Quality Management/Performance Improvement Program Plan Attestation

*The Contractor is to complete a separate attestation for each line of business that will be reviewed as part of the Contractor’s Quality Management/Performance Improvement (QM/PI) Program Plan submission. Please complete, sign, date, and include this attestation as a standalone document within the associated submission.*

***This attestation applies to the following Calendar Year:*** [*Calendar Year*]

**For the calendar year identified above:**

[ ]  There are no changes in the QM/PI Program scope from the previous calendar year.

[ ]  There are changes in the QM/PI Program scope from the previous calendar year and the associated rationale for the changes has been included within the Contractor’s QM/PI Program Plan submission.

**Note:** The QM/PI Program scope is outlined within the AHCCCS Medical Policy Manual (AMPM) Policy 910. Changes in the QM/PI Program scope are defined as any alterations made to the Contractor’s QM/PI Program structure from one year to the next. This may also include line of business, population, and geographic service area changes.

**The QM/PI Program Plan** **submitted (including the associated Work Plan and Work Plan Evaluation) is applicable to the Contractor’s Title XIX and Title XXI populations:**

|  |  |  |
| --- | --- | --- |
| [ ]  Yes | [ ]  No | [ ]  Not Applicable *(ALTCS-EPD Contractors* *only)* |

**The QM/PI Program Plan** **submitted (including the associated Work Plan and Work Plan Evaluation), and any applicable updates related to changes in the QM/PI Program scope, have been reviewed by the Contractor’s governing or policy making body prior to submission to AHCCCS.**

|  |  |  |
| --- | --- | --- |
| [ ]  Yes | [ ]  No |  |

**I attest that the information above and included within the associated QM/PI Program Plan (inclusive of the Work Plan and Work Plan Evaluation) is an accurate representation of the QM/PI Program scope and activities and** **that the QM/PI Program Plan submission has been reviewed and approved, as written and submitted.**

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Signature of the QM Manager/Director***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Date***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Signature of the Chief Medical Officer***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Date***