

CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

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The standards and requirements included in this Chapter are applicable to AHCCCS Acute Care and Arizona Long Term Care System (ALTCS) Contractors, the Arizona Department of Economic Security, Division of Developmental Disabilities (ADES/DDD), the ADES Comprehensive Medical and Dental Plan (ADES/CMDP), the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS), and the ADHS Children's Rehabilitation Services (ADHS/CRS). If requirements of this Chapter conflict with specific AHCCCS contract language, the AHCCCS contract will take precedence. For purposes of this Chapter, the above listed organizations and agencies will be referred to as "Contractors." In addition, for purposes of this Chapter, when policy and procedures are required, they must be written, implemented, and available for AHCCCS review upon request.

The Chapter provides information needed by Contractors to:

1. Promote improvement in the quality of care and services provided to enrolled members through the following processes:
 - a. Monitoring and evaluating the Contractor's processes, service delivery system and provider network for quality management and performance improvement opportunities
 - b. Implementing action plans and activities to correct deficiencies and increase the quality of care and services provided to enrolled members, and
 - c. Initiating performance improvement projects to address trends identified through monitoring activities including, but not limited to:
 - i. Complaint reviews,
 - ii. Quality of care reviews,
 - iii. Provider credentialing, re-credentialing and profiling reviews, and
 - iv. Utilization management reviews.



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2. Comply with Federal, State and AHCCCS requirements.
3. Ensure coordination with State registries.
4. Ensure the Contractor's executive and management staff actively participate in the quality management and performance improvement processes.
5. Ensure that the development and implementation of quality management and performance improvement activities include input from contracted or affiliated providers and consumers, and
6. Identify the best practices for performance and quality improvement.

Definitions

The words and phrases in this Chapter have the following meanings, unless the context explicitly requires another meaning.

1. Assess or Evaluate - the process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to Contractor service delivery systems.
2. Complete credentialing application - a credentialing application in which all of the sections have been legibly and accurately completed, requested attachments are provided and is signed by the applicant.
3. Completion/Implementation Timeframe - the date or time period projected for a project goal or objective to be met, for progress to be demonstrated or for a proven intervention to be established as the standard of care for the Contractor.
4. Clinical Quality Management (CQM) - unit of the AHCCCS Division of Health Care Management. The CQM Unit researches and evaluates quality of care issues; evaluates Contractor Quality Management/Performance Improvement (QM/PI) programs, monitors compliance with required standards, Contractor corrective action plans and Performance Improvement Projects (PIPs), and provides technical assistance for improvement.
5. Corrective Action Plan (CAP) - a written work plan used to improve the Contractor's and/or its provider's performance; enhance QM/PI activities and their outcomes; or resolve identified deficiencies.



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6. Delegated Entity - a qualified organization, agency or provider that holds a subcontract to perform delegated management/administrative functions or responsibilities for the Contractor such as provider credentialing or re-credentialing, transportation brokerage, or durable medical equipment management.
7. Demonstrable Improvement - the projected percentage of performance improvement submitted as a part of the Contractor's PIP proposal and approved by AHCCCS for the project outcome.
8. Federally Qualified Health Care Centers (FQHC) – facilities or programs more commonly known as Community Health Centers, Migrant Health Centers and Health Care for the Homeless Programs. An entity may qualify as an FQHC if it:
 - a. Receives a grant and funding pursuant to section 330 of the Public Health Services Act,
 - b. Is receiving funding from such a grant under a contract with the recipient of a grant and meets the requirements to receive a grant pursuant to Section 330 of the Public Health Service Act.
 - c. Is determined by the Secretary of Department of Health and Human Services (DHHS) as a Federally Funded Health Center (FFHS) for purposes of Part B Medicare as of January 1, 1990. An FQHC includes an outpatient program or facility operated by a Tribe or Tribal organization under the Indian Self-Determination Act (PL 93-638) or an Urban Indian Organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.
9. FQHC Look-alike - an organization that meets all of the eligibility requirements of an organization that receives a Public Health Service Section 330 grant FQHC, but does not receive grant funding.
10. Grievance - expression of dissatisfaction about a matter other than an action as defined in Arizona Administration Code Title 9, Chapter 34 (9 A.A.C. 34). Possible subjects for grievances include, but are not limited to:
 - a. The quality of care or services provided,
 - b. Aspects of interpersonal relationships,
 - c. Such as rudeness of a provider or employee,
 - d. Or failure to respect the member's rights.



11. Health Care Acquired Conditions (HCAC) – means a Hospital Acquired Condition (HAC) under the Medicare program, with the exception of Deep Vein Thrombosis/ Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission.
12. Health Information System - data system composed of the resources, technology, and methods required to optimize the acquisition, storage, retrieval, analysis and use of data. Health informatics tools include not only computers but also clinical guidelines, formal medical terminologies, and information and communication systems.
13. High Volume Specialist - specialist with 50 or more referrals per contract year.
14. Measurable - the ability to determine definitively whether or not an objective has been met, or whether progress has been made toward a positive outcome.
15. Methodology - the planned process, steps, activities or actions taken by a Contractor to achieve a goal or objective, or to progress toward a positive outcome.
16. Monitoring - the process of auditing, observing, evaluating, analyzing and conducting follow-up activities, and documenting results.
17. Objective - a measurable step, generally one of a series of progressive steps, to achieve a goal.
18. Peer Review – evaluating the necessity, quality or utilization of care/service provided by a health care professional/provider. Peer review is conducted by other health care professionals/providers from the same discipline or with similar or essentially equal qualifications who are not in direct economic competition with the health care professional under review. The process compares the health care professional/provider's performance with the performance of peers or with the standards of care and service within the community.
19. Performance Improvement Project (PIP) - a planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.
20. Plan-Do-Study-Act (PDSA) Cycle - a scientific method for testing a change or intervention, designed to result in improvement in a specific area. The cycle is completed by planning the change/intervention, trying it, observing the results, and



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acting on what is learned. When these steps are conducted over a relatively short time period; i.e. over days, weeks or months, the approach is known as Rapid Cycle Improvement.

21. Quality of Care – the Centers for Medicare and Medicaid Services (CMS) defines quality as “the right care for every person every time.”
22. Statistically Significant - the probability of obtaining a finding (e.g., a rate) in which the observed degree of association between variables is the result of chance only is relatively low. It is customary to describe a finding as statistically significant when the obtained result is among those that (theoretically) would occur no more than 5 out of 100 times, $p \leq .05$, or occur no more than 1 out of 100 times, $p \leq .01$, when the only factors operating are the chance variations that occur whenever random samples are drawn. It is important to note that a finding may be statistically significant, but may not be clinically or financially significant.
23. Work Plan – addresses all the requirements of Chapter 900, policy 920A and AHCCCS-suggested guidelines and supports the Contractor’s QM/PI goals and objectives with measurable goals (SMART), timelines, methodologies and designated staff responsibilities. There should be at least three measurable behavioral health goals and objectives.

REFERENCES

1. Title 42 of the Code of Federal Regulations (42 C.F.R.) 431.300 *et seq* Safeguarding Information on Applicants and Recipients
2. 42 C.F.R. 438.100 *et seq* Enrollee Rights and Protections (Right of Enrolled Member including Restraint and Seclusion and Right to Refuse Care)
3. 42 C.F.R. 438.200 *et seq* Quality Assessment and Performance Improvement
 - a. 42 C.F.R. 438.214 (Credentialing and Recredentialing)
 - b. SEC. 1128E. (42 U.S.C. 1320 A-7E)
 - c. 42 C.F.R. 438.230 (Delegation)
 - d. 42 C.F.R. 438.240 (Quality Assurance and Performance Improvement)
 - e. 42 C.F.R. 438.242 (Health Information System)



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4. 45 C.F.R. Part 164 (Security and Privacy)
5. 42 C.F.R. Part 447.26 (Health Care Acquired Conditions)
6. Arizona Revised Statutes (A.R.S.) § 36-441 (Utilization Committee Materials Not Subject to Discovery with Certain Exceptions)
7. A.R.S. § 36-445 (Physician in Hospital or Centers to Have Committees to Review Professional Practices)
8. A.R.S. §§ 36-2401, 36-2402, 36-2403, (Definitions, Immunity to Those Who Provide Records or Make a Decision, Records Not Subject to Subpoena, Staff not Be Subject to Subpoena)
9. A.R.S. §§ 36-2903, 36-2932, 36-2986 (Duties of the Administration)
10. A.R.S. § 36-2917 (Review Committees)
11. Title 9 of the Arizona Administrative Code, Chapter 22 (9 A.A.C. 22), Article 5 (General Provisions and Standards)
12. 9 A.A.C. 22, Article 12 (Behavioral Health, General Provisions and Standards for Service Providers)
13. 9 A.A.C. 28, Article 5 (Program Contractor and Provider Standards, General Provisions and Standards)
14. 9 A.A.C. 28, Article 11 (Behavioral Health Services, General Provisions and Standards for Service Providers)
15. 9 A.A.C. 31, Article 5 (General Provisions and Standards)
16. 9 A.A.C. 31, Article 12 (Behavioral Health Services, General Provisions and Standards for Service Providers)
17. CMS State Medicaid Manual
18. 9 A.A.C. 34 (Grievance System), and
19. AHCCCS Contracts.



910 QUALITY MANAGEMENT / PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM ADMINISTRATIVE REQUIREMENTS

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A. QM/PI PLAN

Each Contractor must develop a written QM/PI Plan that addresses the Contractor's proposed methodology to meet or exceed the standards and requirements of this Chapter. The QM/PI plan must describe how program activities will improve the quality of care and service delivery for enrolled members. The QM/PI Plan, and any subsequent modifications, must be submitted to AHCCCS/Division of Health Care Management/Clinical Quality Management (DHCM/CQM) for review and approval prior to implementation. At a minimum, the QM/PI Plan must describe, in paginated detail, the following components of the Contractor's QM/PI Program:

1. QM/PI Program Administrative Oversight- The contractor's QM/PI Program must be administered through a clear and appropriate administrative structure. This governing or policy making body must oversee and be accountable for the QM/PI program. The Contractor must provide:
 - a. A description to ensure ongoing communication and collaboration between the QM/PI Program and the other functional areas of the organization, such as, but not limited to: Medical Management, Member services, Behavioral Health and Case Management.
 - b. A description of the Contractor's administrative structure for oversight of its QM/PI Program as required by Policy 910C of this Chapter, which includes the role and responsibilities of:
 - i. The governing or policy-making body,
 - ii. The Medical Director,
 - iii. The QM/PI Committee,
 - iv. The Contractor's Executive Management, and
 - v. QM/PI Program staff.



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- c. An organizational chart that shows the reporting channels for QM/PI activities. This chart must also show direct oversight of QM/PI activities by the local Medical Director and the process when reporting to Executive Management.
 - d. Documentation that the governing or policy-making body has reviewed and approved the Plan.
 - e. Documentation that the governing or policy-making body has formally evaluated and documented the effectiveness of its QM/PI program strategy and activities, at least annually.
2. QM/PI Committee - The Contractor must have an identifiable and structured QM/PI Committee that is responsible for QM/PI functions and responsibilities.
- a. At a minimum, the membership must include:
 - i. The local Medical Director as the chairperson of the Committee. The local Medical Director may designate the Associate Medical Director as his/her designee only when the Medical Director is unable to attend the meeting. The local Chief Executive Officer may be identified as the co-Chair of the QM/PI committee.
 - ii. The QM/PI Manager,
 - iii. Representation from the functional areas within the organization,
 - iv. Representation of contracted or affiliated providers serving AHCCCS members,
 - v. AHCCCS members, and
 - vi. The appropriate clinical representatives.
 - b. The local Medical Director is responsible for implementation of the QM/PI Plan and must have substantial involvement in the assessment and improvement of QM/PI activities.
 - c. The QM/PI Committee must ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest by having signed statements on file and/or QM/PI Committee sign-in sheets with requirements noted.
 - d. The committee must meet quarterly or more frequently. The frequency of committee meetings must be sufficient to monitor all program requirements and to monitor any required actions.



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- e. The QM/PI Committee must review the QM/PI Program objectives, policies and procedures at least annually and must modify or update them when necessary. The QM/PI and Behavioral Health (BH) policies and procedures, and any subsequent modification to them, must be available upon request for review by AHCCCS/DHCM/CQM.
 - f. The QM/PI Committee must develop procedures for QM/PI responsibilities and clearly document the processes for each QM/PI function and activity.
 - g. The QM/PI Committee must develop and implement procedures to ensure that Contractor staff and providers are informed of the most current QM/PI requirements, policies and procedures.
 - h. The QM/PI Committee must develop and implement procedures to ensure that providers are informed of information related to their performance (such as results of studies, AHCCCS Performance Measures, profiling data, medical record review results).
 - i. When deficiencies are noted, the QM/PI Committee Meeting Minutes must clearly document discussions of the following:
 - i. Identified issues,
 - ii. Responsible party,
 - iii. Proposed actions,
 - iv. Evaluation of the actions taken,
 - v. Start and end dates,
 - vi. Additional recommendations or acceptance of the results as applicable.
3. Peer Review - The Contractor must have a peer review process with the purpose of improving the quality of medical care provided to members by providers. The peer review scope includes cases where there is evidence of deficient quality, or the omission of the care or service provided by a participating, or non-participating health care professional or provider. Peer review must be defined by specific policies and procedures which must include the following:
- a. Contractors must not delegate functions of peer review to other entities.
 - b. The peer review committee must be scheduled to meet at least quarterly.



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- c. Peer review activities may be carried out as a stand alone committee or in an executive session of the Contractor's Quality Management Committee.
- d. At a minimum, the peer review committee shall consist of:
 - i. Contractor's local Chief Medical Officer as chair.
 - ii. Contracted medical providers from the community that serve AHCCCS members. The peer review process must ensure that providers of the same or similar specialty participate in review and recommendation of individual peer review cases. If the specialty being reviewed is not represented on the contractor's peer review committee the Contractor may utilize peers of the same or similar specialty through external consultation.
 - iii. A Behavioral Health provider must be part of the peer review committee when a Behavioral Health specialty is being reviewed.
- e. Peer review committee members shall sign a confidentiality and conflict of interest statement at each peer review committee meeting. Committee members must not participate in peer review activities if they have a direct or indirect interest in the peer review outcome.
- f. The peer review committee must evaluate the case referred to peer review based on all information made available through the quality management process.
- g. The peer review committee is responsible for making recommendations to the contractor's Medical Director. Together they must determine appropriate action which may include, but is not limited to: peer contact, education, credentials, limit on new member enrollment, sanctions, or other corrective actions. The Medical Director, is responsible for implementing the actions.
- h. The peer review committee is responsible for making appropriate recommendations for the Contractor's Medical Director to make referrals to Child Protective Services, Adult Protective Services, the appropriate regulatory agency or board and AHCCCS for further investigation or action if not already referred during the Quality of Care (QOC) process. Notification must occur when the peer review committee determines care was not provided according to community standards. Initial notification may be verbal but must be followed by a written report.
- i. Peer review policies and procedures must assure that all information used in the peer review process is kept confidential and is not discussed outside of the peer review process. The Contractor's peer review reports, meetings, minutes,



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documents, recommendations, and participants must be kept confidential except for implementing recommendations made by the peer review committee.

- j. Contractors must make peer review documentation available to AHCCCS for purposes of quality management, monitoring and oversight.
 - k. Contractors must demonstrate how the peer review process is used to analyze and address clinical issues.
 - l. Contractors must demonstrate how providers are made aware of the peer review process, and
 - m. Contractors must demonstrate how providers are made aware of the peer review grievance procedure.
4. The QM/PI Staffing - The QM/PI Program must have qualified local personnel to carry out the functions and responsibilities specified in this Chapter in a timely and competent manner. Contractors are responsible for contract performance whether or not subcontractors are used. Policies and procedures must demonstrate:
- a. Staff qualifications for education, experience and training must be developed for each QM/PI position.
 - b. A current organizational chart must be maintained which demonstrates reporting channels and responsibilities for the QM/PI Program.
 - c. The Contractor's Quality Management Coordinator must attend (in person or via teleconference when approved by AHCCCS) AHCCCS Contractor meetings when requested by AHCCCS Administration. These meetings may be attended via teleconference when approved by AHCCCS.
 - d. The Contractor must participate in applicable community initiatives, such as, but not limited to:
 - i. quality management and quality improvement,
 - ii. maternal child health,
 - iii. Early and Periodic Screening, Diagnosis and Treatment (EPSDT),
 - iv. disease management
 - v. behavioral health



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- vi. AHCCCS may require Contractor participation in specific community initiatives and collaborations.
- e. The Contractor must develop a process to ensure that all staff who may have contact with members or providers are trained on how to refer suspected quality of care issues to quality management. This training must be provided during new employee orientation and annually thereafter.
- 5. Delegated Entities - The Contractor must oversee and maintain accountability for all functions and responsibilities described in this Chapter that are delegated to other entities. The Contractor must include a description of how delegated activities are integrated into the overall QM/PI Program and the methodologies for oversight and accountability of all delegated functions, as required by Policy 910C must be met for all delegated functions:
 - a. As a prerequisite to delegation, the Contractor must provide a written analysis of its historical provision of QM/PI oversight function which includes past goals and objectives. The level of effectiveness of the prior QM/PI oversight functions must be documented for later comparison. Examples of comparison may include the number of claims, concerns, grievances or network gaps.
 - b. The Contractor must have policies and procedures requiring that the delegated entity report to the Contractor all quality of care issues. Quality of care investigation and resolution processes may not be delegated to sub-Contractors.
 - c. The Contractor must evaluate the entity's ability to perform the delegated activities prior to delegation. Evidence of which includes the following:
 - i. Review of appropriate internal areas, such as quality management, and
 - ii. Documented evaluation and determination that the entity is able to effectively perform the delegated activities.
 - d. Prior to delegation, a written contract must be agreed upon that specifies the delegated activities and reporting responsibilities of the entity to the Contractor. The agreement must include the Contractor's right to terminate the contract or perform other remedies for inadequate performance.
 - e. The performance of the entity and the Quality of Services (QOS) provided are monitored on an ongoing basis and are annually reviewed by the Contractor.



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Annually, the Contractor must review a minimum of 30 randomly selected files for each function that is delegated. Documentation must be kept on file for AHCCCS review. Monitoring should include, but is not limited to:

- i. Utilization,
 - ii. Member and provider satisfaction, and
 - iii. Quality of Care concerns.
- f. The following documentation must be kept on file and available for AHCCCS review:
- i. Evaluation reports,
 - ii. Results of the Contractor's annual monitoring review of the delegated entity utilizing AHCCCS required standards for the contracted functions, and
 - iii. Corrective Action Plans and appropriate follow up to ensure quality and compliance with AHCCCS requirements for all delegated activities.
6. Chapter 900 Requirements – The Contractor must have policies and procedures to describe the following:
- a. The Contractor's method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with Policy 920B of this chapter
 - b. A description of how members rights and responsibilities are defined, implemented and monitored to meet requirements of Policy 930 of this Chapter
 - c. Documentation that the Contractor has implemented policies and procedures in compliance with Policy 940 of this Chapter to ensure that medical records and communication of clinical information for each member reflect all aspects of member care, including ancillary and behavioral health services. Policies must include processes for digital (electronic) signatures when electronic documents are utilized.
 - d. A description of the Contractor's temporary/provisional credentialing, initial credentialing and recredentialing process for individual providers and assessment and reassessment of organizational providers contracted with the Contractor, as required by Policy 950 of this chapter.



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- e. A description of the Contractor's process for grievance resolution, tracking and trending that meets standards set in Policy 960 of this Chapter and 42 C.F.R. 438.242 *et seq.*
 - f. Documentation of the Contractor's planned activities to meet or exceed AHCCCS-mandated performance measures and performance improvement project goals as specified in AHCCCS contract and required by Policies 970 and 980 of this Chapter.
 - g. Indication or documentation of input from contracted or affiliated providers.
 - h. Indication or documentation of input from AHCCCS members.
 - i. A description of how the Contractor monitors the quality and coordination of behavioral health services. The description must include procedures utilized to ensure timely updates from primary care providers to behavioral health providers regarding a member's change in health status. The update must include but is not limited to: diagnosis of chronic conditions, support for the petitioning process for Arizona Long Term Care System (ALTCS) only, and all medication prescribed.
7. Health Information System - Each Contractor must maintain a health information system that collects, integrates, analyzes, validates and reports data necessary to implement its QM/PI Program (42 C.F.R. 438.242). The Contractor must include a description of the process used by the Contractor related to the health information system and how the system is used to collect, integrate, analyze, validate and report data necessary to implement the QM/PI program. Data elements must include:
- a. Member demographics,
 - b. Provider characteristics,
 - c. Services provided to members, and
 - d. Other information necessary to guide the selection of, and meet the data collection requirements for PIPs and QM/PI oversight.
8. Policies and Procedures - The Contractor must have written policies and procedures to ensure that:
- a. Information/data received from providers is accurate, timely and complete.



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- b. Reported data is reviewed for accuracy, completeness, logic and consistency, and the review and evaluation processes used are clearly documented.
- c. All member and provider information protected by Federal and State law, regulations, or policies is kept confidential, and
- d. Contractor staff and providers are kept informed of at least the following:
 - i. QM/PI requirements, activities, updates or revisions,
 - ii. Study and Performance Improvement Project (PIP) results,
 - iii. Performance measures and results,
 - iv. Utilization data, and
 - v. Profiling results.

B. WORK PLAN

A work plan that addresses all requirements of Policy 920A of this Chapter and AHCCCS-suggested guidelines, and supports the Contractor's QM/PI goals and objectives. The Contractor must develop and implement a work plan with timelines which includes the following information:

1. A description of all planned activities and tasks for both clinical care, Contractor monitoring and all other covered services.
2. Beginning and ending dates for all objectives.
3. Methodologies to accomplish measurable goals and objectives.
4. At least three measurable behavioral health goals and objectives.
5. Local staff positions responsible and accountable for the meeting established goals and objectives.

C. QM/PI PROGRAM EVALUATION

The annual QM/PI evaluation report must contain the following:

1. A summary of all QM/PI activities performed throughout the year with:



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 910

**QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI)
PROGRAM ADMINISTRATIVE REQUIREMENTS**

- a. Title/name of each activity,
- b. Measurable goals and/or objective(s) related to each activity,
- c. Contractor departments or units and local staff positions involved in the QM/PI activities,
- d. Description of communication and feedback related to QM/PI data and activities,
- e. An evaluation of baseline data and outcomes utilizing qualitative and quantitative data which must include a statement describing if goals/objectives were met completely, partially or not at all,
- f. Actions to be taken for the improvement of Corrective Action Plan (CAP),
- g. Documentation of continued monitoring to evaluate the effectiveness of the actions (interventions) and other follow up activities,
- h. Rationale for changes in the scope of the QM/PI program and plan or a statement indicating if no changes were made.
- i. Necessary follow-up with targeted timelines for revisions made to the QM/PI plan, and
- j. Documentation of QM/PI committee review, evaluation and approval of any changes to the QM/PI plan.
- k. An evaluation of the previous year's activities must be submitted as part of the QM/PI Plan after review by the Contractor's governing or policy making body.

D. QM/PI PLAN AND EVALUATION

See Policy 990 of this Chapter, Chapter 400, Exhibit 400-1, and Appendix A for reporting requirements and timelines. For submission to AHCCCS/DHCM/CQM, the following may be combined or written separately and paginated as long as required components are addressed and are easily located within the document(s) submitted:

1. QM/PI Plan,
2. QM/PI Work Plan,



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

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**QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI)
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3. QM/PI Evaluation,
4. Maternity Care Plan and EPSDT Plan and associated work plans and evaluations, as set forth in Exhibit 400-2,
5. PIP Interim Report(s),
6. Quality Management Plan Checklist (see Exhibit 910-1), and
7. Submission of all referenced policies and procedures to implement the requirements of Chapter 900.

E. QM/PI DOCUMENTATION

The Contractor must maintain records that document QM and PI activities. The data must be made available to AHCCCS/DHCM/CQM upon request. The required documentation must include, but is not limited to:

1. Policies and procedures,
2. studies and PIPs,
3. reports,
4. protocols/desktop procedures,
5. standards,
6. worksheets,
7. meeting minutes,
8. Corrective Action Plans (CAPs), and
9. Other information and data deemed appropriate to support changes made to the scope of the QM/PI Plan and Program.

EXHIBIT 910-1

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
QUALITY MANAGEMENT PLAN CHECKLIST**

DRAFT Implementation 10/01/2013

EXHIBIT 910-1
QM Plan Checklist
Contractor

BALANCE BUDGET ACT (BBA) ¹ SECTION AND AHCCCS MEDICAL POLICY MANUAL (AMPM) ² SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	QM PLAN PAGE # ³	YES	NO	EXPLANATION OF "NO" ANSWER
QUALITY MANAGEMENT PROGRAM EVALUATION					
BBA: n/a AMPM: 910 – C – 1	1. Formally evaluate and document the effectiveness of QM/PI Program strategy and activities, at least annually (report on the last year). This annual evaluation report must document the following:				
BBA: 438.240 (e) (1) (i) & (2) AMPM: 910 – C	2. An evaluation of the previous year's activities must be submitted as part of the QM/PI Plan after review by the Contractor's governing or policy making body as required by 910 – C.				
BBA: n/a AMPM: 910 – C – 1 – a, b, c, d & f	3. Summary of all QM/PI Activities: a. Title/name of each activity, b. Measurable goals and/or objective(s) related to each activity c. Contractor departments or units and staff positions involved in QM/PI activities d. Description of communications and feedback related to QM/PI data and activities f. Action to be taken for improvement Corrective Action Plan (CAP)				
BBA: n/a AMPM: 910 – E 2 – 8	4. Trends identified through QM/PI activities and resulting actions taken for improvement.				
BBA: n/a AMPM: 910 – C – e	5. An evaluation of outcomes utilizing qualitative data, including a statement describing if goals/objectives were met completely, partially or not at all.				
BBA: n/a AMPM: 910 – C – 1 – h	6. Rationale for changes in the scope of the QM/PI Program and Plan (and when reported to AHCCCS).				
BBA: n/a AMPM: 910 – C – 1 – j	7. Review, evaluation and approval by the QM/PI Committee of any changes to the QM/PI Plan.				
BBA: n/a AMPM: 910 – C – 1 – i	8. Necessary follow-up with targeted timelines for revisions made to the QM/PI Plan.				

DRAFT Implementation 10/01/20

EXHIBIT 910-1
QM Plan Checklist
Contractor

BBA SECTION AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT	QM PLAN PAGE #	YES	NO	EXPLANATION OF "NO" ANSWER
QUALITY MANAGEMENT WORK PLAN					
BBA: n/a AMPM: 920 – A – 2	9. The QM/PI Program must develop and implement a work plan with timelines to support the objectives including:				
BBA: n/a AMPM: 920 – A – 2 – a	10. A description of all planned activities/tasks for both clinical care and other covered services.				
BBA: n/a AMPM: 920 – A – 2 – b	11. Targeted implementation and completion dates for QM measurable objectives, activities and PI projects.				
BBA: n/a AMPM: 920 – A – 2 – c	12. Methodologies to accomplish measurable goals and objectives.				
BBA: n/a AMPM: 920 – A – 2 – d	13. The inclusion of at least three measurable behavioral health goals and objectives				
BBA: n/a AMPM: 920 – A – 2 – e	14. Staff positions responsible and accountable for meeting established goals and objectives.				
BBA: n/a AMPM: 920 – A – 2 – f	15. Detailed policies and procedures to address all components and requirements of this Chapter including member demographics services on the Health Information System, Advanced Directives (Administrative or Case Manager [CM]), Peer review health risk assessment tools, including Behavioral Health, credentialing, and recredentialing, provisional and organizational credentialing, and quality improvement and Quality of Care complaints.				

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EXHIBIT 910-1
QM Plan Checklist
Contractor

	QUALITY MANAGEMENT PROGRAM NARRATIVE DESCRIPTION AND POLICY AND PROCEDURES				
BBA: n/a AMPM: 910 – A	1. Each Contractor must develop a written QM/PI Plan that addresses the Contractor’s proposed methodology to meet or exceed the standards and requirements of this Chapter. The QM/PI plan must describe how program activities will improve the quality of care and service delivery for enrolled members. The QM/PI Plan, and any subsequent modifications, must be submitted to AHCCCS/ Division of Health Care Management/Clinical Quality Management (DHCM/CQM) for review and approval prior to implementation. At a minimum, the QM/PI Plan must describe, in paginated detail, the following components of the Contractor’s QM/PI Program.				
BBA: n/a AMPM: 910 – A – 1 – c	2. An organizational chart that delineates the reporting channels for QM/PI activities and the relationship to the Contractor Medical Director and Executive Management.				
BBA: n/a AMPM: 910 – A – 6	3. Contractor describes how delegated activities are integrated into the overall QM/PI program and the methodologies for oversight and accountability of all delegated functions as required by Policy 910 C.				
BBA: n/a AMPM: 910 – A – 4 – (a – m)	4. The Contractor must have a peer review process of which the purpose is to improve the quality of medical care provided to members by practitioners and providers.				
BBA: n/a AMPM: 910 – A – 6 – e	5. A process to review and monitor the performance of the entity and the quality of services provided on an ongoing basis and a formal review as least annually. Monitoring should include but is not limited to utilization, member/provider satisfaction and quality of care/service concerns.				
BBA: 438.202 (b) AMPM: 900 – 5	6. The QM/QI Program must include input from employed or affiliated providers and consumers (BBA requirement).				
BBA: n/a AMPM: 910 – A – 7 – h	7. Description of how the Contractor monitors the quality and coordination of behavioral health services. The description must include procedures utilized to ensure timely updates from primary care providers to behavioral health providers regarding a member’s change in health status. The update must include but is not limited to diagnosis of chronic conditions, support for the petitioning process (for Arizona Long Term Care System [ALTCS] only), and all medication prescribed.				
BBA: 488.242, (b) (3) AMPM: 910 – A – 8	8. Descriptions of the process used by the Contractor’s health information system to collect, integrate, analyze and report data necessary to implement the QM/PI program.				

EXHIBIT 910-1
QM Plan Checklist
Contractor

	QUALITY MANAGEMENT PROGRAM NARRATIVE DESCRIPTION AND POLICY AND PROCEDURES				
BBA: n/a AMPM: 910 – A – 1	9. The Contractor’s QM/PI Program must be administered through a clear and appropriate administrative structure. The governing or policy-making body must oversee and be accountable for the QM/PI program.				
BBA: n/a AMPM: 950 – F	10. Description of the process used by the Contractor that ensures that, prior to contracting and credentialing, the subcontractor has established policies and procedures that meet AHCCCS requirements; and the process by which the subcontractor reports at a minimum incidences of Healthcare Acquired conditions, abuse, neglect, exploitation, injuries and unexpected death to the Contractor.				
BBA: n/a AMPM: 910 – 1 – a	11. Ensure ongoing communication and collaboration between the QM/PI Program and the other functional areas of the organization (e.g., medical management, behavioral health, member services and case management).				
BBA: n/a AMPM: 910 – A – 3	12. The Contractor must have an identifiable, structured QM/PI Committee that is responsible for QM/PI functions and responsibilities. At a minimum, membership must include:				
BBA: n/a AMPM: 910 – A – 3 – a – i	13. 1) The Medical Director (The Medical Director may designate the Associate Medical Director as his/her alternate if the Medical Director is unable to attend a QM/PI Committee meeting).				
BBA: n/a AMPM: 910 – A – 3 – a – ii	14. 2) The QM/PI Manager.				
BBA: n/a AMPM: 910 – A – 3 – a – iii	15. 3) Representation from the functional areas within the organization.				
BBA: n/a AMPM: 910 – A – 3 – a – iv	16. 4) Representation of contracted or affiliated providers serving AHCCCS members.				
BBA: n/a AMPM: 910 – A – 3 – a – v	17. 5) The appropriate clinical representatives.				

EXHIBIT 910-1
QM Plan Checklist
Contractor

	QUALITY MANAGEMENT PROGRAM NARRATIVE DESCRIPTION AND POLICY AND PROCEDURES				
BBA: n/a AMPM: 910 – A – 3 – b	18. The Medical Director, as chairperson for the QM/PI Committee, or his/her designee, is responsible for implementation of the QM/PI Plan, and must have substantial involvement in the assessment and improvement of QM/PI activities.				
BBA: n/a AMPM: 910 – A – 3 – e	19. The QM/PI Committee must review the QM/PI Program objectives, policies and procedures at least annually and modify or update them as necessary.				
BBA: n/a AMPM: 920 – A – 1	20. The QM/PI Program must have a detailed, written set of specific measurable objectives that demonstrate how the Contractor’s QM/PI Program meets established goals and complies with all components of Chapter 900.				
BBA: n/a AMPM: 920 – B – 2	21. The QM/PI Program scope of monitoring and evaluation must be comprehensive. It must incorporate the activities used by the Contractor, and demonstrate how these activities will improve the quality of services and the continuum of care in all service sites.				
BBA: n/a AMPM: 910 – A – 5 – e	22. A process to ensure that staff having contact with members or providers (i.e. case managers, customer service, provider relations Behavioral Health Coordinators) are trained on how to refer suspected quality of care issues to quality management. This training must be provided during new employee orientation and annually thereafter.				
BBA: n/a AMPM: 920 – B – 2	23. Information and data gleaned from QM monitoring and evaluation that shows trends in quality of care issues should be used in developing PI projects. Selection of specific monitoring/evaluation activities should be appropriate to each specific service site.				
BBA: n/a AMPM: 920 – C – 1	24. Contractors must develop work plans for taking appropriate actions to improve care if problems are identified. The work plans should address the following:				
BBA: n/a AMPM: 920 – C – 1 – a	25. Specified types(s) of problem(s) that requires corrective action.				
BBA: n/a AMPM: 920 – C – 1 – b	26. Person(s) or body responsible for making the final determination regarding quality issues.				

EXHIBIT 910-1
QM Plan Checklist
Contractor

	QUALITY MANAGEMENT PROGRAM NARRATIVE DESCRIPTION AND POLICY AND PROCEDURES				
BBA: n/a AMPM: 920 – C – 1 – c – (i) – (vi)	27. Types(s) of member/provider actions(s) to be taken: education/training/technical assistance; follow-up monitoring and evaluation of improvement; changes in processes, structures, forms; informal counseling, termination of affiliation with provider, and/or appropriate referrals to regulatory agencies. (If an adverse action is taken with a provider due to a quality of care concern, the Contractor must report the adverse action to the AHCCCS Clinical Quality Management Unit).				
BBA: n/a AMPM: 920 – C – 1 – d	28. Documentation of assessment of the effectiveness of actions taken.				
BBA: n/a AMPM: 920 – C – 1 – e	29. Method(s) for internal dissemination of findings and resulting work plans to appropriate staff and/or network providers, and				
BBA: n/a AMPM: 920 – C – 1 – f	30. Method(s) for dissemination of pertinent information to AHCCCS Administration and/or regulatory boards and agencies (Arizona Department of Health Services, Arizona Medical Board, Arizona State Board of Nursing).				
BBA: n/a AMPM: 920 – C – 2	31. Contractors must maintain documentation that confirms the implementation of corrective actions.				
BBA: n/a AMPM: 940 – 2	32. Contractors must implement appropriate policies and procedures to ensure that the organization and its providers have information required for:				
BBA: n/a AMPM: 940 – 2 – a	33. Effective and continuous member care through accurate medical record documentation (including electronic health records) of each member’s health status, changes in health status, health care needs, and health care services provided.				
BBA: n/a AMPM: 940 – 2 – b	34. Quality review.				
BBA: n/a AMPM: 940 – 2 – c	35. An ongoing program to monitor compliance with those policies and procedures.				

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EXHIBIT 910-1
QM Plan Checklist
Contractor

	QUALITY MANAGEMENT PROGRAM NARRATIVE DESCRIPTION AND POLICY AND PROCEDURES				
BBA: n/a AMPM: 940 – 3 – a	36. Each Contractor must implement policies and procedures that address medical records and the methodologies to be used by the organization to ensure that Providers maintain a legible medical record for each enrolled member who has been seen for medical appointments or procedures and/or receive medical/behavioral health records from other providers who have seen the enrolled member, that the record is kept up-to-date, is well organized and comprehensive with sufficient detail to promote effective member care and quality review. Policies must include processes for digital (electronic) signatures when electronic documents are utilized. A member may have numerous medical records kept by various health care providers that have rendered services to the member, however, the Primary Care Provider (PCP) must maintain a comprehensive record. The medical record must also contain clinical/behavioral health records from other providers who also provide care/services to the enrolled member (see Policy 940 for required medical record components). The Quality Management Program implements policies and procedures that includes requirements of the PCPs referral to, coordination of care with, and transfer of care to Behavioral Health providers.				
BBA: n/a AMPM: 950 – B	37. The Contractor must have a written system in place for credentialing and re-credentialing providers included in their contracted provider network. Providers who are not licensed or certified must be included in the credentialing process and profiled. (See Policy 950 for required credentialing components)				
BBA: n/a AMPM: 950 – B – 3	38. If the Contractor delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this Chapter, it must retain the right to approve, suspend, or terminate any provider selected by that entity and meet the requirements of Policy 910 of this Chapter regarding delegation.				
BBA: n/a AMPM: 950 – B – 3	39. The QM/PI committee or other peer review body is responsible for over-site regarding delegated credentialing or re-credentialing decisions.				
BBA: n/a AMPM: 950 – B – 4 – a	40. Written policies that reflect the direct responsibility of the Medical Director or other designated physician for the oversight of the process and delineate the role of the credentialing committee.				

EXHIBIT 910-1
QM Plan Checklist
Contractor

	QUALITY MANAGEMENT PROGRAM NARRATIVE DESCRIPTION AND POLICY AND PROCEDURES				
BBA: n/a AMPM: 950 – B – 4 – b	41. Written policies indicate the utilization of participating Arizona Medicaid network providers in making credentialing decisions, and				
BBA: n/a AMPM: 950 – D	42. Temporary/Provisional Credentialing Contractors must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.				
BBA: n/a AMPM: 950 – D	43. Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. The Contractor must follow the primary source verification process of initial credentialing when granting temporary or provisional credentialing. Providers working in a Federally Qualified Health Center (FQHC) and an FQHC Look-a-like Center, as well as hospital employed physicians (when appropriate), must be credentialed using the temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional.				
BBA: n/a AMPM: 950—D	44. The Contractor must Review and approve that provider through the Contractor’s credentialing committee.				
BBA: n/a AMPM: 950—D	45. The Contractor shall have 14 calendar days from receipt of a complete application , accompanied by the minimum documents identified above, within which to render a decision regarding temporary or provisional credentialing.				
BBA: n/a AMPM: 950 – F	46. As a prerequisite to contracting and credentialing an organizational provider, the contractor must ensure that the organizational provider has policies and procedures that meet AHCCCS requirements. Policies must include record of onsite inspection of non-licensed organizational providers to ensure compliance with service inspections.				
BBA: n/a AMPM: 960 – A	47. Each Contractor must develop and implement policies and procedures for reviewing, evaluating and resolving issues raised by enrolled members and contracted providers. All issues must be addressed regardless of source (external or internal).				

EXHIBIT 910-1
QM Plan Checklist
Contractor

	QUALITY MANAGEMENT PROGRAM NARRATIVE DESCRIPTION AND POLICY AND PROCEDURES				
BBA: n/a AMPM: 960 – B	48. As part of the Contractor’s process for reviewing and evaluating member and provider issues, there must be written policies and procedures regarding the receipt initial and ongoing processing of these matters that includes the following:				
BBA: n/a AMPM: 960 – B – 1	49. Documentation of each issue raised, when and from whom it was received, and the projected time frame for resolution.				
BBA: 438.402 (a) AMPM: 960 – B – 2 – a – d	50. Prompt determination of whether the issue is to be resolved through the Contractor’s established a) Quality management process, b) grievance and appeals process, c) process for making initial determinations of coverage and payment issues, d) process for resolution of disputed initial determinations.				
BBA: n/a AMPM: 960 – B – 3	51. Acknowledging receipt of the issue and explaining to the member or provider the process to be followed in resolving his or her issue through written correspondence.				
BBA: n/a AMPM: 960 – B – 4	52. Assisting the member or provider as needed in completing forms or taking other necessary steps to obtain resolution of the issue.				
BBA: n/a AMPM: 960 – B – 5	53. Ensuring confidentiality of all member information.				
BBA: n/a AMPM: 960 – B – 6	54. Informing the member or provider of all applicable mechanisms for resolving the issue external to the Contractor processes, and				
BBA: 438.240 (b) (3) AMPM: 960 – B – 7	55. Documenting all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance and appeal (see Policy 960 for examples of resolution; resolution should include both member and systems resolution).				
BBA: n/a AMPM: 960 – C – 1	56. Contractors must develop and implement policies and procedures that address analysis of the quality of care issue through:				
BBA: n/a AMPM: 960 – C – 1 – a	57. Identification of the quality of care issue.				
BBA: n/a AMPM: 960 – C – 1 – b	58. Initial assessment of the severity of the quality care issues.				

EXHIBIT 910-1
QM Plan Checklist
Contractor

	QUALITY MANAGEMENT PROGRAM NARRATIVE DESCRIPTION AND POLICY AND PROCEDURES				
BBA: n/a AMPM: 960 – C – 1 – c	59. Prioritization of action(s) needed to resolve immediate care needs when appropriate.				
BBA: n/a AMPM: 960 – C – 1 – e	60. Research, including but not limited to: a review of the log of events, documentation of conversation, and medical records review etc.				
BBA: n/a AMPM: 960 – C – 1 – d	61. Review of trend reports obtained from the Contractor’s quality of care database to determine possible trends related to the provider(s) (including organizational providers such as but not limited to, nursing facilities and hospitals, involved in the allegation(s) including: type(s) of allegation(s), severity and substantiation, etc				
BBA: n/a AMPM: 960 – C – 1 – f	62. Quantitative and qualitative analysis of the research.				
BBA: n/a AMPM: 960 – C – 2	63. A process to assure that action is taken when needed by:				
BBA: n/a AMPM: 960 – C – 2 – a	64. Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring.				
BBA: n/a AMPM: 960 – C – 2 – b	65. Determining, implementing and documenting appropriate interventions.				
BBA: n/a AMPM: 960 – C – 2 – c	66. Monitoring and documenting the success of the interventions.				
BBA: n/a AMPM: 960 – C – 2 – d	67. Incorporating interventions into the organization’s QM program if successful, or				
BBA: n/a AMPM: 960 – C – 2 – e	68. Assigning new interventions/approaches when necessary.				
BBA: n/a AMPM: 960 – C – 3	69. A process to provide resolution of the issue. Member and system resolutions may occur independently from one another.				
BBA: n/a AMPM: 960 – C – 4	70. A process to determine the level of severity of the quality of care issue.				

EXHIBIT 910-1
QM Plan Checklist
Contractor

	QUALITY MANAGEMENT PROGRAM NARRATIVE DESCRIPTION AND POLICY AND PROCEDURES				
BBA: n/a AMPM: 960 – C – 5	71. Referring/reporting the issue to appropriate regulatory agency, Child or Adult Protective Services and AHCCCS for further research/review or action. Initial reporting may be verbally, but must be followed by a written report.				
BBA: n/a AMPM: 960 – C – 5	72. Referring the issue to the Contractor peer review committee when appropriate				
BBA: n/a AMPM: 960 – C – 7	73. The Contractor must have a process to determine the level of substantiation.				
BBA: n/a AMPM: 960 – C – 8	74. Notifying the appropriate regulatory/licensing board or agency and AHCCCS when a health care professional's organizational provider or other provider's affiliation with their network is suspended or terminated because of quality of care issues, and				
BBA: n/a AMPM: 960 – C – 9	75. A process for documenting the criteria and process for closure of the review including but not limited to:				
BBA: n/a AMPM: 960 – C – 9 – a	76. A description of the problem, including new allegations identified during the investigation/review process.				
BBA: n/a AMPM: 960 – C – 9 – b	77. Written response from or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or medical examiner.				
BBA: n/a AMPM: 960 – D – 1 – a	78. The data from the quality of care data must be analyzed and evaluated to determine any trends related to the quality of care in the Contractor's service delivery system or provider network. A process must be implemented for incorporating the trending of quality of care issues in determining systemic interventions for quality improvement.				
BBA: n/a AMPM: 910 – D – 7	79. All referenced policies and procedures related to the requirements of Chapter 900 (i.e., Credentialing, Peer Review, Quality of Care Issues, Medical Records, Delegation, Reporting to Outside Agencies, Tracking and Trending, Internal Monitoring and Reporting of Performance Measures, Performance Improvement Projects, etc).				

EXHIBIT 910-1
QM Plan Checklist
Contractor

	QUALITY MANAGEMENT PROGRAM NARRATIVE DESCRIPTION AND POLICY AND PROCEDURES				
BBA: 438.240 (e) (1) (i) BBA: 438.240 (a) & (b) BBA: 438.240 (c) (1, 2, and 3) AMPM: 970 – B – d – i	80. Description of a process for internally measuring and reporting to AHCCCS the Contractor’s performance for contractually mandated performance measures, using standardized methodology established or adopted by AHCCCS. The Contractor must use the results of the AHCCCS contractual performance measures (from its internal measurement and rates reported by AHCCCS) in evaluating its quality assessment and performance improvement program. Report performance measures in a table format.				
BBA: n/a AMPM: 970 – B – 1 – b – (i) – (v)	81. Description of a process for developing an evidence-based corrective action plan, which utilizes the Plan-Do-Study-Act, (PDSA) cycle when the Contractor’ performance falls below the minimum level established by AHCCCS.				
BBA: 438.240 (a) (1) BBA: 438.240 (b) (1) & (d) (1) BBA: 438.240 (e) (1) (ii) & (2) AMPM: 970 – B – 1 – (i) – (vii)	82. Description of a process to develop and initiate interventions that result in significant demonstrable improvement, sustained over time, in its performance for the performance indicators being measured. Contractors should utilize Plan-Do-Study-Act, (PDSA) process to test changes (interventions) and refine them as necessary.				
BBA: 438.240 (e) (1) BBA: 438.240 (d) (2) AMPM: 980 – B – 2	83. The Contractor has reported to AHCCCS annually its interventions, analysis of interventions and internal measurements, changes or refinements to interventions and actual or projected results from repeat measurements, as directed by AHCCCS, using the PIP Reporting Template (Exhibit 980-2).				
BBA: n/a AMPM: 930	84. Policy and procedure on members rights including all sections in 930.				

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920 QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM SCOPE

REVISION DATES: XX/XX/XX, 04/01/12, 02/01/11, 10/01/09, 10/01/08, 06/01/07, 02/01/07,
04/01/05, 08/13/03, 10/01/01, 10/01/97

INITIAL

EFFECTIVE DATE: 10/01/1994

A. QM/PI PROGRAM COMPONENTS

The QM/PI Program must:

1. Develop a detailed, written set of specific measurable objectives that demonstrate how the Contractor's QM/PI Program meets established goals and complies with all components of this Chapter.
2. Develop and implement a work plan with timelines to support the objectives including:
 - a. A description of all planned activities/tasks for both clinical care and other covered services.
 - b. Targeted implementation and completion dates for QM measurable objectives, activities and PI projects.
 - c. Methodologies to accomplish measurable goals and objectives.
 - d. The inclusion of at least three measurable behavioral health goals and objectives.
 - e. Local staff positions responsible and accountable for meeting established goals and objectives, and
 - f. Detailed policies and procedures to address all components and requirements of this Chapter.
3. Develop and implement a process to ensure that initial health assessment survey tools are included in the New Member Welcome Packet. Contractors must develop processes to utilize results of health assessments to identify individuals at risk for and or with special health care needs and to coordinate care (42 C.F.R. 438.208).



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 920

QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI)

PROGRAM SCOPE

- a. Refer to [Chapter 1600](#) to obtain time frames in which case managers must have an initial contact with newly enrolled Arizona Long Term Care System (ALTCS) members.
 - b. Refer to AHCCCS contract to obtain time frames in which Arizona Department of Health Services/ Department of Behavioral Health Services (ADHS/DBHS)-affiliated Contractors/providers must have first contact with members referred to Regional Behavioral Health Agencies (RBHAs) and Tribal Regional Behavioral Health Agencies (TRBHAs).
4. Ensure continuity of care and integration of services through:
- a. Policies and procedures allowing each member to select, or the Contractor to assign, a Primary Care Provider (PCP) (or a clinician for an ADHS/DBHS or Integrated RBHA member) who is formally designated as having primary responsibility for coordinating the member's overall health care.

NOTE: For purposes of this Policy, a PCP includes a clinical liaison for an ADHS/DBHS or Integrated RBHA member.
 - b. Policies and procedures specifying under what circumstances services are coordinated by the Contractor, the methods for coordination, and specific documentation of these processes.
 - c. Programs for care coordination that include coordination of covered services with community and social services and behavioral health services generally available through contracted or non-contracted providers, in the Contractor's service area.
 - d. Policies and procedures specifying services coordinated by the Contractor's Disease Management Unit, and
 - e. Policies and procedures for timely and confidential communication of clinical information among providers, as specified in Policy 940 of this Chapter.
5. Implement measures to ensure that members:
- a. Are informed of specific health care needs that require follow-up.
 - b. Receive, as appropriate, training in self-care and other measures they may take to promote their own health, and



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- c. Are informed of their responsibility to comply with ordered treatments or regimens.
6. Develop and implement procedures for members with special health care needs, as defined in the AHCCCS contract, including:
 - a. Identifying members with special health care needs, including those who would benefit from disease management.
 - b. Ensuring an assessment by an appropriate health care professional of ongoing needs of each member identified as having special health care need(s) or condition(s).
 - c. Identifying medical procedures (and/or behavioral health services, as applicable) to address and/or monitor the need(s) or condition(s).
 - d. Ensuring adequate care coordination among providers, including other Contractors and behavioral health providers, as necessary, and
 - e. Ensuring a mechanism to allow direct access to a specialist as appropriate for the member's condition and identified special health care needs (e.g., a standing referral or an approved number of visits).

B. QM/PI PROGRAM MONITORING AND EVALUATION ACTIVITIES

1. If collaborative opportunities exist to coordinate organizational monitoring, all requirements in the collaborative arrangement must be met by the lead Contractor.
2. QM/PI Program scope of monitoring and evaluation must be comprehensive. It must incorporate the activities used by the Contractor, and demonstrate how these activities will improve the quality of services and the continuum of care in all services sites. These activities must be clearly documented in policies and procedures.
3. Information and data gleaned from QM monitoring and evaluation that shows trends in quality of care issues must be used in developing PI projects. Selection of specific monitoring and evaluation activities must be appropriate to each specific service or site.
4. The Contractor must implement policies and procedures that require the individual and organizational providers to report to the proper authorities as well as the Contractor incidents of abuse, neglect, as well any injury (e.g. falls and fractures) exploitation, healthcare acquired conditions, and or unexpected death as soon as the providers are aware of the incident. The Contractor must report all incidents of abuse, neglect,



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exploitation, healthcare acquired conditions and unexpected deaths to the AHCCCS Clinical Quality Management Unit.

5. Contractors must incorporate the ADHS licensure and certification reports and other publicly reported data in their monitoring process, as applicable.
6. Contractor quality of care trend reports must be incorporated into monitoring and evaluation activities. Policies and procedures must be developed and implemented to explain the process.
7. Contractors are responsible for ensuring health and safety of members in facilities that are found to have survey deficiencies that may impact the health and safety of AHCCCS members. Contractors must be active participants in both individual and coordinated efforts to improve the quality of care in facilities that have been identified through Licensure Survey process as having an Immediate Jeopardy situation or has had more than one survey or complaint investigation resulting in a finding of non-compliance with licensure requirements. Based on survey findings, Contractors must:
 - a. Actively participate in meetings focused on ensuring health and safety of members.
 - b. Actively participate in meetings scheduled to develop work plans and corrective action plans to ensure facility compliance with ADHS Licensure requirements.
 - c. Participate in scheduled and unscheduled, as appropriate, monitoring of facilities that are in an Immediate Jeopardy status or have serious identified deficiencies that may effect health and safety of members.
 - d. Assist in the identification of technical assistance resources focused on achieving and sustaining licensure compliance.
 - e. Monitoring facilities upon completion of the activities and interventions to ensure that compliance is sustained.
8. The Contractor shall have local staff available 24 hours a day, seven days a week to work with AHCCCS and at the request of AHCCCS, other State agencies on urgent issue resolutions such as in the case of an Immediate Jeopardy situation called by ADHS Licensure, wildfires, bankruptcies, foreclosures and other public emergency situations. These staff persons shall have access to information necessary to:
 - a. Identify members who may be at risk,



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- b. Identify the member's current health and services status,
 - c. Initiate new placement settings or services,
 - d. Conduct on-site health and safety status checks at affected facilities,
 - e. Conduct ongoing health and safety checks.
9. The Contractor shall supply AHCCCS CQM with the contact information for these staff persons, which should include the Quality Management Coordinator and Case Management Manager, at a minimum. Contact information must include:
- a. Name,
 - b. Title, and
 - c. 24-hour contact telephone numbers for each designated staff person.

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10. The following services and service sites must be monitored at a minimum annually by ADHS/DBHS or its Contractors and must include, but are not limited to, the following:

SERVICES	SERVICE SITES
<ul style="list-style-type: none"> • Behavioral Health Therapeutic Home Care Services • Behavioral Management (behavioral health personal assistance, family support, peer support) • Case Management Services • Emergency/Crisis Behavioral Health Services • Emergency Transportation • Evaluation and Screening (initial and ongoing assessment) • Group Therapy and Counseling • Individual Therapy and Counseling • Family Therapy and Counseling • Inpatient Hospital • Inpatient Psychiatric Facilities (resident treatment centers and sub-acute facilities) • Institutions for Mental Diseases • Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis • Non-emergency Transportation • Nursing • Opioid Agonist Treatment • Partial Care (supervised day program, therapeutic day program and medical day program) • Psychosocial Rehabilitation (living skills training, health promotion and supported employment) • Psychotropic Medication • Psychotropic Medication Adjustment and Monitoring • Respite Care 	<ul style="list-style-type: none"> • Behavioral Health Outpatient Clinics • Behavioral Health Therapeutic Home (Adults and Children) • Community Service Agency • Hospital (if it includes a distinct behavioral health or detoxification unit) • Level I Behavioral Health Facility • Level II Behavioral Health Facility • Level III Behavioral Health Facility • Psychiatric Hospital • Rural Substance Abuse Transitional Center • Unclassified Facility Behavioral Health • Integrated Behavioral Health and Medical Facility



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11. The following services and service sites must be monitored at a minimum every three years, by Acute Care Contractors and Children's Rehabilitative Services (CRS) and must include, but are not limited to, the following:

SERVICES	SERVICE SITES
<ul style="list-style-type: none">• Ancillary• Dental• Emergency• Early Periodic Screening, Diagnosis and Treatment (EPSDT)• Family Planning• Obstetric• Pharmacy• Prevention and Wellness• Primary Care• Specialty Care• Other (e.g. Durable Medical Equipment (DME)/Medical Supplies, Home Health Services, Therapies, Transportation, etc.)	<ul style="list-style-type: none">• Ambulatory Facilities• Hospitals• Nursing Facilities

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12. The following services and service sites must be monitored by Arizona Long Term Care System (ALTCS) Contractors every three years, at a minimum, (unless otherwise noted), and must include, but are not limited to, the following:

SERVICES	SERVICE SITES
<ul style="list-style-type: none"> ● Adult Day Health Care* ● Ancillary ● Attendant Care* ● Behavioral Health ● Dental ● Durable Medical Equipment (DME)/ Medical Supplies ● Emergency ● Emergency Alert ● Environmental Modifications ● Early Periodic Screening, Diagnosis and Treatment (EPSDT) ● Family Planning ● Habilitation Services (as applicable) ● Home Delivered Meals ● Home Health Services ● Homemaker* ● Hospice ● Medical/Acute Care ● Obstetric ● Personal Care* ● Prevention and Wellness ● Respiratory Therapy ● Respite Care ● Specialty Care ● Therapies (Occupational Therapy [OT], Physical Therapy [PT], Speech Therapy [ST]) ● Transportation 	<ul style="list-style-type: none"> ● Assisted Living Centers* ● Assisted Living Homes* ● Ambulatory Facilities ● Behavioral Health Facilities ● Developmentally Disabled (DD) Group Homes* ● Foster Care Homes* ● Hospice* ● Hospitals ● Institution for Mental Diseases* ● Intermediate Care Facility for Persons with Intellectual Disabilities* ● Nursing Facilities* ● Own Home* ● Residential Treatment Centers* ● Traumatic Brain Injury Facilities*
<p>* These services must be reviewed annually.</p>	



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13. Arizona Long Term Care System (ALTCS) Contractors must implement policies and procedures for the annual monitoring of attendant care, homemaker services, and personal care services. When deficiencies or potential deficiencies are identified, they must be addressed from a member and from a system perspective.
14. ALTCS Contractors must coordinate mandatory routine quality monitoring and oversight activities for organizational providers, including Home and Community Based Service (HCBS) placement settings, when the provider is included in more than one ALTCS Contractor network. A collaborative process should be utilized in urban counties (Maricopa and Pima) and in rural counties when more than one ALTCS Contractor is contracted with and utilizes the facility.
15. If collaborative opportunities exist to coordinate organizational monitoring, all requirements must be met by the lead ALTCS Contractor using a standardized and agreed upon tool including at a minimum:
 - a. General Quality Monitoring of these services includes but is not limited to the review and verification of:
 - i. The written documentation of timeliness,
 - ii. The implementation of contingency plans,
 - iii. Customer satisfaction information,
 - iv. The effectiveness of service provision, and
 - v. Mandatory documents in the services or service site personnel file:
 - (a) Cardiopulmonary resuscitation
 - (b) First Aid
 - (c) Verification of skills
 - (d) Evidence that the agency contacted at least three references, all of which must be former employers, if applicable. Results of the contacts must be documented in the employee's personnel record.
 - b. Specific quality monitoring requirements are as follows:
 - i. Attendant care monitoring (refer to AHCCCS Medical Policy Manual (AMPM) Chapter 1200, Policy 1240-B, Attendant Care, for detailed information) must include:
 - (a) Verification of the monitoring and documentation of the following:



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- (i) An applicant interview within 14 days of contacting the Contractor or subcontracting agency unless there are extenuating circumstances that would reasonably prevent this process,
 - (ii) Mandated written agreement between the member and or member representative and the Attendant Case Worker (ACW) which delineates the responsibilities of timeliness and content of supervisory visits as specified in Chapter 1200, Policy 1240, General Requirements,
 - (iii) Evaluation of the appropriateness of allowing the member's immediate relatives to provide attendant care, and
 - (iv) Provision of continuing education/training sessions for certified ACWS on at least an annual basis and as needs are identified.
- (b) An evaluation of the provider's specialized training criteria for a selected certified ACW to provide necessary services to the member.
- ii. Personal care monitoring (refer to AMPM Chapter 1200, Policy 1240-N, Personal Care) must include verification of the monitoring and documentation of the following:
 - (a) The personal care provider rendered services under direct supervision by an experienced, qualified personal care provider or medical services (i.e., registered nurse, physician) until they were verified competent in each of the designated personal care services,
 - (b) Duties and tasks were included in the member's individualized care plan that were necessary to assist the member in maintaining self-sufficiency and these duties and tasks were completed, and
 - (c) Timeliness and content of supervisory visits as specified in Chapter 1200, Policy 1240, General Requirements.
- iii. Homemaker monitoring (refer to AMPM Chapter 1200, Policy 1240-I, Homemaker Services) must include verification of the monitoring and documentation of the following:
 - (a) Tasks including but not limited to the following are completed as designated in the individualized care plan,
 - (i) Cleaning tasks necessary to attain and maintain safe and sanitary living conditions for the member,
 - (ii) Meal planning, shopping, food preparation and storage tasks necessary to provide food/meals that meet the nutritional needs of the member,
 - (iii) Laundry tasks required to maintain the member's clothing in a neat and clean manner, and
 - (iv) Other duties and tasks, as included in the member's individualized care plan that are necessary to assist the member in maintaining self-sufficiency.
 - (b) Timeliness and content of supervisory visits as specified in Chapter 1200, Policy 1240, General Requirements, and



- iv. Sampling methodology for monitoring of attendant care, personal care, and homemaker service must assure that all provider agencies and all direct care workers have an equal opportunity to be sampled (provider agencies must be included in the sample frame even if the number of employees does not meet a statistically significant level. All employees must be included in the sample frame including those who are in the pool of workers but are not currently assigned to a member).

C. IMPLEMENTATION OF ACTIONS TO IMPROVE CARE

1. Contractors must develop work plans for taking appropriate actions to improve care if problems are identified. The work plans should address the following:
 - a. Specified type(s) of problem(s) that requires corrective action. Examples include, but are not limited to abuse, neglect, exploitation, Healthcare acquired conditions, unexpected death, isolated systemic issues, lack of coordination with special needs population, and inappropriate blanket authorizations for specific ongoing care needs.
 - b. Person(s) or body (e.g., Board) responsible for making the final determinations regarding quality issues (all determinations regarding quality issues that are referred to peer review will be made only by the peer review committee chaired by the Chief Medical Officer. For peer review policy, refer to Policy 910-C 4.
 - c. Type(s) of member/provider action(s) to be taken including:
 - i. Education/training/technical assistance,
 - ii. Follow-up monitoring and evaluation of improvement,
 - iii. Changes in processes, structures, forms,
 - iv. Informal counseling,
 - v. Termination of affiliation with provider (if an adverse action is taken with a provider due to a quality of care concern, the Contractor must report the adverse action to the AHCCCS Clinical Quality Management Unit), and/or
 - vi. Appropriate referrals to regulatory agencies.
 - d. Documentation of assessment of the effectiveness of actions taken
 - e. Method(s) for internal dissemination of findings and resulting work plans to appropriate staff and/or network providers, and



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- f. Method(s) for dissemination of pertinent information to AHCCCS Administration and/or regulatory boards and agencies (i.e., Arizona Department of Health Services, Arizona Medical Board, Arizona State Board of Nursing).
2. Contractors must maintain documentation that confirms the implementation of corrective actions.

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930 MEMBER RIGHTS AND RESPONSIBILITIES

REVISION DATES: 04/01/12, 10/01/08, 02/01/07, 04/01/05, 05/01/04, 08/13/03, 10/01/01, 10/01/97

REVIEW DATE: 02/01/11

INITIAL

EFFECTIVE DATE: 10/01/1994

1. Contractors must have written policies and procedures that address, at a minimum, the following member rights and how these rights are disseminated to members and providers. Each member will:
 - a. Be treated with respect and with recognition of the member's dignity and need for privacy.
 - i. The right to privacy includes protection of any information that identifies a particular member except when otherwise required or permitted by law.
 - ii. The Contractor must implement procedures to ensure the confidentiality of health and medical records and of other member information. (Refer to the Medical Records Requirements included in Policy 940 of this Chapter.)
 - b. Not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, intellectual or physical disability, sexual orientation, genetic information, or source of payment.
 - c. Have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitations. Options include access to a language interpreter, a person proficient in sign language for the hearing impaired, and written materials available in Braille for the blind or in different formats, as appropriate.
 - d. Have the opportunity to choose a Primary Care Provider (PCP), within the limits of the provider network, and choose other providers as needed from among those affiliated with the network. This also includes the right to refuse care from specified providers.



- e. Participate in decision-making regarding his or her health care, including:
 - i. The right to refuse treatment Code of Federal Regulations (42 C.F.R. 438.100), and/or
 - ii. Have a representative facilitate care or treatment decisions when the member is unable to do so.
- f. Have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- g. Be provided with information about formulating advance directives (the Contractor must provide for involvement by the member or their representative in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment within the requirements of Federal and State law with respect to advance directives [42 C.F.R. 438.6]).
- h. Receive information, in a language and format that the member understands, about member rights and responsibilities, the amount, duration and scope of all services and benefits, service providers, services included and excluded as a condition of enrollment, and other information including:
 - i. Provisions for after-hours and emergency health care services. Information provided must notify members that they have the right to access emergency health care services from contracting or non-contracting providers without prior authorization, consistent with the member's determination of the need for such services as a prudent layperson.
 - ii. Information about available treatment options (including the option of no treatment) or alternative courses of care.
 - iii. Procedures for obtaining services, including authorization requirements and any special procedures for obtaining mental health and substance abuse services, or referrals for specialty services not furnished by the member's PCP.
 - iv. Procedures for obtaining services outside the geographic service area of the Contractor.
 - v. Provisions for obtaining AHCCCS covered services that are not offered or available through the Contractor, and notice of the right to obtain family planning services from an appropriate AHCCCS registered provider, and
 - vi. A description of how the organization evaluates new technology for inclusion as a covered benefit.
- i. Be provided with information regarding grievances, appeals and requests for hearing.



- j. Have the right to complain about the managed care organization.
- k. Have access to review his/her medical records in accordance with applicable Federal and State laws, and/or:
- l. Have the right to request and receive annually, at no cost a copy of his/her medical records as specified in Title 45 of the Code of Federal Regulations (C.F.R.) 164.524:
 - i. The member's right of access to inspect and obtain a copy of his/her medical records may be denied if the information is:
 - (a) Psychotherapy notes.
 - (b) Compiled for, or in reasonable anticipation of, a civil, criminal or administrative action, or
 - (c) Protected health information that is subject to the Federal Clinical Laboratory Improvements Amendments of 1988, or exempt pursuant to 42 C.F.R. 493.3(a)(2).
 - ii. An individual may be denied access to read or receive a copy of medical record information without an opportunity for review in accordance with 45 C.F.R. Part 164 (above) if:
 - (a) The information meets the criteria stated in section l above.
 - (b) The provider is a correctional institution or acting under the direction of a correctional institution as defined in 45 C.F.R. 164.501.
 - (c) The information is obtained during the course of current research that includes treatment and the member agreed to suspend access to the information during the course of research when consenting to participate in the research.
 - (d) The information was compiled during a review of quality of care for the purpose of improving the overall provision of care and services.
 - (e) The denial of access meets the requirements of the Privacy Act, 5 United States Code (5 U.S.C.) 552a, or
 - (f) The information was obtained from someone other than a health care provider under the protection of confidentiality, and access would be reasonably likely to reveal the source of the information.
 - iii. Except as provided in i and ii above, an individual must be informed of the right to seek review if access to inspect or request to obtain a copy of medical record information is denied when:
 - (a) A licensed health care professional has determined the access requested would reasonably be likely to endanger the life or physical safety of the member or another person, or



- (b) The protected health information makes reference to another person and access would reasonably be likely to cause substantial harm to the member or another person.
- iv. The Contractor must respond within 30 days to the member's request for a copy of the records. The response may be the copy of the record or, if necessary to deny the request, the written denial must include the basis for the denial and written information about how to seek review of the denial in accordance with 45 C.F.R. Part 164.
- m. Have the right to amend or correct his/her medical records as specified in 45 C.F.R. 164.526:
 - i. The Contractor may require the request be made in writing.
 - ii. If the Contractor agrees to amend information in the member's medical record, in whole or in part, at a minimum, the Contractor must:
 - (a) Identify the information in the member's record that is affected, and attach or link to the amended information.
 - (b) Inform the member, in a timely manner, of the amendment.
 - (c) Obtain the member's agreement to allow the Contractor to notify relevant persons with whom the amendment needs to be shared, and
 - (d) The Contractor must make reasonable efforts to inform and provide the amendment, within a reasonable time, to:
 - (i) Persons identified by the member as having received protected health information and who need the amendment, and
 - (ii) Persons, including business associates, that are known to the Contractor as having member information affected by the amendment and who have relied on or may in the future rely on the original information to the detriment of the member.
 - iii. A Contractor may deny the request for amendment or correction if the information:
 - (a) Would not be available for review (as stated in section m i and ii above)
 - (b) Was not created by the Contractor, or one of its providers, unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment.
 - (c) Is not a part of the member's medical record, or
 - (d) Is already accurate and complete.
 - iv. If the request is denied, in whole or in part, the Contractor must provide the member with a written denial within 60 days that includes:
 - (a) The basis for the denial.
 - (b) The member's right to submit a written statement disagreeing with the denial, and how to file the statement.



- (c) A statement that, if the member does not submit a statement of disagreement, the member may request that the Contractor provide the member's request for amendment and the denial with any future disclosures of the protected health information that is related to the amendment, and
 - (d) A description of how the member may seek review of the denial in accordance with 45 C.F.R. Part 164.
2. Contractors must ensure that each member is free to exercise his or her rights and that the exercising of those rights will not adversely affect the treatment of the member by the Contractor or its providers.
 3. Each Contractor must have a written policy addressing member responsibilities. Member responsibilities include:
 - a. Providing, to the extent possible, information needed by professional staff in caring for the member
 - b. Following instructions and guidelines given by those providing health care
 - c. Knowing the name of the assigned PCP
 - d. Scheduling appointments during office hours whenever possible instead of using urgent care facilities and/or emergency rooms
 - e. Arriving for appointments on time
 - f. Notifying the provider in advance when it is not possible to keep an appointment, and
 - g. Bringing immunization records to every appointment for children 18 years of age or younger.
 4. Contractors must refer to the AHCCCS contract for requirements concerning member handbooks and notification of members regarding their rights and responsibilities. Member rights must be included in the member handbook.
 5. Contractors must refer to Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34) and the AHCCCS contract for information regarding requirements for the grievance system for members and providers.



940 MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

REVISION DATES: 04/01/12, 02/01/11, 10/01/09, 10/01/08, 02/01/07, 04/01/05, 01/01/04,
08/13/03, 10/01/01, 10/01/97

INITIAL

EFFECTIVE DATE: 10/01/1994

1. Contractors must have policies and procedures in place for use of electronic medical records (including electronic Early and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking forms) and digital (electronic) signatures (when electronic documents are utilized) that include processes for:
 - a. Signer authentication
 - b. Message authentication
 - c. Affirmative act
 - d. Efficiency
 - e. Record review
2. Contractors must implement appropriate policies and procedures to ensure that the organization and its providers have information required for:
 - a. Effective and continuous member care through accurate medical record documentation (including electronic health records) of each member's health status, changes in health status, health care needs, and health care services provided
 - b. Quality review, and
 - c. An ongoing program to monitor compliance with those policies and procedures. If during the quality of care review process, or other processes, issues are identified with the quality or content of a Provider's medical record, the contractor must conduct a focused review, implement corrective actions or other remedies until the provider's medical records process meets standards specified in the AHCCCS Medical Policy Manual (AMPM).
 - d. The sample of files chosen for medical record review must be reflective of Geographical Service Area (GSA) and product line. If there is more than one



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product line, populations must be combined to determine if 50 or more members are in the specialty provider's panel.

3. Each Contractor must implement policies and procedures that address medical records, electronic records as well as hard copy files, and the methodologies to be used by the organization to:
 - a. Ensure that contracted Primary Care Providers (PCPs), maintain a legible medical record (including electronic health record/medical record) for each enrolled member who has been seen for medical appointments or procedures. The medical record must also contain clinical/behavioral health records from other providers who also provide care/services to the enrolled member,
 - b. The medical record documents provider's referral to, coordination of care with, and transfer of care to behavioral health providers, as appropriate
 - c. The medical record is legible, kept up-to-date, is well organized and comprehensive with sufficient detail to promote effective patient care and quality review. A member may have numerous medical records kept by various health care providers that have rendered services to the member. However, the provider must maintain a comprehensive record that incorporates at least the following components:
 - i. Behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established.
 - ii. Member identification information on each page of the medical record (i.e., name or AHCCCS identification number)
 - iii. Documentation of identifying demographics including the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
 - iv. Initial history for the member that includes family medical history, social history and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member)
 - v. Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received



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- vi. Immunization records (required for children; recommended for adult members if available)
 - vii. Dental history if available, and current dental needs and/or services
 - viii. Current problem list
 - ix. Current medications
 - x. Current and complete EPSDT forms (required for all members age 0 through 20 years)
 - xi. Documentation, initialed by the member's provider, to signify review of:
 - (a) Diagnostic information including:
 - (i) Laboratory tests and screenings,
 - (ii) Radiology reports,
 - (iii) Physical examination notes, and
 - (iv) Other pertinent data.
 - (b) Reports from referrals, consultations and specialists,
 - (c) Emergency/urgent care reports,
 - (d) Hospital discharge summaries,
 - (e) Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed, and
 - (f) Behavioral health history and behavioral health information received from a Regional Behavioral Health Authority (RBHA) behavioral health provider who is also treating the member.
 - x. Documentation as to whether or not an adult member has completed advance directives and the location of the document.
 - xi. Documentation that the provider responds to behavioral health provider information requests pertaining to behavioral health recipient members within ten business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations. Documentation must also include the provider's initials signifying review of member behavioral health information received from a behavioral health provider who is also treating the member.
 - xii. Documentation related to requests for release of information and subsequent releases, and
 - xiii. Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the provider including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.
- d. Ensure that obstetric providers complete a standardized, evidence-based risk assessment tool for obstetric members (i.e. Mutual Insurance Company of Arizona [MICA] Obstetric Risk Assessment Tool or American College of Obstetricians and



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Gynecologists [ACOG]). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines.

- e. Each organizational provider of services (e.g., hospitals, nursing facilities, rehabilitation clinics, etc.) maintains a record of the services provided to a member, including:
 - i. Physician or provider orders for the service,
 - ii. Applicable diagnostic or evaluation documentation,
 - iii. A plan of treatment,
 - iv. Periodic summary of the member's progress toward treatment goals,
 - v. The date and description of service modalities provided, and
 - vi. Signature/initials of the provider for each service.
 - f. Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines.
 - g. The Contractor must have an implemented process to assess and improve the content, legibility, organization, and completeness of member health records when concerns are identified, and
 - h. Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants are allowed to provide services.
4. Medical records may be documented on paper or in an electronic format.
- a. If records are documented on paper, they must be written legibly in blue or black ink, signed and dated for each entry. Electronic format records must also include the name of the provider who made the entry and the date for each entry.
 - b. If records are physically altered, the stricken information must be identified as an error and initialed by the person altering the record along with the date when the change was made; correction fluid or tape is not allowed.
 - c. If kept in an electronic file, the provider must establish a method of indicating the initiator of information and a means to assure that information is not altered inadvertently.
 - d. If revisions to information are made, a system must be in place to track when, and by whom, they are made. In addition, a backup system including initial and revised information must be maintained.



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- e. Medical record requirements are applicable to both hard copy and electronic medical records. Contractors may go on site to review the records electronically or utilize a secure process to review electronic files received from the provider when concerns are identified.
5. Each Contractor must have written policies and procedures addressing appropriate and confidential exchange of member information among providers, including behavioral health providers, and must conduct reviews to verify that:
 - a. A provider making a referral transmits necessary information to the provider receiving the referral.
 - b. A provider furnishing a referral service reports appropriate information to the referring provider.
 - c. Providers request information from other treating providers as necessary to provide appropriate and timely care.
 - d. Information about services provided to a member by a non-network provider (i.e., emergency services, etc.) is transmitted to the member's Primary Care Provider (PCP).
 - e. Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP.
 - f. Member information is shared, when a member subsequently enrolls with a new Contractor, in a manner that maintains confidentiality while promoting continuity of care, and
 - g. Member information is shared with behavioral health providers for members with ongoing care needs or changes in health status.
 6. Information from, or copies of, records may be released only to authorized individuals, and the Contractor must implement a process to ensure that unauthorized individuals cannot gain access to, or alter, member records.
 7. Original and/or copies of medical records must be released only in accordance with Federal or State laws and AHCCCS policy and contracts. Contractors must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 C.F.R. 431.300 *et seq.*



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8. Contractors must participate/cooperate in State of Arizona and AHCCCS activities related to the development and implementation of electronic health records and e-prescribing. Electronic EPSDT tracking forms must include all elements of the AHCCCS approved EPSDT tracking forms.

9. Prior to discontinuing the medical record review process, the Contractor must:
 - a. Conduct a comprehensive review of its use of the medical record review process and how it is used to document compliance with AHCCCS requirements such as EPSDT and behavioral health.

 - b. Document what processes will be used in place of the medical record review process to ensure compliance with AHCCCS requirements.

 - c. Submit the process the Contractor plans to use to ensure provider compliance with AHCCCS medical record requirements to the AHCCCS Clinical Quality Management Administrator prior to discontinuing the medical record review process.

Refer to [Chapter 600](#), Policy 640 and AHCCCS contract for a complete discussion on advance directives for adult members.

DRAFT Implementation 10/01/2013



950 CREDENTIALING AND RECREDENTIALING PROCESSES

REVISION DATES: XX/XX/XX, 10/01/12, 04/01/12, 02/01/11, 10/01/10, 10/01/09, 10/01/08,
05/01/07, 02/01/07, 04/01/05, 08/13/03, 10/01/01, 10/01/97

INITIAL

EFFECTIVE DATE: 10/01/1994

A. OVERVIEW

This Policy covers credentialing, temporary/provisional credentialing and recredentialing policies for both individual and organizational providers. The Contractor is required to process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing a Contractor must follow the guidelines located in their contract with AHCCCS. Contractors must submit a Quarterly Credentialing Report, using the AHCCCS Template, Exhibit 950-1. Refer to Policy 990, Reporting Requirements, for a schedule of report due dates.

B. CREDENTIALING INDIVIDUAL PROVIDERS

The Contractor must have a written system in place for credentialing and recredentialing providers included in their contracted provider network. Providers who are not licensed or certified must be included in the credentialing process and profiled.

1. Credentialing and recredentialing must be conducted and documented for at least the following contracted health care professionals:
 - a. Physicians (Medical Doctor [MD], Doctor of Osteopathic Medicine [DO]) and
 - b. Doctor of Podiatric Medicine (DPM)
 - c. Nurse practitioners, physician assistants and certified nurse midwives acting as primary care providers, including prenatal care/delivering providers
 - d. Dentists (Doctor of Dental Surgery [DDS] and Doctor of Medical Dentistry [DMD])
 - e. Psychologists (master's level and above)



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- f. Affiliated Practice Dental Hygienists, and
 - g. Independent behavioral health professionals who contract directly with the Contractor.
2. The Contractor must ensure:
- a. The credentialing and recredentialing processes do not discriminate against:
 - i. A health care professional, solely on the basis of license or certification, or
 - ii. A health care professional who serves high-risk populations or who specializes in the treatment of costly conditions.
 - b. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid.
3. If the Contractor delegates to another entity any of the responsibilities of credentialing/recredentialing or selection of providers that are required by this chapter, it must retain the right to approve, suspend, or terminate any provider selected by that entity and meet the requirements of Policy 910 of this Chapter regarding delegation. The Quality Management/Performance Improvement (QM/PI) committee or other peer review body is responsible for over-site regarding delegated credentialing or recredentialing decisions.
4. Written policies must reflect the scope, criteria, timeliness and process for credentialing and recredentialing providers. The policies and procedures must be reviewed and approved by the Contractor's executive management, and
- a. Reflect the direct responsibility of the local Medical Director or other designated physician to,
 - i. act as the chair of the credentialing committee,
 - ii. implement the decisions made by the credentialing committee, and
 - iii. to oversee the credentialing process.
 - b. Indicate the use of participating Arizona Medicaid network providers in making credentialing decisions, and



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- c. Describe the methodology to be used by Contractor staff and the Contractor Medical Director to provide documentation that each credentialing or recredentialing file was completed and reviewed, as per 1 above, prior to presentation to the credentialing committee for evaluation.
5. Contractors must maintain an individual credentialing/recredentialing file for each credentialed provider. Each file must include:
 - a. The initial credentialing and all subsequent recredentialing applications, including attestation by the applicant of the correctness and completeness of the application as demonstrated by signature on the application,
 - b. Information gained through credentialing and recredentialing queries,
 - c. Utilization data, quality of care concerns, performance measure rates, and level of member satisfaction, and
 - d. Any other pertinent information used in determining whether or not the provider met the Contractor's credentialing and recredentialing standards.
6. Provider information must be entered into the contractor's claims payment system by the effective date of the application.

C. INITIAL CREDENTIALING

Contractors are required to utilize the Arizona Health Plan Association's Credential Verification Organization as part of its credentialing process. At a minimum, policies and procedures for the initial credentialing of physicians and other licensed health care providers must include:

1. A written application to be completed, signed and dated by the provider that attests to the following elements:
 - a. Reasons for any inability to perform the essential functions of the position, with or without accommodation.
 - b. Lack of present illegal drug use.



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- c. History of loss of license and/or felony convictions.
 - d. History of loss or limitation of privileges or disciplinary action.
 - e. Current malpractice insurance coverage, and
 - f. Attestation by the applicant of the correctness and completeness of the application. (A copy of the signed attestation must be included in the provider's credentialing file).
2. Minimum five year work history.
 3. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification.
 4. Verification from primary sources of:
 - a. Licensure or certification,
 - b. Board certification, if applicable, or highest level of credentials attained,
 - c. Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training (a signed statement from the medical, dental or nursing board of examiners stating they do primary verification of education and internship/residency as part of the licensing process is acceptable).
 - d. National Provider Databank (NPDB) query or, in lieu of the NPDB query, all of the following must be verified:
 - i. Minimum five year history of professional liability claims resulting in a judgment or settlement,
 - ii. Disciplinary status with regulatory board or agency,
 - iii. Medicare/Medicaid sanctions, and
 - iv. State sanctions or limitations of licensure.



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- e. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated without the right to appeal:
 - i. Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) <http://oig.hhs.gov/fraud/exclusions.asp>
 - ii. General Services Administration (GSA) Excluded Parties List System (EPLS) www.epls.gov
5. Behavioral health providers and affiliated practice dental hygienists may request a copy of their transcript or proof of education from their educational institution and deliver it themselves in a sealed envelope from the educational institution.
6. Affiliated practice dental hygienists must provide documentation of the affiliation agreement with an AHCCCS registered dentist.
7. Initial site visits for Primary Care Providers (PCP) and Obstetrics/Gynecology (OB/GYN) applicants must include but are not limited to verification of compliance with the following:
 - a. Vaccine and drug storage regulations.
 - b. Emergency and resuscitation equipment policy.
 - c. Americans with Disabilities Act requirements.
8. Contractor must conduct timely verification of information, as evidenced by notification of provider of approval status within 180 days of receipt of complete application. Contractor must also enter all required information in to Contractor's information system by the effective date of the application.
9. The Contractor must conduct timely verification of information, as evidenced by notification of provider of approval status within 180 days of receipt of complete application. Contractor must also enter all required information in to Contractor's information system by the effective date of the application.



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10. The Contractor must have written policies and procedures for notifying practitioners of their right to review information it has obtained to evaluate their credentialing application, attestation or Curriculum Vitae (CV).

D. TEMPORARY/PROVISIONAL CREDENTIALING

Contractors must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-alike Center, as well as hospital employed physicians (when appropriate), must be credentialed using the temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional.

The Contractor must follow the “Initial Credentialing” guidelines when granting temporary or provisional credentialing to:

1. Providers in a Federally Qualified Health Center (FQHC).
2. Providers in a FQHC Look-alike organization.
3. Hospital employed physicians (when appropriate) and
4. Providers needed in medically underserved areas.

The Contractor shall have 14 calendar days from receipt of a complete application, accompanied by the minimum documents specified in the section, in which to render a decision regarding temporary or provisional credentialing. Once provisional/temporary credentialing is approved, provider information must be entered into the Contractor’s information system to allow payment to the provider effective the date the provisional credentialing is approved.

For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that must include the following items:

1. Reasons for any inability to perform the essential functions of the position, with or without accommodation.



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2. Lack of present illegal drug use.
3. History of loss of license and/or felony convictions.
4. History of loss or limitation of privileges or disciplinary action.
5. Current malpractice insurance coverage, and
6. Attestation by the applicant of the correctness and completeness of the application. (A copy of the most current signed attestation must be included in the provider's credentialing file).

In addition, the applicant must furnish the following information:

1. Work history for past five years, and
2. Current Drug Enforcement Agency (DEA) or Controlled Drug System (CDS) certificate.

The Contractor must conduct primary verification of the following:

1. Licensure or certification (A signed statement from the medical, dental or nursing board of examiners stating they do primary verification of education and internship/residency as part of the licensing process is acceptable).
2. Board certification, if applicable, or the highest level of credential attained, and
3. National Provider Data Bank (NPDB) query, or, in lieu of the NPDB query, all of the following:
 - a. Minimum five year history of professional liability claims resulting in a judgment or settlement, and
 - b. Disciplinary status with regulatory board or agency, and
 - c. Medicare/Medicaid sanctions.



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The Contractor's Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and committee review, as outlined in this Section, should be completed.

E. RECREDENTIALING INDIVIDUAL PROVIDERS

Contractors are required to utilize the Arizona Health Plan Association's Credential Verification Organization as part of its credentialing process. At a minimum, the recredentialing policies for physicians and other licensed health care providers must identify procedures that address the recredentialing process and include requirements for:

1. Recredentialing at least every three years.
2. An update of information obtained during the initial credentialing for sections 1, 3 and 4 (except 4c) as discussed in the Initial Credentialing Section of this Policy.
3. A process for monitoring provider specific information such as, but not limited to, the following:
 - a. Member concerns which include grievances (complaints).
 - b. Utilization management information (such as: emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization).
 - c. Performance improvement and monitoring (such as: performance measure rates).
 - d. Results of medical record review audits conducted as a result of identified noncompliance with AHCCCS medical record requirements, if applicable.
 - e. Quality of care issues (including trend data). If an adverse action is taken with a provider due to a quality of care concern, the Contractor must report the adverse action to the AHCCCS Clinical Quality Management Unit.
 - f. Pay for performance and value driven health care data/outcomes if applicable.



F. INITIAL ASSESSMENT OF ORGANIZATIONAL PROVIDERS

As a prerequisite to contracting with an organizational provider, the Contractor must ensure that the organizational provider has established policies and procedures that meet AHCCCS requirements. The requirements described in this section must be met for all organizational providers included in its network (including, but not limited to, hospitals, home health agencies, attendant care agencies, group homes, nursing facilities, behavioral health facilities, dialysis centers, transportation companies, dental and medical schools, and free-standing surgi-centers).

Prior to contracting with an organization provider, each Contractor must:

1. Confirm that the provider has met all the state and federal licensing and regulatory requirements (a copy of the license or letter from the regulatory agency will meet this requirement).
2. Confirm that the provider is reviewed and approved by an appropriate accrediting body as specified by Centers for Medicare and Medicaid Services (CMS) (a copy of the accreditation report or letter from the accrediting body will meet this requirement). The Contractor must state in policy which accrediting bodies it accepts,
3. Conduct an onsite quality assessment if the provider is not accredited. The Contractor must develop a process and utilize assessment criteria for each type of unaccredited organizational provider for which it contracts which must include, but is not limited to, confirmation that the organizational provider has the following:
 - a. A process for ensuring that they credential their practitioners,
 - b. Liability insurance,
 - c. Business license, or
 - d. Centers for Medicare and Medicaid Services (CMS) certification or state licensure review/audit may be substituted for the required site visit. In this circumstance, the Contractor must obtain the review/audit documentation from CMS or the state licensing agency and verify that the review/audit was conducted and that the provider meets the Contractor's standards. A letter from CMS that states the organizational provider was reviewed/audited and passed inspection is sufficient



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documentation when the Contractor has documented that they have reviewed and approved the CMS criteria and they meet the Contractor's standards.

4. Review and approve the provider through the Contractor's credentialing committee.

G. REASSESSMENT OF ORGANIZATIONAL PROVIDERS

Contractors must reassess organizational providers at least every three years. The reassessment must include the following components, and all information utilized by Contractors must be current.

1. Confirmation that the organizational providers remain in good standing with State and Federal bodies, and, if applicable, are reviewed and approved by an accrediting body. To meet this component the Contractor must validate that the organization provider meets the conditions listed below:
 - a. Is licensed to operate in the State, and is in compliance with any other State or Federal requirements as applicable.
 - b. Is reviewed and approved by an appropriate accrediting body. If an organization provider is not accredited or surveyed and licensed by the State an on-site review must be conducted.
2. Assess data available to the Contractor including:
 - a. The most current review conducted by the Arizona Department of Health Services (ADHS) and/or summary of findings (please include date of ADHS review). If applicable, review the online hospital/nursing home compare.
 - b. Record of on-site inspection of non-licensed organizational providers to ensure compliance with service specifications.
3. Evaluate organizational provider specific information including, but not limited to, the following:
 - a. Member concerns which include grievances (complaints).
 - b. Utilization management information.



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- c. Performance improvement and monitoring.
 - d. Quality of care issues and (if an adverse action is taken with a provider due to a quality of care concern, the Contractor must report the adverse action to the AHCCCS Clinical Quality Management Unit).
 - e. Onsite assessment.
4. Review and approval by the Contractor's credentialing committee with formal documentation that includes any discussion, review of thresholds, and complaints or grievances.
 5. In addition to the requirements in this Policy, Arizona Long Term Care System (ALTCS) Contractors must review and monitor other types of organizational providers in accordance with their contract.

H. NOTIFICATION REQUIREMENTS (LIMITED TO PROVIDERS)

The Contractor must have procedures for reporting (in writing) to appropriate authorities (AHCCCS, the provider's regulatory board or agency, Office of the Attorney General, etc.) any known serious issues and/or quality deficiencies. If the issue/quality deficiency results in a provider's suspension or termination from the Contractor's network, it must be reported. If the issue is determined to have criminal implications, a law enforcement agency must also be notified.

1. The Contractor must maintain documentation of implementation of the procedure, as appropriate.
2. The Contractor must have an appeal process for instances in which the Contractor chooses to alter the provider's contract based on issues of quality of care and/or service, and
3. The Contractor must inform the provider of the appeal process.
4. The Contractor must notify AHCCCS Clinical Quality Management (CQM) of all reported events.



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I. NOTIFICATION REQUIREMENTS (HEALTH CARE PROVIDERS, SUPPLIERS AND PRACTITIONERS)

The contractor must have procedures for reporting (in writing) any final adverse action (not including settlements in which no findings or liability have been made) taken against a health care provider, supplier, or practitioner.

1. The Contractor must submit to the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB):
 - a. Within 30 calendar days from the date the final adverse action was taken or the date when the Contractor became aware of the final adverse action, or
 - b. By the close of the Contractor's next monthly reporting cycle, whichever is later.
2. A "final adverse action" includes:
 - a. Civil judgments in Federal or State court related to the delivery of a health care item or service.
 - b. Federal or State criminal convictions related to the delivery of a health care item or service.
 - c. Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including:
 - i. Formal or official actions, such as revocation or suspension of license (and the length of any such suspension), reprimand, censure or probation,
 - ii. Any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or
 - iii. Any other negative action or finding by such Federal or State agency that is publicly available information.
 - iv. Exclusion from participation in Federal or State health care programs (as defined in sections 1128B(f) and 1128(H), respectively) and
 - v. Any other adjudicated actions or decisions that the Secretary shall establish by regulation.



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A “final adverse action” does not include any action with respect to a malpractice claim.

3. The contractor must report, no less frequently than monthly, the following information:
 - a. The name and Tax Identification Number (TIN) (as defined in section 7701(A)(41) of the Internal Revenue Code of 1986[1121]).
 - b. The name (if known) of any health care entity with which the health care provider, supplier, or practitioner is affiliated or associated.
 - c. The nature of the final adverse action and whether such action is on appeal.
 - d. A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.
 - e. The date the final adverse action was taken, its effective date and duration of the action.
 - f. Corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner.
 - g. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated without the right to appeal:
 - i. Health and Human Services-Office of the Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) <http://oig.hhs.gov/foia/exclusions.asp>
 - ii. General Services Administration (GSA) Excluded Parties List System (EPLS) www.epls.gov
 - iii. Social Security Administration’s Death Master File
 - iv. National Plan and Provider Enumeration System (NPPES).

J. TEACHING PHYSICIANS AND TEACHING DENTISTS

1. In general AHCCCS permits services to be provided by medical students or medical residents and dental students or dental residents under the direct supervision of a teaching physician or a teaching dentist. In limited circumstances when specific criteria



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are met, medical residents may provide low level evaluation and management services to members in designated settings without the presence of the teaching physician. Refer to AHCCCS Contractor Operations Manual (ACOM) Policy 204 for a complete discussion of this option.

2. The teaching physicians and teaching dentists must be an AHCCCS registered provider and must be credentialed by the AHCCCS Contractors in accordance with AHCCCS policy as set forth in this Policy (Policy 950-B and 950-C).

DRAFT Implementation 10/01/2013

EXHIBIT 950-1

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CONTRACTOR QUARTERLY CREDENTIALING REPORT**

DRAFT Implementation 10/01/2013

Exhibit 950-1 AHCCCS Contractor Quarterly Credentialing Report

AHCCCS Contractor: _____

Address: _____

Quarter: _____

Person submitting report: _____

Contact telephone number: _____

Category <i>Include data only for those providers (for dental/oral health providers, see below) who completed credentialing within the quarter</i>	Number of providers credentialed within the reported quarter	Shortest time for determination*	Longest time for determination	Average time for determination*	Shortest time to load provider ID in claims system**	Longest time to load provider ID in claims system**	Average length of time to load provider ID into claims system**
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Initial Credentialing							
-----------------------	--	--	--	--	--	--	--

Recredentialing							N/A
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Provisional Credentialing							
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Organizational Credentialing							
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*Begin from receipt of completed application

** Begin from date of approval

Comments

Exhibit 950-1 AHCCCS Contractor Quarterly Credentialing Report

AHCCCS Contractor: _____

Address: _____

Quarter: _____

Person submitting report: _____

Contact telephone number: _____

Category <i>Include data only for those dental/oral health providers who completed credentialing within the quarter.</i>	Number of providers credentialed within the reported quarter	Shortest time for determination*	Longest time for determination	Average time for determination*	Shortest time to load provider ID in claims system**	Longest time to load provider ID in claims system**	Average length of time to load provider ID into claims system**
Initial Credentialing							
Recredentialing							N/A
Provisional Credentialing							

*Begin from receipt of completed application

** Begin from date of approval

Comments



960 TRACKING AND TRENDING OF MEMBER AND PROVIDER ISSUES

REVISION DATES: XX/XX/XX, 04/01/12, 02/01/11, 10/01/09, 10/01/08, 02/01/07, 06/01/05,
04/01/05, 08/13/03, 10/01/01, 10/01/97

INITIAL

EFFECTIVE DATE: 10/01/1994

A. OVERVIEW

Each Contractor must develop and implement policies and procedures for reviewing, evaluating and resolving quality issues raised by enrolled members and contracted providers. The issues may be received from anywhere within the organization or externally from anywhere in the community. All issues must be addressed regardless of source (external or internal).

[NOTE: References to a member in this Policy also include reference to a member's guardian and/or representative.]

B. DOCUMENTATION RELATED TO QUALITY OF CARE CONCERNS

As a part of the Contractor's process for reviewing and evaluating member and provider issues, there must be written policies and procedures regarding the receipt, initial and ongoing processing of these matters that include the following:

1. Documenting each issue raised, when and from whom it was received, and the projected time frame for resolution
2. Determining promptly whether the issue is to be resolved through the Contractor's established:
 - a. Quality management process (the quality management process may review and assign a different area within the organization to review and address the issues).
 - b. Grievance and appeals process,
 - c. Process for making initial determinations on coverage and payment issues, or
 - d. Process for resolving disputed initial determinations.



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3. Acknowledging receipt of the issue and explaining to the member or provider the process to be followed in resolving his or her issue through written correspondence.
4. Assisting the member or provider as needed in completing forms or taking other necessary steps to obtain resolution of the issue.
5. Ensuring confidentiality of all member information.
6. Informing the member or provider of all applicable mechanisms for resolving the issue external to the Contractor processes, and
7. Documenting all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance and appeal, including but not limited to:
 - a. Corrective action plan(s) or action(s) taken to resolve the concern.
 - b. Documentation that education/training was completed. This may include, but is not limited to, in-service attendance sheets and training objectives.
 - c. New policies and/or procedures, and
 - d. Follow-up with the member that includes, but is not limited to:
 - i. Assistance as needed to ensure that the immediate health care needs are met, and
 - ii. Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns.

(Refer to 9 A.A.C. 34 and the AHCCCS contract for information regarding requirements for the grievance system for members and providers.)



C. PROCESS OF EVALUATION AND RESOLUTION OF QUALITY OF CARE CONCERNS

The quality of care concern process must include documentation of identification, research, evaluation, intervention, resolution and trending of member and provider issues. Resolution must include both member and system interventions when appropriate. The quality of care concern process must be a stand alone process and shall not be combined with other agency meetings or processes.

1. The Contractor must develop and implement policies and procedures that address analysis of the quality of care issues through:
 - a. Identification of the quality of care issues
 - b. Initial assessment of the severity of the quality of care issue
 - c. Prioritization of action(s) needed to resolve immediate care needs when appropriate
 - d. Review of trend reports obtained from the Contractor's quality of care data system to determine possible trends related to the provider(s) (including organizational providers such as but not limited to, nursing facilities and hospitals) Involved in the allegation(s) including: type(s) of allegation(s), severity and substantiation, etc.
 - e. Research, including, but not limited to: a review of the log of events, documentation of conversations, and medical records review, mortality review, etc.
 - f. Quantitative and qualitative analysis of the research, which may include root cause analysis
2. The Contractor must develop a process to assure that action is taken when needed by:
 - a. Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring
 - b. Determining, implementing and documenting appropriate interventions
 - c. Monitoring and documenting the success of the interventions
 - d. Incorporating interventions into the organization's Quality Management (QM) program if successful, or
 - e. Assigning new interventions/approaches when necessary



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 960

TRACKING AND TRENDING OF MEMBER AND PROVIDER ISSUES

3. The Contractor must develop a process to provide resolution of the issue. Member and system resolutions may occur independently from one another.
4. The Contractor must develop a process to determine the level of severity of the quality of care issue.
5. The Contractor must develop a process to refer/report the issue to the appropriate regulatory agency, Child or Adult Protective Services, Arizona Department of Health Services (ADHS), the Attorney General's Office, law enforcement and/or AHCCCS for further research/review or action. Initial reporting may be made verbally, but must be followed by a written report.
6. The Contractor must have a process to refer the issue to the Contractor peer review committee when appropriate. Referral to the peer review committee is not a substitute for implementing interventions.
7. If an adverse action is taken with a provider due to a quality of care concern, the Contractor must report the adverse action to the AHCCCS Clinical Quality Management Unit.
8. The Contractor must have a process to determine the level of substantiation.
9. The Contractor must have a process to provide written notification to the appropriate regulatory/licensing board or agency and AHCCCS when a health care professional's organizational provider or other provider's affiliation with their network is suspended or terminated because of quality of care issues, and
10. The Contractor must have a process to document the criteria and process for closure of the review including, but not limited to the following:
 - a. A description of the problems, including new allegations identified during the investigation/review process
 - b. Written response from or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or medical examiner



D. TRACKING AND TRENDING OF QUALITY OF CARE ISSUES

Tracking and trending of member and provider issues is crucial to quality improvement.

1. The Contractor must develop and implement a system to document, track and evaluate complaints and allegations received from members and providers, inclusive of quality of care issues.
 - a. The data from the quality of care data system must be analyzed and evaluated to determine any trends related to the quality of care or service in the Contractor's service delivery system or provider network. Contractors are responsible for incorporating trending of quality of care issues in determining systemic interventions for quality improvement.
 - b. The Contractor must document quality tracking and trending information as well as documentation that the information was submitted, reviewed, and considered for action by the Contractor's local Quality Committee and local Medical Director, as Chairman of the Quality Management Committee.
 - c. Quality tracking and trending information from all closed quality of care issues within the reporting quarter must be submitted to AHCCCS/Department of Health Care Management/Clinical Quality Management (AHCCCS/DHCM/CQM) utilizing the Quarterly Quality Management Report (Exhibit 960-1), and must include the following reporting elements:
 - i. Types and numbers/percentages of substantiated quality of care issues
 - ii. Interventions implemented to resolve and prevent similar incidences, and
 - iii. Resolution status of "substantiated", "unsubstantiated" and "unable to substantiate" quality of care issues.

If significant negative trends are noted, the Contractor may consider making it the topic for one of its performance improvement activities to improve the issue resolution process itself, and to make improvements that address other system issues raised in the resolution process.

- d. The Contractor must submit to AHCCCS CQM all pertinent information regarding an incident of Healthcare Acquired Conditions (HCAC), abuse, neglect, exploitation and unexpected death (including all unexpected transplant deaths) as soon as the Contractor is aware of the incident. Pertinent information must not be limited to autopsy results only, and must include a broad review of all issues and possible areas of concern.



2. The Contractor must ensure that member health records are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, allegations of abuse, neglect, exploitation grievances and Healthcare Acquired Conditions (HCAC). Member record availability and accessibility must be in compliance with Federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. 431.300 *et seq.*
3. Information related to coverage and payment issues must be maintained for at least five years following final resolution of the issue, and must be made available to the member, provider and/or AHCCCS authorized staff upon request.
4. In addition to care coordination as specified in their contract with AHCCCS, the Contractor must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes, but is not limited to, members who do not meet the Contractor's criteria for case management as well as members who contact governmental entities for assistance, including AHCCCS.

E. PROVIDER-PREVENTABLE CONDITIONS (EFFECTIVE 07/01/2012)

42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable conditions. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC).

If an HCAC or OPPC is identified, the Contractor must conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

The terms HCAC and OPPC are defined as follows:

Health Care - Acquired Condition (HCAC) – means a Hospital Acquired Condition (HAC) under the Medicare program, with the exception of Deep Vein Thrombosis/ Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission.



The list of HCACs is as follows:

1. Foreign object retained after surgery,
2. Air embolism,
3. Blood incompatibility,
4. Stage III and IV Pressure ulcers,
5. Falls and Trauma,
 - a. Fractures,
 - b. Dislocations,
 - c. Intracranial Injuries,
 - d. Crushing Injuries,
 - e. Burns,
 - f. Electric Shock.
6. Manifestations of Poor Glycemic Control
 - a. Diabetic Ketoacidosis,
 - b. Nonketotic Hyperosmolar Coma,
 - c. Hypoglycemic Coma,
 - d. Secondary Diabetes with Ketoacidosis,
 - e. Secondary Diabetes with Hyperosmolarity.
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection.



9. Surgical Site Infection following:
 - a. Coronary Artery Bypass Graft (CABG)
 - i. Mediastinitis
 - b. Bariatric Surgery
 - i. Laparoscopic Gastric Bypass
 - ii. Gastroenterostomy
 - iii. Laparoscopic Gastric Restrictive Surgery
 - c. Orthopedic Procedures
 - i. Spine
 - ii. Neck
 - iii. Shoulder
 - iv. Elbow

10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)

- a. Total Knee Replacement
- b. Hip Replacement

(Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients is not considered an HCAC).

Other Provider Preventable Conditions (OPPC) - means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

1. Surgery on the wrong member,
2. Wrong surgery on a member, and
3. Wrong site surgery.

EXHIBIT 960-1

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CONTRACTOR QUARTERLY QUALITY MANAGEMENT REPORT**

DRAFT Implementation 10/01/2013

EXHIBIT 960-1 AHCCCS Contractor Quarterly Quality Management Report

AHCCCS CONTRACTOR:		FOR QUARTER:		DATE:	
ADDRESS:		LINE OF BUSINESS:			
PERSON SUBMITTING REPORT:		CONTACT PHONE NUMBER:			
CATEGORY (TOTAL INCLUDES NON-QUALITY OF CARE (QOC))		NUMBER OF COMPLAINTS/CASES		PERCENT OF TOTAL COMPLAINTS/CASES	
ABUSE (A)					
AVAILABILITY, ACCESSIBILITY, ADEQUACY (AAA)					
DENIAL, DECREASE, DISCONTINUANCE OF COVERED BENEFITS (DDD)					
EFFECTIVENESS/APPROPRIATENESS (E/A)					
FRAUD, MEMBER OR PROVIDER (FRAUD)					
HEALTH CARE ACQUIRED CONDITION (HCAC)					
MEMBER RIGHTS/RESPECT AND CARING (MR)					
NEGLECT (N)					
SAFETY/RISK MANAGEMENT (SAFETY)					
UNEXPECTED DEATH (U/D)					
NON-QUALITY OF CARE (NON-QOC)					
TOTAL				Must equal 100%	
QUALITY OF CARE RESOLUTION STATUS (INCLUDES NON-QOC)		NUMBER OF COMPLAINTS/CASES		PERCENT OF TOTAL COMPLAINT/CASES	
SUBSTANTIATED					
UNABLE TO SUBSTANTIATE					
UNSUBSTANTIATED					
TOTAL					

EXHIBIT 960-1 AHCCCS Contractor Quarterly Quality Management Report

QUALITY OF CARE INTERVENTION STATUS (SUBSTANTIATED CASES ONLY)	NUMBER OF INTERVENTIONS IMPLEMENTED	PERCENT OF TOTAL INTERVENTIONS IMPLEMENTED
ADVOCACY		
CARE CONFERENCE		
COUNSELING (MEMBER)		
EDUCATION/TRAINING(PROVIDER)		
LEGAL		
MEMBER CONTRACTS		
PEER REVIEW		
PLACEMENT CHANGE		
POLICY/PROCEDURAL CHANGE		
PROVIDER CHANGE		
REFERRAL (CHILD PROTECTIVE SERVICES [CPS], ADULT PROTECTIVE SERVICES [APS], LICENSURE/CERTIFICATION, OFFICE OF PROGRAM INTEGRITY [OPI], AHCCCS CLINICAL QUALITY IMPROVEMENT [CQI])		
RESOLUTION MONITORING		
SANCTIONS		
SERVICE PLAN/TREATMENT CHANGE		
TERMINATION, SUSPENSION		
TOTAL		



970 PERFORMANCE MEASURES

REVISION DATES: XX/XX/XX, 04/01/12, 02/01/11, 10/01/08, 02/01/07, 04/01/05, 10/01/01,
10/01/97

INITIAL

EFFECTIVE DATE: 10/01/1994

A. OVERVIEW

AHCCCS measures the quality of care provided to members. Examples of areas that may be measured include maternal and child health services, wellness and screening services, disease management processes and non-clinical areas such as provider turnover, interpreter services, and cultural competency. Performance measures using Healthcare Effectiveness Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA), or other methodology are integral to each Contractor's Quality Management/Performance Improvement (QM/PI) program and are used to evaluate whether Contractors are fulfilling key contractual obligations. Such performance measures established or adopted by AHCCCS also are an important element of the Agency's approach to transparency in health services and value-based purchasing. Contractor performance is publicly reported on the AHCCCS website and through other means, such as sharing of data with state agencies and other organizations. Contractor performance is compared to AHCCCS requirements and to national Medicaid and commercial health plan means.

Performance Measures must be reported to AHCCCS CQM on a quarterly basis (refer to Appendix A: Quarterly Monitoring Reports). Performance measures must be analyzed and reported separately, by line of business Acute, E/PD, DDD, BHS (Acute and SMI populations, DDD and CMDP). In addition, contractors should evaluate performance based on sub-categories of populations when reasonable to do such. An example of this would be DBHS analyzing aggregate performance data as well as data for special need populations served such as DDD and CMDP populations or by RBHA. At this time, KidsCare data is not reported on a quarterly basis; however, Contractors should monitor KidsCare measures internally to ensure compliance with contractual standards.

B. QUALITY MANAGEMENT PERFORMANCE MEASURE REQUIREMENTS

1. The Contractor must:
 - a. Achieve at least the Minimum Performance Standards (MPS) established by AHCCCS for each measure, based on the rate calculated by AHCCCS or



- b. Develop an evidence-based Corrective Action Plan (CAP) for each measure not meeting the MPS to bring performance up to at least the minimum level established by AHCCCS. Each CAP should utilize a Plan Do Study Act (PDSA) and Repeat cycle as described below.

PDSA cycles consist of the following steps (for more information, refer to the Institute for Healthcare Improvement's website at www.ihl.org):

- i. **Plan** Plan the change(s) or intervention(s), including a plan for collecting data. State the objective(s) of the intervention(s).
- ii. **Do** Try out the intervention(s) and document any problems or unexpected results.
- iii. **Study** Analyze the data and study the results. Compare the data to predictions and summarize what was learned.
- iv. **Act** Refine the change(s)/intervention(s), based on what was learned, and prepare a plan for retesting the intervention(s).
- v. **Repeat** Continue the cycle as new data becomes available until improvement is achieved.

The action plan must be approved by AHCCCS prior to implementation. Each CAP must minimally include the following components.

- i. Document the results of an evaluation of existing interventions to achieve AHCCCS performance standards, including barriers to utilization of services and/or reasons why the interventions have not achieved the desired effect (*i.e. plan*)
- ii. Identify new or enhanced interventions that will be implemented in order to bring performance up to at least the minimum level established by AHCCCS, including evidence-based practices that have been shown to be effective in the same/similar populations (*plan*)
- iii. Demonstrate that the Contractor is allocating increased administrative resources to improving rates for a particular measure or service area (*do*)
- iv. Identify staff positions responsible for implementing/overseeing interventions with specific timeframes for implementation (*do*)
- v. Provide a means for measuring the results of new/enhanced interventions on a frequent basis (*study*)
- vi. Provide a means for refining interventions based on what is learned from testing different approaches or activities (*act*), and
- vii. Describe a process for repeating the cycle until the desired effect – a rate that meets or exceeds the minimum level established by AHCCCS – is achieved.



- c. Show demonstrable improvement from year to year, which is sustained over time, in order to meet goals for performance established by AHCCCS.
- d. Comply with national performance measures and levels that may be identified and developed by the Centers for Medicare and Medicaid Services in consultation with AHCCCS and/or other relevant stakeholders.
 - i. The Contractor's QM/PI Program must internally measure and report to AHCCCS its performance for contractually mandated performance measures, using standardized methodology established or adopted by AHCCCS. These results should be reported to AHCCCS via the Early Periodic Screening, Diagnosis and Treatment (EPSDT) and adult quarterly monitoring report. Refer to Appendix A for more details.
 - ii. The Contractor must use the results of the AHCCCS contractual performance measure (from its internal measurement and rates reported by AHCCCS) in evaluating its quality assessment and performance improvement program.

Refer to the AHCCCS contract for standards related to each AHCCCS required Performance Measure.

Contractor rates for each measure will be compared with the MPS specified in the contract in effect during the measurement period. For example, performance standards in the CYE2012 contract apply to results calculated by AHCCCS based on the measurement period of CYE2012.

DRAFT Implementation 10/1/2015



980 PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

REVISION DATES: 10/01/08, 02/01/07, 04/01/05, 08/13/03, 10/01/01, 10/01/97

REVIEW DATE: 04/01/12, 02/01/11

INITIAL

EFFECTIVE DATE: 10/01/1994

A. OVERVIEW

AHCCCS mandates that Contractors participate in Performance Improvement Projects (PIPs) selected by AHCCCS (Contractors also may select and design, with AHCCCS approval, additional PIPs specific to needs and data identified through internal surveillance of trends). AHCCCS-mandated PIP topics are selected through analysis of internal and external data/trends and may include Contractor input. Topics take into account comprehensive aspects of enrollee needs, care and services for a broad spectrum of members or a focused subset of the population.

AHCCCS may also mandate that a PIP be conducted by a Contractor or group of Contractors, according to standardized methodology developed by AHCCCS.

B. PERFORMANCE IMPROVEMENT PROJECTS (PIPs) DESIGN

1. PIPs are designed, through ongoing measurement and intervention, to achieve:
 - a. Demonstrable improvement, sustained over time, in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction
 - b. Correction of significant systemic problems
 - c. Clinical focus topics may include the following:
 - i. Primary, secondary, and/or tertiary prevention of acute conditions.
 - ii. Primary, secondary, and/or tertiary prevention of chronic conditions.
 - iii. Care of acute conditions.
 - iv. Care of chronic conditions.
 - v. High-risk services, and
 - vi. Continuity and coordination of care.



- d. Non-clinical focus topics may include the following:
 - i. Availability, accessibility and adequacy of the Contractor's service delivery system.
 - ii. Cultural competency of services.
 - iii. Interpersonal aspects of care (i.e., quality of provider/member encounters), and
 - iv. Appeals, grievances, and other complaints.
2. PIP methodologies are developed according to C.F.R. 438.240, Quality Assessment and Performance Improvement Program for Medicaid Managed Care Organizations. The protocol for developing and conducting PIPS is found in Exhibit 980-1.

C. DATA COLLECTION METHODOLOGY

Assessment of the Contractor's performance on the selected measures will be based on systematic, ongoing collection and analysis of accurate, valid and reliable data, as collected and analyzed by AHCCCS. Contractors may be directed to collect all or some of the data used to measure performance. In such cases, qualified personnel must be used to collect data and the Contractor must ensure inter-rater reliability if more than one person is collecting and entering data. Contractors must submit specific documentation to verify that indicator criteria were met.

D. MEASUREMENT OF DEMONSTRABLE IMPROVEMENT

1. The Contractor must initiate interventions that result in significant demonstrable improvement, sustained over time, in its performance for the performance indicators being measured. Improvement must be evidenced in repeated measurements of the indicators specified for each PIP undertaken by the Contractor.
2. Contractors must strive to meet a benchmark level of performance defined in advance by AHCCCS for Statewide projects (such as the National Healthy People Objectives, or another appropriate goal).
3. A Contractor will have demonstrated improvement when:
 - a. It meets or exceeds the AHCCCS overall average for the baseline measurement if its baseline rate was below the average and the increase is statistically significant.
 - b. It shows a statistically significant increase if its baseline rate was at or above the AHCCCS overall average for the baseline measurement, or
 - c. It is the highest performing (benchmark) plan in any remeasurement and maintains or improves its rate in a successive measurement.



4. A Contractor will have demonstrated sustained improvement when:
 - a. The Contractor maintains or increases the improvements in performance for at least one year after the improvement in performance is first achieved.
 - b. The Contractor must demonstrate how the improvement can be reasonably attributable to interventions undertaken by the organization (i.e., improvement occurred due to the project and its interventions, not another unrelated reason).

E. PERFORMANCE IMPROVEMENT PROJECTS (PIPs) TIMEFRAMES

1. The PIP begins on a date, established by AHCCCS, and will correspond with a contract year. Baseline data will be collected and analyzed at the beginning of the PIP.
2. During the first year of the PIP, the Contractor will implement interventions to improve performance, based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance, as well as any unique factors such as its membership, provider network, or geographic area(s) served. AHCCCS may provide baseline data by Contractor, and may provide additional data by race/ethnicity, and/or geographic area, which may assist Contractors in refining interventions.
3. Contractors should utilize a Plan-Do-Study-Act (PDSA) cycle, to test changes (interventions) quickly and refine them as necessary. It is expected that this process will be implemented in as short a time frame as practical based on the PIP topic. See description of PDSA cycle included in Policy 970.
4. AHCCCS will conduct annual measurements to evaluate Contractor performance, and may conduct interim measurements, depending on the resources required to collect and analyze data.
5. A Contractor's participation in the PIP will continue until demonstration of significant improvement and the improvement has been sustained for one year.

F. PERFORMANCE IMPROVEMENT PROJECTS (PIPs) REPORTING REQUIREMENTS

1. After the first year of the PIP, Contractors will report to AHCCCS annually their interventions, analysis of interventions and internal measurements, changes or refinements to interventions and actual or projected results from repeat measurements.



CHAPTER 900
QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 980
PERFORMANCE IMPROVEMENT PROJECTS – SELECTION /ASSESSMENT

2. Contractors must use the AHCCCS PIP Reporting Template (Exhibit 980-2) to submit the annual reports, which are due with the Contractor’s annual quality management plan and evaluation.

DRAFT Implementation 10/01/2013

EXHIBIT 980-1

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PERFORMANCE IMPROVEMENT PROJECT (PIP) PROTOCOL**

DRAFT Implementation 10/01/2013

EXHIBIT 980-1
Protocol for Conducting Performance Improvement Projects (PIP)

PROTOCOL ACTIVITY	HOW THE PROTOCOL IS IMPLEMENTED
STEP 1: STUDY TOPIC	
<p>1.1 Select topic through data collection and analysis of comprehensive aspects of enrollee needs, care and services.</p>	<p>AHCCCS has established a process for selection of clinical and non-clinical focus topics for PIPs, based on the Centers for Medicare and Medicaid Services final protocol for Validating Performance Improvement Projects. Project topics, and the performance indicators used to assess each project, are identified through data collection and analysis of enrollee needs, care and services. Topics are systematically selected and prioritized to achieve the greatest practical benefit for enrolled members. Selection of topics must take into account:</p> <ol style="list-style-type: none"> (1) The prevalence of a condition among, or the need for a specific service by, AHCCCS members (2) Member demographic characteristics and health risks, and (3) The interest of members, providers, AHCCCS and/or Centers for Medicare and Medicaid Services (CMS), in the aspect of care or services to be addressed. <p>Contractor input is sought in selection of topics to ensure that enrollee needs, health risks, utilization data and delivery systems are considered in selecting topics.</p>
<p>1.2 Ensure that PIPs, over time, address a broad spectrum of key aspects of enrollee care and services.</p>	<p>The selection of topics each year takes into account topics of PIP already under way, as well as clinical studies or medical audits that have been conducted in recent years. PIPs implemented include:</p> <ul style="list-style-type: none"> • Diabetes (Hb A1c Testing and Levels) – Arizona Long Term Care System (ALTCS) Elderly and/or Physically Disabled (E/PD), Division of Developmental Disabilities (DDD) and Acute-care adult members • Children’s Dental Visits – ALTCS E/PD members three to 20 years old; DDD and Acute-care members three to eight years • Management of Comorbid Disease – ALTCS adult members • Childhood Immunizations – DDD and Acute-care members 24 months old • Physician Reporting to the State Immunization Registry – Acute-care members up to 19 years old • Advance Directives –ALTCS E/PD and DDD members • Appropriate Use of Asthma Medications – Acute-care members five through 56 years old
<p>1.3 Ensure that PIPs, over time, include all enrolled populations; i.e., do not exclude certain enrollees such as those with special health care needs.</p>	<p>At any given time, all enrolled populations are included in at least one mandated PIP. This includes enrollees with special health care needs, such as the ALTCS E/PD and DDD populations, as well as members who are dually enrolled with both Acute-care Contractors and Children’s Rehabilitative Services.</p>

EXHIBIT 980-1
Protocol for Conducting Performance Improvement Projects (PIP)

PROTOCOL ACTIVITY	HOW THE PROTOCOL IS IMPLEMENTED
STEP 2: STUDY QUESTION(S)	
<p>2.1 State study question(s) for each PIP clearly in writing.</p>	<p>Utilizing input from Contractors and external clinical resources (previous research, community health care professionals), a team composed of staff from the AHCCCS Clinical Quality Management Unit and the Data analysis and Research Unit develop study questions and overall methodology for PIPs. The methodology, including the study questions, is reviewed by AHCCCS Administrators, including Quality Management staff and the Chief Medical Officer. Methodologies also are reviewed by Contractor Medical Directors and Quality Management staff. This extensive review process ensures that study questions are clearly defined and that any ambiguous wording in the methodology is corrected before it is finalized.</p>
STEP 3: STUDY INDICATOR(S)	
<p>3.1 Develop objective, clearly defined, measurable indicators.</p>	<p>AHCCCS defines requirements for PIP methodology development, including study indicators, in the AHCCCS Medical Policy Manual (AMPM). As described above, PIP methodologies are reviewed extensively to ensure that the studies utilize objective, clearly defined and measurable indicators that are appropriate to the topic and purpose.</p>
<p>3.2 Ensure that indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes.</p>	<p>Study indicators are designed to measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes, according to requirements for PIP methodology development specified in the AMPM. For example:</p> <ul style="list-style-type: none"> • The project on Management of Comorbid Disease is designed to measure changes in the health status or acuity level of members using a longitudinal approach, as well as whether those members moved from a Home and Community Based Setting to placement in a Nursing Facility and the median number of Emergency Department visits and hospital admissions vs. physician office/outpatient visits. • The project on Children’s Oral Health measures rates of at least one dental visit per year among children and adolescents. Routine dental visits are strongly associated with prevention of dental disease in young children and optimal health status. • The PIP to improve Management of Diabetes measured the percent of members who received one or more glycosylated hemoglobin test in the measurement year and the median laboratory level of the test. Lower glycemic levels are critical to preventing or minimizing complications of diabetes.

EXHIBIT 980-1
Protocol for Conducting Performance Improvement Projects (PIP)

PROTOCOL ACTIVITY	HOW THE PROTOCOL IS IMPLEMENTED
STEP 4: STUDY POPULATION	
4.1 Clearly identify all Medicaid enrollees to whom the study question(s) and indicators are relevant.	The study population is clearly identified in the PIP methodology.
4.2 Identify a data collection process to capture all enrollees to whom the study questions apply.	Technical specifications appended to the PIP methodology specifically identify which enrollees are to be selected for the denominator; e.g., by health plan identification number, contract type, etc., for use by the AHCCCS Information Services Division in writing programs to collect data from the Prepaid Medicaid Management Information System.
STEP 5: SAMPLING METHODS	
5.1 Utilize a sampling technique that considers the true or estimated frequency of occurrence of the event, and specify the confidence interval to be used and the margin of error that will be acceptable.	Frequency of occurrence and margin of error is estimated based on prior studies or published research. Confidence levels are selected at the medical standard of 95 percent or 99 percent, with a power of .80. The PIP methodology specifies the confidence level/confidence interval for the sample.
5.2 Ensure that the sampling technique protects against bias.	Random sampling techniques are used to select each sample and thus protect against bias.
5.3 Ensure that the sample contains a sufficient number of enrollees.	Samples are selected to achieve a power of .80 or greater, and the appropriate inferential statistical tests are utilized.
STEP 6: DATA COLLECTION PROCEDURES	
6.1 Clearly specify the data to be collected.	The PIP methodology specifies what data is to be collected in the Indicator Description, Indicator Criteria, and Denominator and Numerator statements.
6.2 Clearly specify the source(s) of data.	The PIP methodology specifies the source(s) of data to be collected for each type of data. For example, enrollment data from the Prepaid Medical Management Information System (PMMIS) Recipient Subsystem is used to identify members who meet sample frame (denominator) criteria. The methodology also may specify that diagnosis or encounter data from the Encounter Subsystem are used to further identify members in the denominator.
6.3 Specify a systematic method of collecting valid and reliable data that represents the entire population to which the study indicators apply.	The PIP methodology specifies data collection methods. If the entire population is not used in a study, a representative random sample is collected for the denominator.

EXHIBIT 980-1
Protocol for Conducting Performance Improvement Projects (PIP)

PROTOCOL ACTIVITY	HOW THE PROTOCOL IS IMPLEMENTED
STEP 6: DATA COLLECTION PROCEDURES (CONTINUED)	
6.4 Do instruments for data collection provide for consistent, accurate data collection over the time periods studied?	If a data collection tool is used, it is included as part of the PIP methodology. Such a tool would be used for baseline and successive measurements. In cases where Contractors collect additional numerator data for AHCCCS-mandated PIPs, AHCCCS provides a standardized instrument to all Contractors with detailed instructions and provides ongoing technical assistance during data collection. Contractors also are provided with a copy of the study methodology with any request for PIP data.
6.5 Does the study design prospectively specify a data analysis plan?	Prior to collection of data, the PIP methodology is developed, which specifies an analysis plan, including comparisons with benchmarks and goals.
6.6 Are qualified staff and personnel used to collect data?	The Data Analysis and Research (DA&R) Unit in the AHCCCS Division of Health Care Management employs qualified staff to collect and analyze data utilized in PIPs. In addition, AHCCCS reviews qualifications of Contractor personnel involved in data collection and analysis for both Contractor-selected and mandated PIPs.
STEP 7: INTERVENTION AND IMPROVEMENT STRATEGIES	
7.1 Reasonable interventions are undertaken to address causes/barriers identified through data analysis and QI processes undertaken.	<p>Contractors must initiate interventions that result in significant demonstrable improvement in performance for the performance indicators being measured. Interventions should be evidence-based, and directly related to causes and barriers identified. In addition to Contractor analysis of data and identification of interventions, AHCCCS facilitates analysis of causes and barriers, and researches and recommends evidence-based interventions to Contractors. AHCCCS may require all Contractors participating in a PIP to collaboratively implement standardized interventions.</p> <p>Contractors must demonstrate how the improvement can be reasonably attributable to interventions undertaken by the organization (i.e., improvement occurred due to the project and its interventions, not another unrelated reason). Contractors' specific interventions, as identified in their PIP reports, are evaluated for effectiveness by AHCCCS.</p>

EXHIBIT 980-1
Protocol for Conducting Performance Improvement Projects (PIP)

PROTOCOL ACTIVITY	HOW THE PROTOCOL IS IMPLEMENTED
STEP 8: DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS	
8.1 Analysis of findings is conducted according to the data analysis plan.	AHCCCS conducts an evaluation of PIP measurement results — overall, by Contractor and for any other stratifications identified in the methodology — using statistical analysis techniques defined in the data analysis plan.
8.2 Results and findings present numerical data in a way that provides accurate, clear and easily understood information.	<i>Using a statistical software program, numbers, percentages and overall rates for each indicator are produced for use in tables and graphs. Statistical tests (e.g., Pearson’s chi square analysis) are applied. Tables, graphs and/or written analysis for each indicator reflecting rates overall, by Contractor and for any other stratifications identified in the methodology, are verified for accuracy and presented in an easily understood manner in reports produced by AHCCCS.</i>
8.3 The analysis identifies initial and repeated measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity.	Following the data analysis plan, AHCCCS identifies: <ul style="list-style-type: none"> • Initial and repeat measurements of the prospectively identified indicators for the project. • Statistical significance of any differences between the initial and repeat measurements. • Factors that influence the comparability of initial and repeat measurements. • Factors that threaten the internal or external validity of the findings.
8.4 The analysis includes an interpretation of the extent to which the PIP was successful and follow-up activities.	The AHCCCS analysis and interpretation of study results is based on continuous quality improvement philosophies. It includes an interpretation of the extent to which the PIP was successful and any recommended follow-up activities.
STEP 9: EVALUATION OF “REAL” IMPROVEMENT	
9.1 The same methodology as the baseline measurement is used, when measurement is repeated.	AHCCCS ensures that consistent methodology is used to conduct repeat measurements.
9.2 An analysis is conducted to determine if there are quantitative improvements in processes or outcomes of care.	AHCCCS utilizes baseline and repeat measures of quality indicators, tests of statistical significance calculated on baseline and repeat indicator measurements, and comparison with benchmarks specified by the agency or found in industry standards. AHCCCS requires Contractors to submit PIP remeasurement reports that discuss improvements in processes or outcomes of care. If demonstrable or sustained improvement in study indicators is not achieved, Contractors should describe the probable reason(s) that improvement was not achieved, and identify proposed actions to revise, replace and/or initiate new interventions, along with the timeframe for implementing these activities.

EXHIBIT 980-1

Protocol for Conducting Performance Improvement Projects (PIP)

PROTOCOL ACTIVITY	HOW THE PROTOCOL IS IMPLEMENTED
STEP 9: EVALUATION OF “REAL” IMPROVEMENT (CONTINUED)	
9.3 An assessment is made to determine if improvement in performance has face validity.	AHCCCS assesses whether an intervention appears to have been successful in improving performance; i.e., whether improvement appears to have been the result of the planned intervention as opposed to some unrelated occurrence.
9.4 An analysis is conducted to determine statistical evidence of observed improvement.	Statistical tests are applied by AHCCCS. Variability of distribution will be calculated to determine appropriate methods of statistical analysis. Data variability will also determine if categorization of variables is possible and ensure data is reported appropriately (mean, median).
STEP 10: SUSTAINED IMPROVEMENT	
10.1 Repeated measurements are conducted to determine sustained improvement.	AHCCCS conducts one or more remeasurements after the first remeasurement of performance is taken to ensure that improvement is sustained. Contractors demonstrate sustained improvement when they maintain or increase improvements in performance for at least one year after the improvement is first achieved. Because of random year-to-year variation, population changes, and sampling errors, performance on any given individual measure may decline in the second measurement. However, when all of the repeat measurements for a given project are taken together, this decline should not be statistically significant.

EXHIBIT 980-2

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE**

DRAFT Implementation 10/01/2013

**EXHIBIT 980-2
AHCCCS PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE**

Contractor Name:

Project Title:

Year Implemented: CYE

INDICATOR DESCRIPTION #1: (If results for this indicator are analyzed by county, age group or other stratifications, attach separate tables of results for each stratification).							
MEASUREMENT	MEASUREMENT PERIOD	NUMERATOR	DENOMINATOR	RATE (%)	RELATIVE % CHANGE	STATISTICAL SIGNIFICANCE*	INDICATOR GOAL
Baseline					N/A	N/A	
Remeasurement 1							
Remeasurement 2							
Remeasurement 3							
Remeasurement 4							
Remeasurement 5							
* SPECIFY THE TEST AND SPECIFIC MEASUREMENTS USED (i.e., Pearson's chi square test for baseline to remeasurement 1, remeasurement 1 to remeasurement 2, baseline to final remeasurement, etc.):							
SPECIFY ANY CHANGES IN METHODOLOGY BETWEEN BASELINE AND ANY REMEASUREMENT: Provide a brief rationale for the change(s).							

**EXHIBIT 980-2
AHCCCS PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE**

INDICATOR DESCRIPTION #2: (If results for this indicator are analyzed by county, age group or other stratifications, attach separate tables of results for each stratification).

MEASUREMENT	MEASUREMENT PERIOD	NUMERATOR	DENOMINATOR	RATE (%)	RELATIVE % CHANGE	STATISTICAL SIGNIFICANCE*	INDICATOR GOAL
Baseline					N/A	N/A	
Remeasurement 1							
Remeasurement 2							
Remeasurement 3							
Remeasurement 4							
Remeasurement 5							

* **SPECIFY THE TEST AND SPECIFIC MEASUREMENTS USED** (i.e., Pearson's chi square test for baseline to remeasurement 1, remeasurement 1 to remeasurement 2, baseline to final remeasurement, etc.):

SPECIFY ANY CHANGES IN METHODOLOGY BETWEEN BASELINE AND ANY REMEASUREMENT: Provide a brief rationale for the change(s).

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**EXHIBIT 980-2
AHCCCS PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE**

INDICATOR DESCRIPTION #3: (If results for this indicator are analyzed by county, age group or other stratifications, attach separate tables of results for each stratification).

MEASUREMENT	MEASUREMENT PERIOD	NUMERATOR	DENOMINATOR	RATE (%)	RELATIVE % CHANGE	STATISTICAL SIGNIFICANCE*	INDICATOR GOAL
Baseline					N/A	N/A	
Remeasurement 1							
Remeasurement 2							
Remeasurement 3							
Remeasurement 4							
Remeasurement 5							

* **SPECIFY THE TEST AND SPECIFIC MEASUREMENTS USED** (i.e., Pearson's chi square test for baseline to remeasurement 1, remeasurement 1 to remeasurement 2, baseline to final remeasurement, etc.):

SPECIFY ANY CHANGES IN METHODOLOGY BETWEEN BASELINE AND ANY REMEASUREMENT: Provide a brief rationale for the change(s).

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**EXHIBIT 980-2
AHCCCS PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE**

INDICATOR DESCRIPTION #4: (If results for this indicator are analyzed by county, age group or other stratifications, attach separate tables of results for each stratification).

MEASUREMENT	MEASUREMENT PERIOD	NUMERATOR	DENOMINATOR	RATE (%)	RELATIVE % CHANGE	STATISTICAL SIGNIFICANCE*	INDICATOR GOAL
Baseline							
Remeasurement 1							
Remeasurement 2							
Remeasurement 3							
Remeasurement 4							
Remeasurement 5							

* **SPECIFY THE TEST AND SPECIFIC MEASUREMENTS USED** (i.e., Pearson's chi square test for baseline to remeasurement 1, remeasurement 1 to remeasurement 2, baseline to final remeasurement, etc.):

SPECIFY ANY CHANGES IN METHODOLOGY BETWEEN BASELINE AND ANY REMEASUREMENT: Provide a brief rationale for the change(s).

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EXHIBIT 980-2
AHCCCS PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE

ANALYSIS OF RESULTS

QUANTITATIVE ANALYSIS: Describe any additional analysis, comparison with national benchmarks, trends, etc. Identify any changes in goals and/or describe the effect of any methodological changes on results. If a survey was conducted, identify the overall response rate and describe any effect the response rate may have had on results. Discuss the effect of any data limitations on results.

QUALITATIVE ANALYSIS: Describe any qualitative analysis, such as literature search, root cause analysis, Pareto diagram, flow chart, focus groups, etc. Describe barriers and opportunities identified through this analysis.

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**EXHIBIT 980-2
AHCCCS PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE**

INTERVENTIONS			
<p>IF THIS IS A BASELINE REPORT: List proposed interventions, what barrier(s) will be addressed by each intervention, timeframes for implementation and, if applicable, end dates. IF THIS IS A REMEASUREMENT REPORT: In chronological order, list the interventions implemented after analysis of baseline data was completed. Please be specific in describing interventions; e.g., identify the number of new FTEs hired to work on an intervention, the number of provider in-services scheduled, etc.</p>			
IMPLEMENTATION DATE (MM/YY)	DESCRIPTION OF INTERVENTION	BARRIER ADDRESSED	ONGOING OR END DATE
<p>STRATEGIES FOR IMPLEMENTING INTERVENTIONS: If this is a Baseline Report, briefly list any specific strategies that will be required to implement the above interventions.</p>			

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EXHIBIT 980-2
AHCCCS PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE

ASSESSMENT OF IMPROVEMENT

IF DEMONSTRABLE IMPROVEMENT IN STUDY INDICATORS IS ACHIEVED FROM BASELINE TO REMEASUREMENT: Describe how the improvement can be reasonably attributed to interventions, rather than due to another unrelated reason.

IF DEMONSTRABLE IMPROVEMENT IN STUDY INDICATORS IS NOT ACHIEVED FROM BASELINE TO REMEASUREMENT: Briefly describe the probable reason(s) that improvement was not achieved. Identify proposed actions to revise, replace and/or initiate new interventions, as well as the timeframe for implementing these activities.

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EXHIBIT 980-2
AHCCCS PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE

Assessment of Improvement (continued)

IF THIS IS A FINAL REMEASUREMENT REPORT: Briefly discuss the extent to which the PIP was successful and any follow-up or ongoing activities planned. In addition to the study indicators, describe any documented, quantitative improvements in processes or outcomes related to this PIP.

Attach any trend charts or graphs of results if three or more measurements have been conducted. Additional documentation of analysis (e.g., root cause analysis diagram or focus group responses) may also be attached.

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CHAPTER 900
QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 990
REPORTING REQUIREMENTS

990 REPORTING REQUIREMENTS

REVISION DATES: 10/01/08, 02/01/07, 01/01/06, 04/01/05, 08/13/03, 10/01/01, 10/01/97

REVIEW DATE: 04/01/12, 02/01/2011

INITIAL

EFFECTIVE DATE: 10/01/1994

Contractors must submit the following data and reports as indicated:

REPORT	DUE DATE	REPORTS DIRECTED TO
Quality Management/Performance Improvement (QM/PI) Plan/Evaluation Quality Management Plan Checklist (Exhibit 910-1) must be included	Annually by December 15	Division of Health Care Management/Clinical Quality Management Unit (DHCM/CQM)
Quarterly Credentialing Report (Exhibit 950-1)	30 days after end of quarter	DHCM/CQM
Quarterly QM Report (Exhibit 960-1)	30 days after end of quarter	DHCM/CQM
Performance Improvement Project (PIP) Annual Report (separate report for each PIP in process). (Exhibit 980-2)	By December 15 following initial year of PIP	DHCM/CQM
Performance Improvement Project Final Evaluation Report (including any new QM/PI activities implemented as a result of the project). (Exhibit 980-2)	By March 31 after the contract year in which the PIP was completed	DHCM/CQM
Corrective Action Plan for deficiencies noted in: 1. An Operations Field Review 2. A Focused Review 3. QM/PI Plan 4. Performance related to Quality Measures	30 days after receipt of notice to submit a Corrective Action Plan (CAP) unless otherwise stated.	DHCM/CQM

NOTE: The Arizona Department of Health Services/Division of Behavioral Health (ADHS/DBHS) must:

- Refer to their AHCCCS Contract for due dates, and
- Submit all reports to AHCCCS DHCM/Behavioral Health Unit.

If an extension of time is needed to complete a report, the Contractor may submit a request in writing to the AHCCCS/DHCM/Clinical Quality Management Unit, or, for ADHS/DBHS, a request to the DHCM/Behavioral Health Unit.

Refer to [Chapter 400](#) for reporting requirements related to maternity services and/or Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Refer to [Chapter 1000](#) for reporting requirements related to Utilization Management.

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