition.

AHCCCS receives several hundred quality-of-care complaints annually. Specifically, for federal fiscal year 2001, AHCCCS reports that it directly received approximately 410 potential quality-of-care complaints from a variety of sources, including members, providers, elected officials, and AHCCCS staff. AHCCCS referred most of these complaints to the appropriate health plans for investigation and resolution. However, AHCCCS does investigate and resolve a small number of complaints that it receives involving members who are not served by a health plan.

AHCCCS has also developed and recently implemented a database to track all of the complaints that it receives. In October 2001, AHCCCS began entering information related to the nature and resolution of complaints it receives into this database, whether investigated and resolved by the health plan or AHCCCS. With this complaint information, AHCCCS will be able to identify trends and work to resolve any systemic problems these trends identify.

Complaint resolution inconsistently occurs

AHCCCS' approach does not ensure complaints are appropriately resolved and changes are implemented to help prevent similar problems from reoccurring. Auditors' review of complaint files found that neither AHCCCS nor the plans consistently ensure that complaints AHCCCS refers are appropriately resolved. Therefore, AHCCCS should follow up and document that necessary corrective actions have been implemented for all of the complaints it receives.

AHCCCS does not consistently document the appropriate resolution of its complaints.

AHCCCS cannot ensure all complaints are appropriately resolved—

While it appears appropriate for AHCCCS to refer the quality-of-care complaints it receives to health plans for investigation and resolution, the steps AHCCCS is using do not ensure that members' concerns or systemic problems identified are appropriately resolved. Auditors' review of 40 complaints found no assurance that AHCCCS or the health plans consistently document the appropriate resolution of member concerns and implementation of corrective actions.[1] Twelve of the 28 complaint files reviewed that required corrective actions lacked documentation that the health plan addressed member concerns and took necessary corrective actions. The following examples illustrate complaints for which evidence of appropriate resolution could not be located in AHCCCS' or the health plans' files.

- **Inappropriate use of pain medications**—In March 2001, AHCCCS received a complaint from a doctor's office regarding a member who was inappropriately

1 Auditors reviewed ten complaints each from four health plans—two of which serve acute care members and two of which serve ALTCS members. AHCCCS received these complaints during federal fiscal year 2001.

seeking prescription pain medications. After the complaint investigation identified an abnormal pattern of prescribing medications for this member, the health plan informed AHCCCS of several actions it planned to take to address the member's needs and prevent this situation from reoccurring. These actions included: 1) identifying the specific physicians who contributed to the member's over-utilization of prescriptions; 2) sharing the drug utilization profile with these physicians; 3) contacting the member's new doctor to alert him of the member's prior history and discuss a treatment plan; and 4) limiting the member to one pharmacy. However, AHCCCS' and the health plan's files lacked evidence that any of these actions were taken.

- Poor monitoring of patient's blood sugar levels—In December 2000, AHCCCS received a complaint regarding a facility that was not properly documenting and monitoring care to address a member's blood sugar levels. The health plan's investigation determined that the facility did not properly follow physician orders, and the plan informed AHCCCS that the facility would: 1) develop a policy regarding nursing interventions for episodes of hyperglycemia and hypoglycemia; 2) train nursing staff on this policy; and 3) train nursing staff on the facility's policies for following physician orders and documenting care. While documentation in AHCCCS' file indicates that the health plan would follow up with the facility on the new policy and trainings, auditors found no evidence in AHCCCS or plan files that these actions occurred.

AHCCCS needs to ensure its complaints are resolved—AHCCCS should ensure that corrective actions are implemented for all complaints it receives. Specifically, AHCCCS should obtain documentation and confirm that appropriate corrective actions have been taken. In some instances, contacting the complaint originator may be the best way for AHCCCS to confirm that the concern has been resolved. However, in other instances, AHCCCS needs to work with the health plan to obtain evidence of corrective actions, such as copies of policies or training attendance records. Whether contacting the complainant directly and/or requiring evidence from the health plan, AHCCCS should follow up as long as necessary to ensure that complaints are appropriately resolved. In many cases, AHCCCS should be able to obtain this information through phone calls or letters.

AHCCCS should confirm that its complaints have been appropriately resolved.

AHCCCS should address deficient complaint handling

In addition to ensuring that complaints are resolved, AHCCCS should investigate and resolve the complaints it receives when it has previously identified concerns with health plan complaint-handling practices, and take action to remedy these practices. Even though AHCCCS has identified problems with the complaint-handling processes of 4 of 17 its health plans, it has continued to refer complaints to these plans for investigation and resolution. To better ensure appropriate complaint

investigation and resolution, if AHCCCS identifies health plan complaint-handling problems, it should work with the health plan to address these problems, but also investigate and resolve the complaints it receives until these problems are addressed. Additionally, AHCCCS should enhance its monitoring of the complaints received directly and investigated by health plans with deficient complaint-handling processes.

AHCCCS continues to refer complaints to its health plans even after identifying deficient processes.

Complaints referred to plans with inadequate processes—AHCCCS continues to refer complaints it receives to health plans for investigation and resolution even in those instances in which it has identified deficiencies with these plans' complaint-handling processes. Examples of the four plans that were found to have inadequate complaint-handling processes include the following:

- In 2001, AHCCCS found several problems with a health plan, including concerns with how it documents and responds to complaints. Specifically, AHCCCS noted that complaints were not thoroughly researched and properly resolved to prevent their reoccurrence.

- In 2001, AHCCCS found that a different health plan failed to document resolution for 11 (73.3 percent) of 15 complaints reviewed. For example, one complaint was labeled as an unexpected death and closed without the health plan receiving medical records or other documentation regarding the circumstances of the death. In another two complaints, the files did not contain documentation of the health plan following up on the concerns it had identified.

Despite these deficiencies, AHCCCS' complaint databases show that it referred at least 83 complaints to these 4 health plans for investigation and resolution after AHCCCS identified deficiencies with their complaint-handling processes and before it accepted the health plans' corrective actions. Fifty-four of these complaints were referred to one health plan.

AHCCCS should increase its oversight and handle its complaints—When AHCCCS has identified significant problems with a health plan's complaint-handling process, it should take appropriate action against the health plan. This action could include a formal notice to cure, which would require specific corrective actions within a specified time period, or financial sanctions. Further, until problems are resolved, AHCCCS should investigate and resolve the complaints it receives. Even though health plans are required to investigate and resolve these complaints, AHCCCS is ultimately responsible to ensure complaints are properly investigated and member concerns addressed.

Further, for those health plans with complaint-handling deficiencies, AHCCCS should also increase its monitoring of how the health plan handles the complaints it receives directly. This monitoring could include AHCCCS requesting periodic reports from the health plan about complaints the plan receives and reviewing how they were handled. If through monitoring, AHCCCS continues to have concerns with the health plan's

process, AHCCCS should work with and educate the plan on how to properly investigate and resolve these complaints.

Where deficiencies are identified, AHCCCS should handle complaints and increase its oversight.

AHCCCS may need additional resources to handle its complaints and increase its oversight of the way health plans handle complaints. Once AHCCCS has implemented these recommendations and assessed their impact on its workload, AHCCCS should determine if additional resources are needed and, if so, whether the State or the health plans with deficient complaint-handling processes should pay for them.

Recommendations

1. AHCCCS should ensure that complaints are appropriately resolved by obtaining evidence that the member concern has been addressed and, when appropriate, changes have been implemented to help prevent similar problems from reoccurring. Where appropriate, AHCCCS should contact the complainant to determine if the concern has been satisfactorily addressed.

2. In those instances where AHCCCS has identified significant problems with a health plan's complaint-handling process, AHCCCS should:

    a. Take appropriate action against the health plan for its failure to properly investigate and resolve complaints, possibly including a formal notice to cure, which would require corrective actions within a specified time period, or financial sanctions.

    b. Investigate and resolve the complaints it receives rather than refer them to the health plan until the plan has implemented a complaint-handling system that meets AHCCCS' requirements.

    c. Increase its monitoring of how the health plan handles the complaints they receive directly until the plan has demonstrated its ability to adequately investigate and resolve complaints.

FINDING 3

AHCCCS needs to do more to address concerns with care for the developmentally disabled

AHCCCS needs to do more to ensure that quality-of-care concerns for its ALTCS developmentally disabled members are addressed. Statute currently requires AHCCCS to contract with the Department of Economic Security's Division of Developmental Disabilities (DDD) to provide services to the State's developmentally disabled population. However, AHCCCS has two long-standing concerns with DDD's provision of services to its members: complaint handling and tracking and the provision of home modification services. Since 1996, DDD has not met AHCCCS' standards for complaint tracking and resolution. Because AHCCCS is ultimately responsible for ensuring that members' complaints are appropriately resolved, AHCCCS should expand its review of DDD's complaint handling until DDD complies with these standards. Additionally, AHCCCS has not ensured that DDD provides home modification services, such as wheelchair ramps, in a timely manner. Although AHCCCS took action in 2000 to address the delays in providing these services, it has taken limited action to address the current delays in providing these services to its members.

DDD serves the developmentally disabled

Statute currently requires DDD to oversee services to the State's developmentally disabled population. As a result, AHCCCS must contract with DDD to provide services for its developmentally disabled Arizona Long Term Care System (ALTCS) members. Nearly 40 percent of AHCCCS' total ALTCS population (13,402 people) is developmentally disabled and served by DDD.

DDD serves nearly 40 percent of AHCCCS' ALTCS population.

Since statute requires that DDD serve this population, AHCCCS' options for ensuring that DDD is in compliance with contractual requirements are limited. As with other plans, if DDD does not comply with its contract, AHCCCS can issue what is called a

"notice to cure," which describes what the health plan must do to be in compliance, and provides a deadline for completing these tasks. However, AHCCCS' tools for enforcing this notice to cure are more limited for DDD than for other plans. If other plans do not comply, AHCCCS can issue a fine, cap enrollment, or terminate the contract. Since DDD is the only health plan allowed to serve the developmentally disabled, AHCCCS can impose fines, but cannot cap enrollment or terminate the contract.

Complaint-handling concerns continue

DDD's complaint-handling process has not met AHCCCS' contractual standards for many years. Until DDD meets AHCCCS standards, AHCCCS should expand its review of DDD's complaint handling and continue to help the division reach compliance with complaint-tracking and resolution standards.

DDD has not complied with AHCCCS' complaint-handling requirements for several years.

Complaint-handling has not met standards since 1996—DDD's complaint-handling process has not met AHCCCS' contractual standards for many years. AHCCCS requires its health plans to track all member problems and complaints and analyze the information to prevent similar problems from reoccurring. However, DDD's complaint-handling process has not met these standards since 1996, according to AHCCCS Operational and Financial Reviews. In December 2000, AHCCCS issued a notice to cure, stating, among other things, that DDD had "consistently failed to meet the complaint tracking and resolution standards contained in their contract with AHCCCS…." and that "These standards have repeatedly been out of compliance in past reviews."

DDD has not carried out all of the actions AHCCCS required in its December 2000 notice to cure. Specifically, AHCCCS' notice required DDD to develop a comprehensive, centralized, statewide written complaint system that aggregates all complaint data statewide by June 15, 2001. DDD's current complaint process is decentralized, with most complaint information located in files spread across approximately 40 local offices. Complaint information and investigation details are often also separate—partly in members' files, and partly in investigators' files. DDD failed to meet the June 2001 deadline but, as discussed further below, it is currently working on a system to meet AHCCCS requirements.

As a result of DDD's inadequate progress in addressing the quality-of-care issues identified in the December 2000 notice to cure, AHCCCS imposed a financial sanction of $6,000 in February 2001. The notice to cure also remains in effect as of May 2002. In addition, AHCCCS discovered another problem in its 2001 OFR. It found DDD in noncompliance with the standard to appropriately respond to complaints and evaluate the effectiveness of actions taken to improve care. AHCCCS found that four of the ten

complaints it reviewed at the central office did not meet this standard and that some lacked evidence of adequate research and documentation.

AHCCCS should expand its review of DDD complaint handling—

Because AHCCCS is ultimately responsible for ensuring that member complaints are appropriately resolved, AHCCCS should continue to assist DDD in implementing an acceptable system that captures all complaints and increase its complaint monitoring. In response to the notice to cure, DDD began developing a computerized complaint-tracking system that currently captures the most severe high-risk incidents, such as abuse, accidental injury, and neglect. DDD plans on adding other incidents, such as medications being given to the wrong person or medications not being given at all, to this system. However, DDD's system will still not contain all complaints or quality-of-care concerns. As such, DDD has developed a work plan to ensure that the remainder of its system development meets AHCCCS requirements. AHCCCS reviewed this work plan in August 2002 and provided direction to DDD on additional steps it should take to meet AHCCCS' requirements. Because AHCCCS has expertise in these systems, it should continue to work with DDD to help it develop a system that meets standards.

AHCCCS should expand its review of DDD complaint handling.

Additionally, AHCCCS should expand its review of DDD complaint files during its OFRs. Specifically, AHCCCS should review complaint files not only from the central office, as it currently does, but from the local offices as well to ensure that all types of complaints are being handled appropriately. The central office complaints are limited to cases referred by AHCCCS to DDD for investigation. Because AHCCCS directs DDD on issues that should be further investigated on these complaints, they are not representative of how the majority of complaints DDD receives are handled. Reviewing complaints handled by DDD's local offices would provide AHCCCS with a more accurate assessment of DDD's complaint-handling practices. If AHCCCS determines, as a result of these reviews, that DDD is not handling complaints appropriately, it needs to determine what corrective action is necessary.

Home modifications remain untimely

In many instances, DDD has not provided timely home modification services that enable AHCCCS' developmentally disabled members to remain independent. AHCCCS contractually requires DDD to provide timely home modifications, such as roll-in showers and wheelchair ramps, to its members. However, DDD has not met the approval time frames in nearly two-thirds of the cases reviewed. Providing timely home modifications to AHCCCS members has previously been a concern and while AHCCCS took action in 2000 to address this concern, it has taken limited action to address the current problem. Therefore, AHCCCS should take the necessary actions to ensure modifications are provided in a timely manner, and provide additional policy direction to DDD regarding home modification requests.

Home modifications delayed—DDD's contract with AHCCCS calls for home modification projects to be approved within 90 days of a request, with service provision to occur within 150 days. However, based on a review of the January 2002 through May 2002 monthly tracking reports, of the 85 home modifications reported as approved, 55 (65 percent) took longer than 90 days to approve. On average, it currently takes DDD about 118 days to approve a home modification. As a result of approval delays, 44 percent of the 64 modifications processed within this period took more than the AHCCCS maximum of 150 days to complete.

Forty-four percent of the home modifications took over 150 days to complete.

Delays in providing medically necessary modifications may hinder AHCCCS' developmentally disabled members' ability to function independently in the community and place them in potentially unsafe environments. Under 42 U.S.C. §1396(2), state Medicaid programs must provide service that helps members retain their independence. However, based on a review of 12 DDD modification cases that took more than 90 days to approve, auditors identified examples of members whose independence was hindered and whose safety and care, as well as their providers' safety, were potentially affected. These included examples of a woman and a boy who each waited over 8 months for the completion of modification to assist with bathing and access to important areas of their homes.

Untimely provision of medically necessary home modifications has been a problem for DDD in the past and untimely provision resulted in AHCCCS issuing a notice to cure in April 2000. At that time, DDD had 112 modifications that had not been completed. DDD eventually completed all 112 modifications and AHCCCS lifted the notice in March 2001.

AHCCCS needs to ensure timely modifications—AHCCCS should take action to ensure ALTCS members receive timely home modifications. After AHCCCS lifted the notice to cure in March 2001, it required DDD to submit monthly modification tracking reports so it could monitor the timely provision of modification services. Although these reports have shown delays since at least January of 2002, AHCCCS has not taken further action against DDD and stated it would not know if the delays are justified until it conducts its OFR in September 2002. However, given the number of delays and DDD's history in providing untimely home modification services, AHCCCS should review DDD's home modification files as soon as possible to determine if the delays are justified. If they are not, AHCCCS should use its various options, such as another notice to cure or financial sanctions, to see that DDD provides these services in a timely manner.

AHCCCS should consider additional actions to see that DDD completes home modifications in a timely manner.

AHCCCS should reconfirm policy direction—Additionally, AHCCCS should reconfirm its previous direction given to DDD regarding home modification requests. Specifically, AHCCCS may need to further clarify for DDD at which point or date the 90-day approval time frame begins. Based on auditors' review of the January 2002 through May 2002 monthly tracking reports, DDD revised the home modification request date or "need identified" date for numerous home modification requests. Although AHCCCS sent

a letter to DDD in April 2002 directing DDD to use the date that the member makes the request, DDD states that further clarification would be helpful.

Additionally, AHCCCS needs to specify under what circumstances DDD can close home modification requests. Auditors' review of the monthly tracking reports found that DDD closed eight home modification requests when the member did not provide documentation supporting the medical necessity of the request in a timely manner. However, according to an AHCCCS official, it is inappropriate for DDD to close a home modification request for this reason as DDD is responsible for obtaining the necessary documentation. As a result, AHCCCS should provide direction to DDD on this issue. In the meantime, DDD has instituted additional mechanisms to track whether the necessary documentation has been provided and/or to obtain the necessary documentation in a timely manner.

Recommendations

1. AHCCCS should continue to help DDD develop a centralized complaint-handling system that meets standards.

2. AHCCCS should increase its monitoring of DDD complaints by reviewing files not only from the central office, as it currently does, but also from the local offices to ensure that all types of complaints are being handled appropriately.

3. AHCCCS should review DDD's home modification files as soon as possible to determine if delays in providing home modification services are justified.

4. If AHCCCS determines that DDD's delays in providing home modification services are not justified, AHCCCS should use its various options, such as another notice to cure or financial sanctions, to see that DDD provides these services in a timely manner.

5. AHCCCS should provide direction to DDD on which date the 90-day home modification approval time frame begins and under what circumstances home modification requests may be closed.

FINDING 4

Clinical performance indicators provide useful information

In addition to conducting annual reviews and monitoring complaints, AHCCCS uses clinical performance indicators to track how well the system is delivering services that help to keep members healthy. These indicators cover such services as immunizations, cancer screenings, and well-child checkups. AHCCCS also periodically reviews the indicators to ensure they present meaningful information on the health care provided to AHCCCS members. While such indicators are useful, some changes could enhance their impact. First, because the indicators provide valuable information about how well health plans are delivering services, AHCCCS should use them as part of its annual OFR assessments. Second, AHCCCS should take additional steps to ensure that corrective action is taken when indicator results show problems with individual health plans.

Indicators help monitor progress

AHCCCS currently collects data on 17 clinical performance indicators that span a variety of services. These indicators are helpful both in assessing how individual plans are performing and in helping AHCCCS determine how Arizona's program is progressing in meeting national goals.

Current indicators cover a wide variety of services—AHCCCS requires health plans to submit information on 17 clinical performance indicators, such as the percentage of low-birth weight babies and the percentage of elderly members receiving flu shots. Most of these indicators are based on the Health Plan Data and Information Set (HEDIS). HEDIS is a standardized set of performance measures used by employers and consumers to compare the quality of care rendered by managed care organizations. HEDIS has become the standard for assessing managed care organizations' performance, with almost 90 percent of such organizations collecting and reporting HEDIS results.

Clinical Performance Indicator Standards

Minimum Performance Standard
This standard represents the minimally expected level of performance. In deriving this standard, AHCCCS considers the existing statewide average and the high and low health plan results from previous years. If a health plan does not achieve this standard for 2 consecutive years, it may be subject to sanctions. This standard can change as the statewide average changes.

Goal
The goal represents the next step for those health plans that have met the minimum standard but have not yet achieved the benchmark. The goal can also change as the minimum performance standard changes.

Benchmark
The benchmark represents the ultimate standard to be achieved and is generally based on the Healthy People 2000 or Healthy People 2010 initiative, whichever is the most current for the indicator.

AHCCCS health plans are contractually required to meet minimum performance standards for each of the indicators as well as continually improve their performance from year to year. These requirements are conveyed in three performance levels incorporated into contracts with plans providing acute care services (refer to the text box for a description of these performance levels).[1] For example, the minimum performance standard for cervical cancer screening calls for providing at least one Pap smear within a 3-year period to at least 57 percent of enrolled women aged 16-64. Beyond this minimum standard, the plan must keep making progress to a goal of 60 percent and an eventual benchmark of 85 percent. Table 4 (see page 31) shows the 17 clinical performance indicators and the levels of performance stipulated for each one. The current set of performance standards and performance levels pertains only to health plans that provide acute care. However, AHCCCS has incorporated such standards and measures into its next contracts with long-term plans, which will start in federal fiscal year 2003.

Indicators track individual plans' performance—One purpose of the indicators is to track individual health plan performance. When an acute care health plan has not shown demonstrable and sustained improvement toward meeting contractual performance standards for the clinical performance indicators listed on Table 4 (see page 31), AHCCCS requires the plan to submit a corrective action plan. These plans typically involve the health plan analyzing its operations for possible causes or links to the poor performance and devising strategies to improve it. For example, as a strategy to reduce the percentage of low-birth weight deliveries, one health plan determined it would provide case management services to high-risk pregnancies. Another health plan strategy to affect its indicator results is to advertise $50 gift certificates to pregnant women who show up for at least five prenatal visits.

Indicators assess progress toward national goals—Even though AHCCCS has established three levels of performance for its indicators, it ultimately strives to reach national health goals. The benchmarks that health plans should target are derived from the U.S Department of Health and Human Services' Office of Public Health and Science, "Healthy People 2010" initiative. Healthy People began in 1979 as a comprehensive, nationwide health promotion and disease prevention agenda. It is designed to serve as a road map for improving the health of all people in the United States and has two main goals: to increase the quality and years of healthy life and to eliminate health disparities. Arizona has a similar statewide health agenda called "Healthy Arizona 2010," which is based on the national model.

As illustrated in Table 5 (see page 32), AHCCCS' success at moving its population toward these benchmarks has been mixed. Of the 14 indicators for which historical

[1] Prior to October 2001, AHCCCS' Acute Care contract had only one performance level required of health plans. This level was typically based on the statewide average.

Table 4 Clinical Performance Indicators Required by AHCCCS' Federal Fiscal Year 2002 Contracts

Performance Indicator	Description	Percentage of Population: Statewide Average	Percentage of Population: AHCCCS Goal	Percentage of Population: National Benchmark
Acute Care				
Low-birth weight deliveries[1]	Babies born under 2,500 grams	8.2%	7.5%	5%
Well-child visits in the first 15 months	Children who received at least six well-child visits in the first 15 months of life	58.3	64	90
Immunizations in 2-year-olds	Children who received series of five different vaccines by 24 months of age	65.0	73	90
Well-child visits in 3- to 6-year-olds	Children who received at least one well-child visit within reporting year	44.5	64	80
Children's access to primary care providers (PCP)	Children ages 1-20 years who received at least one PCP visit during reporting year	72.9	80	95
Adolescent well-care visits	Adolescents ages 11-20 years who received at least one well-care visit during 2-year reporting period	49.0	49	50
Annual dental visits	Members ages 3-20 years who had at least one dental visit within reporting year	43.5	55	90
Prenatal care in the first trimester	Women who had a prenatal care visit during the first trimester of pregnancy	55.2	65	90
Breast cancer screening	Women ages 52-64 who received a mammogram during 2-year reporting period	56.1	60	60
Cervical cancer screening	Women ages 16-64 who received a Pap smear during 3-year reporting period	54.7	60	85
Adult access to ambulatory and preventative care services	Members ages 21-64 who received at least one preventative visit during the reporting year	77.9	80	95
Long-Term Care[2]				
Initiation of home- and community-based (HCB) services	Newly enrolled members in a HCB setting who received services within 30 days of enrollment	87.0	100	N/A
Influenza immunizations in nursing facilities (NF)	Members living in NF who received an influenza immunization	82.7	90	90
Influenza immunizations in home- and community-based (HCB) settings	Members living in HCB settings who received an influenza immunization	50.5	90	90
Pneumonia vaccinations in nursing facilities (NF)	Members living in NF who received a pneumonia vaccination	69.6	90	90
Pneumonia vaccinations in home- and community-based (HCB) settings	Members living in HCB settings who received a pneumonia vaccination	43.9	90	90
Diabetes indicator[3]	Diabetic members who receive three types of assessment services	N/A	N/A	N/A

1 For the low-birth weight deliveries indicator, a lower percentage indicates better performance; for all other indicators, a higher percentage indicates better performance.

2 Long-term care indicators do not apply to the developmentally disabled population.

3 Data is not cited because comparison information is not yet available.

Source: Auditor General staff summary of data from the Arizona Health Care Cost Containment System's 2000 through 2002 performance indicator reports and analysis of AHCCCS' acute care contracts for federal year 2002.

Table 5 Statewide Clinical Performance Indicator Results[1]
Federal Years Ended September 30, 1998 through 2000

Improved Results	Mixed Results	Decline in results
Well-child visits up to 15 months	Prenatal care in the first trimester	Children's access to primary care providers[2]
Immunizations in 2-year-olds	Low-birth weight deliveries	Influenza immunizations in nursing facilities[3]
Adolescent well-care visits	Well-child visits in 3- to 6-year-olds	
Annual dental visits	Cervical cancer screening	
Pneumococcal vaccination in nursing facilities	Breast cancer screening	
	Adult access to ambulatory and preventative care	
	Influenza immunizations in home- and community-based settings	

1 The Arizona Health Care Cost Containment System (AHCCCS) has 17 clinical performance indicators; however, results are presented for only those indicators for which 3 consecutive years of data were available.

2 Although the results of this indicator declined, the results remained above AHCCCS' goal.

3 In 2000-2001, there was a vaccine shortage which could have contributed to the decline.

Source: Auditor General staff analysis of AHCCCS statewide clinical performance indicator results for federal fiscal years 1998 through 2000.

data is available, 5 showed improvement. For example, pneumonia vaccinations in nursing facilities, immunizations of 2-year-olds, and annual dental visits all improved over a 3-year period. In contrast, breast and cervical cancer screenings, low-birth weight deliveries, and well-child visits for 3- to 6-year-olds fluctuated within this time frame. Finally, performance on children's access to primary care and influenza immunizations in nursing facilities declined.

AHCCCS' success in reaching national health goals has been mixed.

AHCCCS periodically reviews indicators

Because the indicators help monitor how well the system is delivering services, AHCCCS periodically reviews them to ensure they are providing meaningful information to its health plans. For example, AHCCCS recently replaced two of its ALTCS indicators, prevalence

of bedsores and fractures related to falls, because it felt its efforts would be better served in other health areas. Specifically, the prevalence of bedsores on the elderly indicator showed substantial improvement over time. The fractures related to falls indicator showed no trend and therefore provided limited information to health plans. In addition, although HEDIS has dropped the low-birth weight indicators, AHCCCS has indicated it will continue to track this information because continuing to track low birth weight helps identify opportunities to improve birth outcomes and reduce costs.

In addition, AHCCCS may be revising its indicators in the future to comply with a proposal for national mandated Medicaid performance indicators. As a result of increased federal pressure to report on the performance of Medicaid programs and the need for comparable state-to-state information, the Centers for Medicare and Medicaid Services (CMS) has convened the Performance Measurement Partnership Project. This project is a collaborative effort between the National Academy for State Health Policy and federal and state officials to explore whether a consensus can be reached on developing a limited core set of performance measures for all Medicaid programs. AHCCCS is one of 15 states asked to participate in selecting, collecting, and reporting a core set of performance measures. Final recommendations to CMS on the development of this core measurement set are scheduled to be submitted in September 2002.

Minor changes could enhance impact

While the indicators offer valuable information about the quality of care for AHCCCS members, minor changes could enhance their impact. First, because the indicators provide important information at the health plan level, AHCCCS should use the indicator results when assessing health plan performance during its OFR process. In addition, AHCCCS should take additional steps to ensure that health plans implement their corrective action plans when indicator results do not meet AHCCCS standards.

AHCCCS should use indicator results during OFR—Because the clinical performance indicators provide valuable information about the performance of individual health plans, AHCCCS should incorporate these results into its OFR report and use the information when assessing performance. As indicated in Finding 1 (see pages 9 through 15), one of the OFR's primary goals is to ensure the effective delivery of health services. While the indicators provide important information in this area, they are not routinely used during the OFR when judging health plan performance. If AHCCCS implements the recommendations in Finding 1 (see page 15) and begins moving the OFR from a process-oriented, strict compliance review of health plans to a more performance-oriented review, indicator results can provide readily available information about performance.

AHCCCS should enhance its followup to ensure corrective actions are implemented.

AHCCCS should expand followup—To ensure that health plans address substandard performance related to these standards, AHCCCS may also need to take additional steps beyond its existing practice of requiring corrective action plans. Similar to the OFR corrective action plans discussed in Finding 1 (see pages 9 through 15), AHCCCS should request additional documentation that demonstrates that the health plan has implemented the actions described in its plan. In those cases where the health plans' performance has declined for consecutive years in spite of their corrective action plans, or it is not possible to verify corrective action through documentation, AHCCCS may need to conduct a site visit to ensure the plan was ultimately implemented.

Recommendations

1. Because the clinical performance indicators provide valuable information about the performance of individual health plans, and where applicable to OFR standards, AHCCCS should incorporate the indicator results into its OFR report and use the information when assessing performance.

2. As part of the process for improving performance when health plans do not meet the contract specifications, AHCCCS should either request documentation or conduct a site visit to ensure that the health plan has implemented the actions described in its plan.

Agency Response

AHCCCS

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Committed to Excellence in Health Care

Jane Dee Hull
Governor

Phyllis Biedess
Director

September 11, 2002

Debra Davenport, CPA
Auditor General
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85034

Re: Performance Audit, AHCCCS Processes for Monitoring the Quality of Care

Dear Ms. Davenport:

Thank you for the opportunity to review and comment on the Quality of Care performance audit. Quality of Care is obviously one of the core functions at AHCCCS. It is critical to our Medicaid system and the services that are provided to over 800,000 Arizonans. For that reason, AHCCCS has spent years developing and refining four different tools that are used to evaluate the Quality of Care provided within the AHCCCS system. AHCCCS is proud of the system that has been developed and we appreciate the Auditor General acknowledging this in the report which states;

"*Additionally, a U.S. General Accounting Office report notes that AHCCCS requires its health plans to provide data documenting the patient care provided to conduct various patient outcome studies and also indicates that (Arizona's AHCCCS program can serve as a model for other Medicaid programs).*"

That being said, there are no doubt some areas of improvement where the implementation of Auditor General recommendations will continue to improve the program. However, AHCCCS continues to believe that the Auditor General report over-emphasizes the need for the agency to rely on the Operational and Financial Review (OFR) to serve as the ultimate measure of Quality of Care. As stated above, the OFR is just one of four tools that AHCCCS relies on to monitor Quality of Care in Arizona. The other tools that do provide critical information include:

- Quality Management Plans
- Clinical Performance Indicators
- Quality of Care Complaints

It is also important to acknowledge at the outset of our comments that almost half of the recommendations contained within the Auditor General report pertain to the Developmentally Disabled program within the Department of Economic Security. This program faces numerous challenges and fundamental change can occur only when both state agencies work together.

DES is a critical component and partner in addressing DDD recommendations identified by the Auditor General.

Page 15 Recommendations:

Recommendation #1

AHCCCS should modify its annual operational and financial reviews of health plans to focus more on evaluating health plan performance.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

However, AHCCCS will continue to rely on all four tools to evaluate the Quality of Care for our members.

Recommendation #2

If AHCCCS increases its focus on health plan performance outcomes in its OFRs, which may require increased resources, AHCCCS should prioritize and consider reducing the overall number of OFR standards that it evaluates during each operational and financial review.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Recommendation #3

AHCCCS should enhance its follow-up efforts to ensure that health plans resolve the problems identified in the operational and financial reviews, including obtaining evidentiary documentation and conducting more frequent follow-up visits when necessary to verify that corrective actions have occurred.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. It will however, have resource implications.

Page 21 Recommendations:

Recommendation #1

AHCCCS should ensure that complaints are appropriately resolved by obtaining evidence that the member concern has been addressed and, when appropriate, changes have been

implemented to help prevent similar problems from reoccurring. Where appropriate, AHCCCS should contact the complainant to determine if the concern has been satisfactorily addressed.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

While AHCCCS believes much of this recommendation is being done, we will develop a policy that will outline a process that includes, where appropriate, contacting the complainant to determine if there has been satisfactory resolution. We will also, where appropriate, ensure that changes have been implemented to help prevent reoccurrence of similar complaints. The implementation of this policy may have a resource impact and require additional staff.

Recommendation #2

In those instances where AHCCCS has identified significant problems with a health plan's complaint-handling process, AHCCCS should:

a. Take appropriate action against the health plan for its failure to properly investigate and resolve complaints, possibly including a formal notice to cure, which would require corrective actions within a specified time period, or financial sanctions.

b. Investigate and resolve the complaints it receives rather than refer them to the health plan until the plan has implemented a complaint-handling system that meets AHCCCS requirements.

c. Increase its monitoring of how the health plan handles the complaints they receive directly until the plan has demonstrated its ability to adequately investigate and resolve complaints.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

In regard to a. above, AHCCCS has utilized notice to cure and monetary sanctions against health plans for these infractions. We will continue to utilize these actions to ensure timely and complete resolution of complaint handling problems by our health plans.

Page 27 Recommendations:

Recommendation #1

AHCCCS should continue to help DDD develop a centralized complaint-handling system that meets standards.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

As AHCCCS has done for the last several years, we will continue to try and work closely with DES to accomplish all recommendations regarding DDD.

Recommendation #2

AHCCCS should increase its monitoring of DDD complaints by reviewing files not only from the central office, as it currently does, but also from the local offices to ensure that all types of complaints are being handled appropriately.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

The implementation of the recommendation may require additional resources.

Recommendation #3

AHCCCS should review DDD's home modification files as soon as possible to determine if delays in providing home modification services are justified.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

As we did in 2000, AHCCCS has begun a forms review of DDD home modification files, and have scheduled a comprehensive review of DDD's home modification approval process. This will take place in September 2002. We will increase our efforts at holding DDD to this standard and apply sanctions as appropriate.

Recommendation #4
If AHCCCS determines that DDD's delays in providing home modification services are not justified, AHCCCS should use its various options, such as another notice to cure or financial sanctions, to see that DDD provides these services in a timely manner.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Recommendation #5
AHCCCS should provide direction to DDD on which date the 90-day home modification approval time frame begins and under what circumstances home modification requests may be closed.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. It should be noted that AHCCCS has both met with DES on several occasions and provided written instructions with regard to the time frame issue.

Page 34 Recommendations:

Recommendation #1
Because the clinical performance indicators provide valuable information about the performance of individual health plans, and where applicable to OFR standards, AHCCCS should incorporate the indicator results into its OFR report and use the information when assessing performance.

Response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

The OFR is a snapshot in time that assesses the contracted health plan's compliance with financial, operational and contractual requirements. The Annual Quality Management Plan and Evaluation, along with the required medical audits and studies, combined with the mandated clinical performance indicators give an ongoing, trended, record of the plan's outcomes as related to the delivery of health care and health maintenance services. We feel these give a much broader assessment of the health plan's quality of health care delivery to our members. To merge these all into the OFR process would create blurring of these important distinctions and add significant operational burden to both AHCCCS and our contracted plans.

We propose to continue our present process, but in order to implement this recommendation, we will add to the OFR a review of all instances of substandard scores on clinical performance indicators and any corrective action plans (as per recommendation #1 and #2 on page 15). These will then be factored into the scoring of the OFR.

Recommendation #2

As part of the process for improving performance when health plans do not meet the contract specifications, AHCCCS should either request documentation or conduct a site visit to ensure that the health plan has implemented the actions described in its plan.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

We appreciate the efforts of the audit team.

Sincerely,

Phyllis Biedess
Director

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
1717 West Jefferson • P.O. Box 6123 • Phoenix, Arizona 85005

Jane Dee Hull
Governor

John L. Clayton
Director

Debbie Davenport
Arizona Auditor General
2910 N. 44th St, Suite 410
Phoenix, AZ 85018

Dear Ms. Davenport:

Thank you for the opportunity to provide comments on the AHCCCS audit and DES efforts to address quality of care concerns and home modifications for ALTCS members who have developmental disabilities.

The following are our responses to the findings contained in the report. We have noted each recommendation in italics, and listed our response following each finding.

I believe it is important to mention that this audit should be placed in the context of the economics of the past 18 months. This has been a period of increasing financial and resource constraints due to the contractions of the state budget. Indeed during this past fiscal year, AHCCCS reduced its capitation rate by 5% to the Division. Additional resources were planned for investment in both the quality management area (care concerns) and the home modifications unit. These additional resources were not allocated in order to constrain budgets, at a time when membership growth averaged 80 new members per month and home modification requests increased 60%. Because we concur with the importance of appropriately managing care concerns and ensuring the timeliness of home modifications, we are assessing current resources for the possible redeployment of staff from other functions to these activities.

We firmly believe that at no time were the 'safety and care' of any member or their caregivers jeopardized due to the failure to meet either the 90 day or 150 day timeline. Where life safety was the case, the Division acted with priority dispatch to complete the home modification.

Sincerely,

John L. Clayton

AHCCCS' and DES' Efforts to Address Quality of Care Concerns for Developmental Disabilities Members

Finding III recommendations:

1. *AHCCCS should continue to help DDD develop a centralized complaint handling system that meets standards.*

   The Department welcomes any additional assistance AHCCCS can provide in the completion of this effort. Our current work plan commits to a retooling of our Phase 1 incident reporting system and the implementation of a web-based Phase 2-complaint management system by January 2003. AHCCCS has been vigorously engaged in monitoring our response to the 2001 Notice to Cure. We have, for the past year, met in regularized meetings to discuss progress made and problems encountered. We have kept them apprised of our efforts and they have been equally forthcoming with their expectations.

2. *AHCCCS should increase its monitoring of DDD complaints by reviewing files not only from the central office, as it currently does, but also from the local offices to ensure that all types of complaints are being handled appropriately.*

   The Department welcomes any additional assessment and recommendations AHCCCS may have as a result of broader file reviews.

3. *AHCCCS should review DDD's home modification files as soon as possible to determine if delays in providing home modification services are justified.*

   The Department welcomes any additional assessment and recommendations AHCCCS may make after additional review of files. While we believe many of these delays have their origins in satisfying member expectations and requirements within a program with numerous policy and procedural constraints, the Division recognizes that there have been some requests that have taken too long for approval. These have resulted from limited resources and exploding growth in the use of and cost of the program. An additional staff support was added recently to improve the processing of requests. This cleared the calendar for the primary employee to complete home studies. We are assessing the need for additional resource investments in this area.

4. *If AHCCCS determines that DDD's delays in providing home modification services are not justified, AHCCCS should use its various options, such as another notice to cure or financial sanctions, to see that DDD provides these services in a timely manner.*

   The Department disagrees with the use of financial sanctions in an environment where resource constraints and exploding growth are the likely source of delays. As you correctly report, the last notice to cure was lifted 18 months ago when AHCCCS

determined that home modifications were being handled in a timely fashion. Since then, the rate of requests has increased 60%, but the Division's available resources for this area have been frozen or reduced and the AHCCCS capitation rate has been reduced. The resources required to meet a financial sanction would be far better invested in an additional investment in staffing resources.

5. *AHCCCS should provide direction to DDD on which date the 90 day home modification approval time frame begins and under what circumstances home modification requests may be closed.*

   These clarifying discussions have been initiated.

Performance Audit Division reports issued within the last 12 months

01-17 Arizona Board of Dispensing Opticians
01-18 Arizona Department of Corrections—Administrative Services and Information Technology
01-19 Arizona Department of Education—Early Childhood Block Grant
01-20 Department of Public Safety—Highway Patrol
01-21 Board of Nursing
01-22 Department of Public Safety—Criminal Investigations Division
01-23 Department of Building and Fire Safety
01-24 Arizona Veterans' Service Advisory Commission
01-25 Department of Corrections—Arizona Correctional Industries
01-26 Department of Corrections—Sunset Factors
01-27 Board of Regents
01-28 Department of Public Safety—Criminal Information Services Bureau, Access Integrity Unit, and Fingerprint Identification Bureau
01-29 Department of Public Safety—Sunset Factors
01-30 Family Builders Program
01-31 Perinatal Substance Abuse Pilot Program
01-32 Homeless Youth Intervention Program
01-33 Department of Health Services—Behavioral Health Services Reporting Requirements

02-01 Arizona Works
02-02 Arizona State Lottery Commission
02-03 Department of Economic Security—Kinship Foster Care and Kinship Care Pilot Program
02-04 State Parks Board—Heritage Fund
02-05 Arizona Health Care Cost Containment System—Member Services Division
02-06 Arizona Health Care Cost Containment System—Rate Setting Processes
02-07 Arizona Health Care Cost Containment System—Medical Services Contracting

Future Performance Audit Division reports

Arizona Health Care Cost Containment System—Sunset Factors
Department of Economic Security—Child Protective Services