ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Quality Assurance (QA) Compliance and Monitoring 101

The Division of Fee-for-Service Management (DFSM)

January 27, 2026

Purpose of Quality Assurance in AHCCCS

DFSM QA's oversight process is designed to help providers meet the standards set forth in AMPM and the PPA, supporting safe, effective, and compliant care for AHCCCS members.

Here's an overview of how DFSM QA functions within AHCCCS:

- DFSM QA supports providers by ensuring high-quality care and compliance.
- It supports program integrity, member safety, and continuous improvement in healthcare service delivery.
- The Tracking and Trending of member and provider concerns is crucial to quality assurance and quality improvement.

Why QA Matters

- Ensures alignment with AHCCCS policies, Arizona law, and federal Medicaid standards.
- Helps providers improve care delivery and avoid more severe adverse actions.
- Promotes a culture of accountability, transparency, and member-centered care.

DFSM QA Compliance and Monitoring Plans

Two pathways: MOC vs CAP

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Compliance and Monitoring Plans

After a DFSM Quality Management (QM) Audit, virtual record review or onsite, providers found to have substantiated deficiencies may be placed on a compliance and monitoring plan.

Types of Compliance and Monitoring Plans:

- **Memos of Concern (MOC)-** Issued for lower-severity concerns, most often substantiated at level 1 or 2
- **Corrective Action Plans (CAP)-** Issued for significant and/or systemic concerns, generally substantiated at level 2 or higher

The severity levels of quality-of-care concerns are outlined in AMPM 960 and AMPM 830.

Compliance and Monitoring Plans Purpose

- For DFSM to work collaboratively with the provider to support quality improvement and program integrity of AHCCCS covered services to members.
- MOCs and CAPs are designed to help providers address concerns early, prevent future issues, and maintain compliance with AHCCCS policy.
- The process emphasizes partnership, guidance, and continuous improvement—not punishment.

What is a Memo of Concern (MOC)?

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A MOC is…

- A **non-punitive alert** issued to providers when areas for improvement are identified during:
  - Clinical Quality Reviews
  - Virtual Record Audits
  - Onsite Investigations

- Serve as a **first-level notification**, giving providers the opportunity to correct issues **before** formal Corrective Action Plans (CAPs) or other adverse actions are taken.
- Are a key component of **DFSM's oversight strategy**, supporting safe, effective, and compliant care for AHCCCS Fee-for-Service members.

Why MOCs Matter

- MOCs are part of a **collaborative oversight model** designed to:
  - Encourage **continuous quality improvement**
  - Provide **guidance and tools** for enhanced care delivery
  - Enable **early intervention** to prevent future issues
- This proactive approach helps providers align with **best practices** and regulatory expectations, without immediate punitive consequences.
- The MOC is a critical checkpoint in maintaining compliance.

⚠️ **Important**: Failure to respond or correct cited issues may result in future adverse actions such as CAP or termination of the PPA.

What is required?

- It outlines **deficiencies in care delivery or operations**, citing specific **regulatory violations**. While a formal CAP is **not required**, providers must:
  - **Acknowledge receipt** of the MOC within **5 business days of receipt**
  - Submit intended **strategies for correction**
  - Identify the **staff responsible** for implementing improvements

Memos of Concern also reinforce adherence to AHCCCS policies when gaps exist.

Understanding Your MOC Letter

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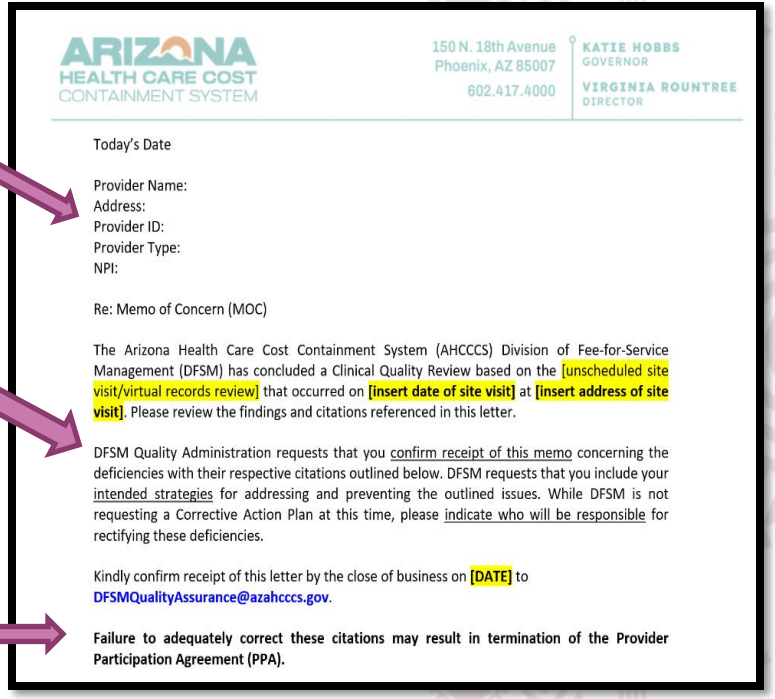
Key Sections of the MOC

- **Subject Line & Provider Info:** Identifies the provider and the context of the review (e.g., site visit, virtual record audit).
- **What Required:** States what information is required to be submitted.
- **Due Date:** For MOC documents is typically within 5 business days from receipt of the MOC and includes a warning: Failure to correct may result in PPA termination



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KATIE HOBBS
GOVERNOR

VIRGINIA ROUNTREE
DIRECTOR

Today's Date

Provider Name:
Address:
Provider ID:
Provider Type:
NPI:

Re: Memo of Concern (MOC)

The Arizona Health Care Cost Containment System (AHCCCS) Division of Fee-for-Service Management (DFSM) has concluded a Clinical Quality Review based on the [unscheduled site visit/virtual records review] that occurred on **[insert date of site visit]** at **[insert address of site visit]**. Please review the findings and citations referenced in this letter.

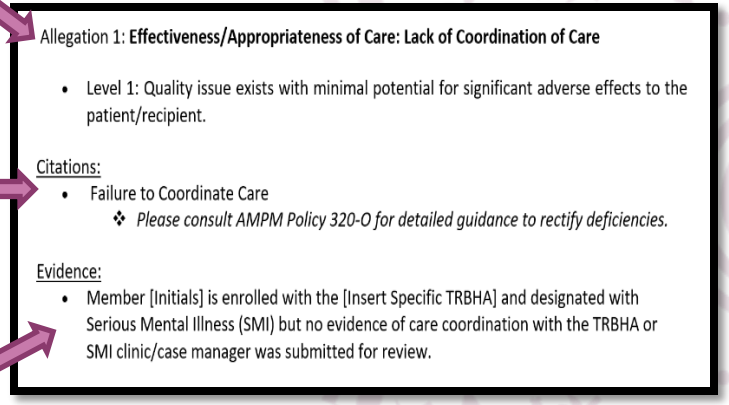
DFSM Quality Administration requests that you confirm receipt of this memo concerning the deficiencies with their respective citations outlined below. DFSM requests that you include your intended strategies for addressing and preventing the outlined issues. While DFSM is not requesting a Corrective Action Plan at this time, please indicate who will be responsible for rectifying these deficiencies.

Kindly confirm receipt of this letter by the close of business on **[DATE]** to DFSMQualityAssurance@azahcccs.gov.

Failure to adequately correct these citations may result in termination of the Provider Participation Agreement (PPA).

Key Sections of the MOC

- **Allegations & Severity Determination:** Presents substantiated findings and assigns a severity level in accordance with AMPM 830 & 960.
- **Citation & Applicable Reference:** Identifies relevant policies and regulations supporting each finding.
- **Evidence:** Details observed deficiencies, such as documentation gaps, insufficient oversight, or care coordination concerns.



Allegation 1: **Effectiveness/Appropriateness of Care: Lack of Coordination of Care**

- Level 1: Quality issue exists with minimal potential for significant adverse effects to the patient/recipient.

Citations:

- Failure to Coordinate Care
  - ❖ *Please consult AMPM Policy 320-O for detailed guidance to rectify deficiencies.*

Evidence:

- Member [Initials] is enrolled with the [Insert Specific TRBHA] and designated with Serious Mental Illness (SMI) but no evidence of care coordination with the TRBHA or SMI clinic/case manager was submitted for review.

Key Sections of the MOC

- **Training & Resources:** Use AHCCCS policy documents, training, and support contacts to ensure compliance.
- **Additional Requirement:** Coordinate care with Tribal Regional Behavioral Health Authorities (TRBHAs) for members assigned.
- **IAD Reporting Requirements:** Provides a link to the QM Portal and cites AMPM 961 and 830, outlining provider responsibilities for IAD reporting.

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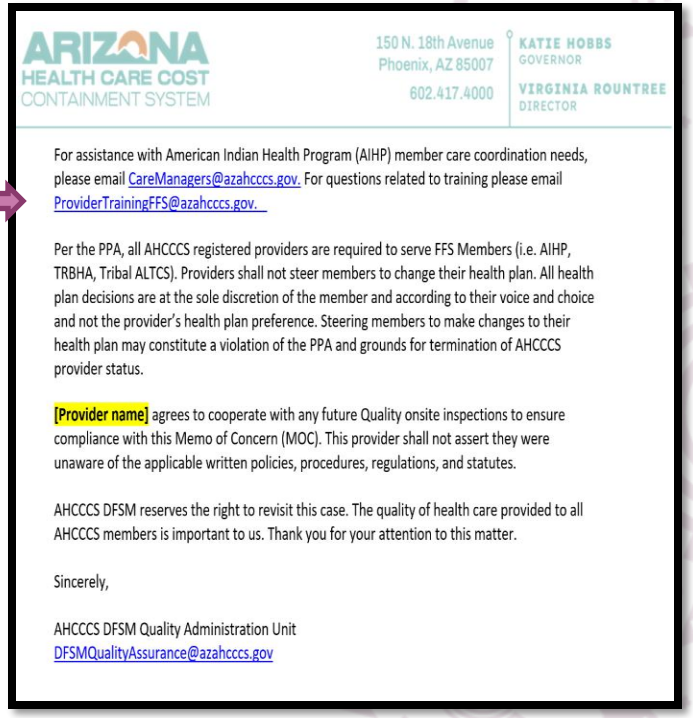
Training and resources:
Please review the applicable AHCCCS policies related to these citations and sign up for additional provider training opportunities. Please refer to the AHCCCS website to sign up for upcoming training, view pre-recorded training sessions, and sign up for the Constant Contact Claims Clues Newsletters.
DFSM training resources can be found here:
https://www.azahcccs.gov/Resources/Training/DFSM_Training.html.

Additional Requirements:
AHCCCS registered providers are required to coordinate care with Tribal Regional Behavioral Health Authorities (TRBHAs) for members enrolled with a TRBHA for their behavioral health assignment. For more information on TRBHAs please visit
https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/ProgramsAndPopulations/TRBHA.html.

Fee-for-Service providers must report all incident, accident, death (IAD) reportable concerns via the Quality Management (QM) Portal at: https://qmportal.azahcccs.gov/ . Please also refer to AMPM 961 and AMPM 830.

Key Sections of the MOC

- **AIHP Care Manager & Training:** Lists contact information for the AIHP Care Managers, available to support providers as needed. Training contact information.
- **Serving FFS Member:** Reminds providers of the requirement to serve AIHP members and prohibits steering members to change their health plan.
- **Cooperation Agreement:** Provider agrees to cooperate with future onsite inspections and is responsible for understanding all applicable policies, procedures, regulations, and statutes.



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For assistance with American Indian Health Program (AIHP) member care coordination needs, please email CareManagers@azahcccs.gov. For questions related to training please email ProviderTrainingFFS@azahcccs.gov.

Per the PPA, all AHCCCS registered providers are required to serve FFS Members (i.e. AIHP, TRBHA, Tribal ALTCS). Providers shall not steer members to change their health plan. All health plan decisions are at the sole discretion of the member and according to their voice and choice and not the provider's health plan preference. Steering members to make changes to their health plan may constitute a violation of the PPA and grounds for termination of AHCCCS provider status.

[Provider name] agrees to cooperate with any future Quality onsite inspections to ensure compliance with this Memo of Concern (MOC). This provider shall not assert they were unaware of the applicable written policies, procedures, regulations, and statutes.

AHCCCS DFSM reserves the right to revisit this case. The quality of health care provided to all AHCCCS members is important to us. Thank you for your attention to this matter.

Sincerely,

AHCCCS DFSM Quality Administration Unit
DFSMQualityAssurance@azahcccs.gov

Provider Responsibilities When Receiving a Memo of Concern

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What Providers Should Do

- **Review Carefully:**
  - Read the entire memo thoroughly.
  - Pay close attention to each citation and finding.
  - Understand the specific AHCCCS policy or regulation cited and how it applies to your practice.
- **Coordinate Internally:**
  - Identify the appropriate staff responsible for rectifying the cited deficiencies.
  - Gather relevant documentation, records, or internal policies.
  - Discuss the root cause of the issue collaboratively within your team.

What Providers Should Do

- **Respond Promptly:**
  - Submit acknowledgment of receipt by the listed deadline.
  - Outline your improvement strategies and how you'll achieve compliance.
  - Provide the responsible party's name and contact information.
- **Reach Out for Support:**
  - DFSM QA is here to help, this is a collaborative process.
  - Email: DFSMQualityAssurance@AZAHCCCS.gov
  - Utilize available resources: https://www.azahcccs.gov/Resources/Training/DFSM_Training.html

What is a Corrective Action Plan (CAP)?

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A CAP is…

- A **formal, structured plan** issued by DFSM QA to address **significant deficiencies** identified during a Quality Management review.
- Is **required** when findings pose a risk to member safety, violate AHCCCS policy, or reflect systemic issues in care delivery or documentation.
- CAPs are **not optional**—they are an obligation under the Provider Participation Agreement (PPA) and AHCCCS Medical Policy Manual (AMPM).

Why CAPs Matter

- A CAP is a formal requirement issued by DFSM when deficiencies are significant enough to risk member harm, violate AHCCCS policy, or reflect systemic issues.
- While DFSM does not contract directly with providers, all AHCCCS-registered providers operate under a Provider Participation Agreement (PPA).
- Failure to comply with a CAP may result in termination of the Provider Participation Agreement (PPA), rendering the provider ineligible to bill for services rendered to any Medicaid member in Arizona.

Understanding Your CAP Letter

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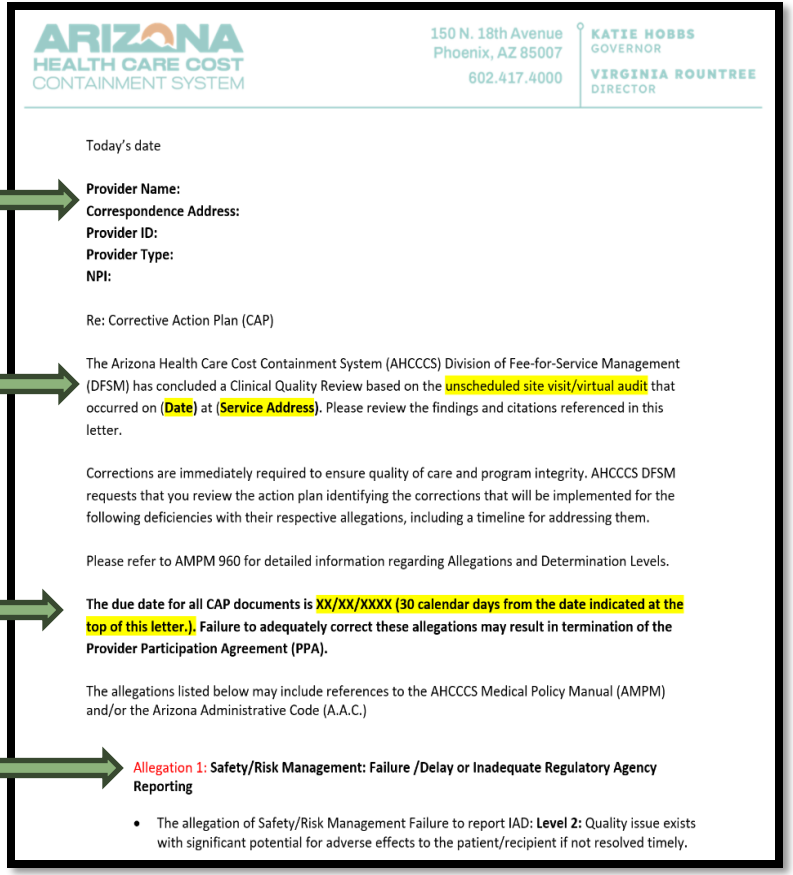
Key Sections of a CAP

- **Provider Info:** Including AHCCCS Provider ID, Type, NPI
- **Context:** Clarification if the CAP is a result of unscheduled site visit or virtual audit and includes the date & service address.
- **Due Date:** For all CAP documents is typically **30 calendar days** from letter date and includes a w*arning:* Failure to correct may result in PPA termination
- **Allegations & Severity:** Allegations will be listed with a determination of severity based on AMPM 830 & 960, helping providers understand the seriousness and risk to member safety.



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GOVERNOR

VIRGINIA ROUNTREE
DIRECTOR

Today's date

Provider Name:
Correspondence Address:
Provider ID:
Provider Type:
NPI:

Re: Corrective Action Plan (CAP)

The Arizona Health Care Cost Containment System (AHCCCS) Division of Fee-for-Service Management (DFSM) has concluded a Clinical Quality Review based on the unscheduled site visit/virtual audit that occurred on (**Date**) at (**Service Address**). Please review the findings and citations referenced in this letter.

Corrections are immediately required to ensure quality of care and program integrity. AHCCCS DFSM requests that you review the action plan identifying the corrections that will be implemented for the following deficiencies with their respective allegations, including a timeline for addressing them.

Please refer to AMPM 960 for detailed information regarding Allegations and Determination Levels.

The due date for all CAP documents is XX/XX/XXXX (30 calendar days from the date indicated at the top of this letter.). Failure to adequately correct these allegations may result in termination of the Provider Participation Agreement (PPA).

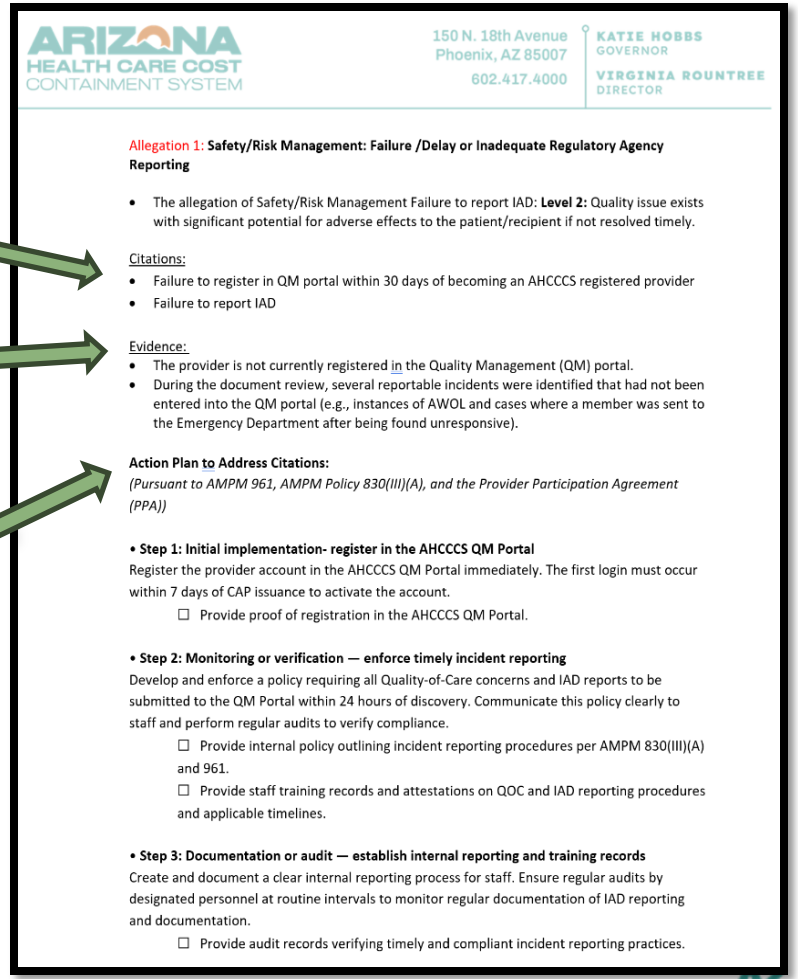
The allegations listed below may include references to the AHCCCS Medical Policy Manual (AMPM) and/or the Arizona Administrative Code (A.A.C.)

Allegation 1: **Safety/Risk Management: Failure /Delay or Inadequate Regulatory Agency Reporting**

- The allegation of Safety/Risk Management Failure to report IAD: **Level 2:** Quality issue exists with significant potential for adverse effects to the patient/recipient if not resolved timely.

Key Sections of a CAP

- **Citation of Concern:** Lists the specific AHCCCS policy or regulation that was not met.
- **Evidence:** Summarizes the documentation, examples, or observations that support each allegation. Helps providers understand what was found and why it's a concern.
- **Required Actions**: Specifies the corrections the provider must make for each deficiency, including updating policies to align with AMPM, retraining staff, or improving documentation practices. Actions should directly address the cited policies.



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Allegation 1: **Safety/Risk Management: Failure /Delay or Inadequate Regulatory Agency Reporting**

- The allegation of Safety/Risk Management Failure to report IAD: **Level 2:** Quality issue exists with significant potential for adverse effects to the patient/recipient if not resolved timely.

Citations:

- Failure to register in QM portal within 30 days of becoming an AHCCCS registered provider
- Failure to report IAD

Evidence:

- The provider is not currently registered in the Quality Management (QM) portal.
- During the document review, several reportable incidents were identified that had not been entered into the QM portal (e.g., instances of AWOL and cases where a member was sent to the Emergency Department after being found unresponsive).

Action Plan to Address Citations:
(Pursuant to AMPM 961, AMPM Policy 830(III)(A), and the Provider Participation Agreement (PPA))

• Step 1: Initial implementation- register in the AHCCCS QM Portal
Register the provider account in the AHCCCS QM Portal immediately. The first login must occur within 7 days of CAP issuance to activate the account.

☐ Provide proof of registration in the AHCCCS QM Portal.

• Step 2: Monitoring or verification — enforce timely incident reporting
Develop and enforce a policy requiring all Quality-of-Care concerns and IAD reports to be submitted to the QM Portal within 24 hours of discovery. Communicate this policy clearly to staff and perform regular audits to verify compliance.

☐ Provide internal policy outlining incident reporting procedures per AMPM 830(III)(A) and 961.

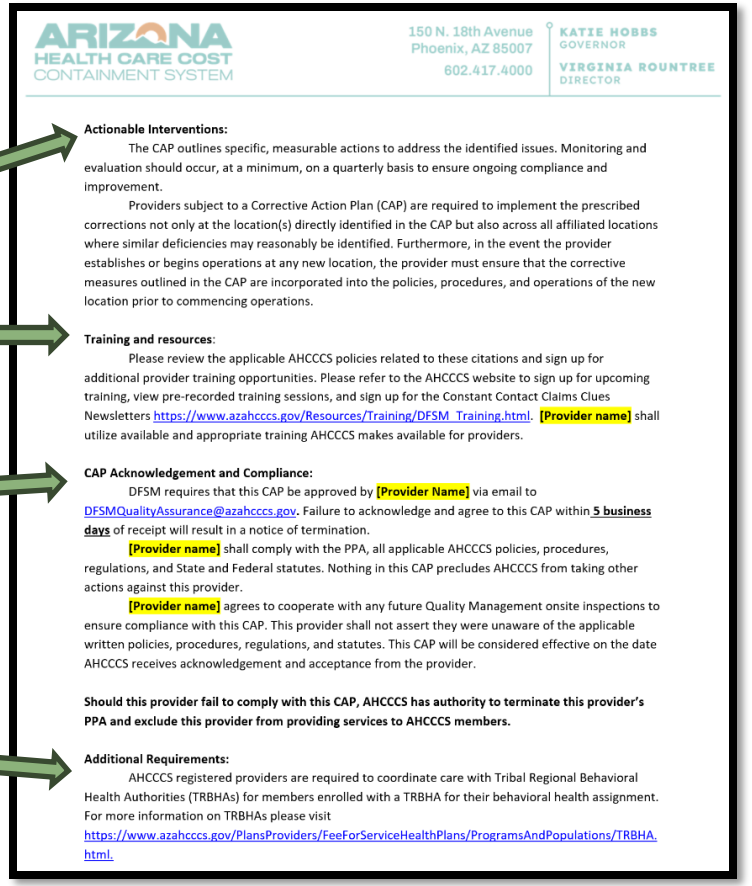
☐ Provide staff training records and attestations on QOC and IAD reporting procedures and applicable timelines.

• Step 3: Documentation or audit — establish internal reporting and training records
Create and document a clear internal reporting process for staff. Ensure regular audits by designated personnel at routine intervals to monitor regular documentation of IAD reporting and documentation.

☐ Provide audit records verifying timely and compliant incident reporting practices.

Key Sections of a CAP

- **Actionable Interventions:** Take measurable steps for improvement (e.g., quarterly audits). Apply corrections at all relevant locations.
- **Training & Resources:** Use AHCCCS policy documents, training, and support contacts to ensure compliance.
- **CAP Acknowledgement:** Acknowledge and agree to the CAP within 5 business days. Comply with PPA, AHCCCS policies, and all laws. Cooperate with future Quality Management Reviews.
- **Additional Requirement:** Coordinate care with Tribal Regional Behavioral Health Authorities (TRBHAs) for members assigned.



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Actionable Interventions:

The CAP outlines specific, measurable actions to address the identified issues. Monitoring and evaluation should occur, at a minimum, on a quarterly basis to ensure ongoing compliance and improvement.

Providers subject to a Corrective Action Plan (CAP) are required to implement the prescribed corrections not only at the location(s) directly identified in the CAP but also across all affiliated locations where similar deficiencies may reasonably be identified. Furthermore, in the event the provider establishes or begins operations at any new location, the provider must ensure that the corrective measures outlined in the CAP are incorporated into the policies, procedures, and operations of the new location prior to commencing operations.

Training and resources:

Please review the applicable AHCCCS policies related to these citations and sign up for additional provider training opportunities. Please refer to the AHCCCS website to sign up for upcoming training, view pre-recorded training sessions, and sign up for the Constant Contact Claims Clues Newsletters https://www.azahcccs.gov/Resources/Training/DFSM_Training.html. **[Provider name]** shall utilize available and appropriate training AHCCCS makes available for providers.

CAP Acknowledgement and Compliance:

DFSM requires that this CAP be approved by **[Provider Name]** via email to DFSMQualityAssurance@azahcccs.gov. Failure to acknowledge and agree to this CAP within **5 business days** of receipt will result in a notice of termination.

[Provider name] shall comply with the PPA, all applicable AHCCCS policies, procedures, regulations, and State and Federal statutes. Nothing in this CAP precludes AHCCCS from taking other actions against this provider.

[Provider name] agrees to cooperate with any future Quality Management onsite inspections to ensure compliance with this CAP. This provider shall not assert they were unaware of the applicable written policies, procedures, regulations, and statutes. This CAP will be considered effective on the date AHCCCS receives acknowledgement and acceptance from the provider.

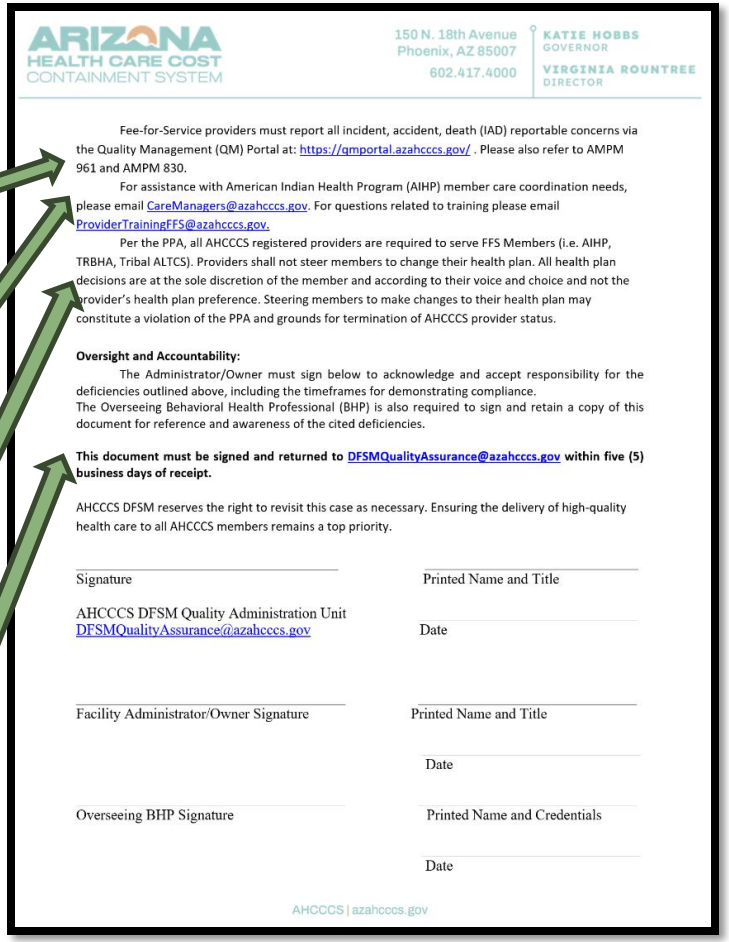
Should this provider fail to comply with this CAP, AHCCCS has authority to terminate this provider's PPA and exclude this provider from providing services to AHCCCS members.

Additional Requirements:

AHCCCS registered providers are required to coordinate care with Tribal Regional Behavioral Health Authorities (TRBHAs) for members enrolled with a TRBHA for their behavioral health assignment. For more information on TRBHAs please visit https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/ProgramsAndPopulations/TRBHA.html.

Key Sections of a CAP

- **IAD Reporting Requirements:** Provides a link to the QM Portal and cites AMPM 961 and 830, outlining provider responsibilities for IAD reporting.
- **AIHP Care Manager:** Lists contact information for the AIHP Care Managers, available to support providers as needed.
- **Serving FFS Member:** Reminds providers of the requirement to serve AIHP members and prohibits steering members to change their health plan.
- **Oversight & Accountability:** Confirms provider's agreement to future quality management inspections and ongoing compliance. Includes signature lines.



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Fee-for-Service providers must report all incident, accident, death (IAD) reportable concerns via the Quality Management (QM) Portal at: https://qmportal.azahcccs.gov/ . Please also refer to AMPM 961 and AMPM 830.

For assistance with American Indian Health Program (AIHP) member care coordination needs, please email CareManagers@azahcccs.gov. For questions related to training please email ProviderTrainingFFS@azahcccs.gov.

Per the PPA, all AHCCCS registered providers are required to serve FFS Members (i.e. AIHP, TRBHA, Tribal ALTCS). Providers shall not steer members to change their health plan. All health plan decisions are at the sole discretion of the member and according to their voice and choice and not the provider's health plan preference. Steering members to make changes to their health plan may constitute a violation of the PPA and grounds for termination of AHCCCS provider status.

Oversight and Accountability:

The Administrator/Owner must sign below to acknowledge and accept responsibility for the deficiencies outlined above, including the timeframes for demonstrating compliance.
The Overseeing Behavioral Health Professional (BHP) is also required to sign and retain a copy of this document for reference and awareness of the cited deficiencies.

This document must be signed and returned to DFSMQualityAssurance@azahcccs.gov within five (5) business days of receipt.

AHCCCS DFSM reserves the right to revisit this case as necessary. Ensuring the delivery of high-quality health care to all AHCCCS members remains a top priority.

Signature

Printed Name and Title

AHCCCS DFSM Quality Administration Unit
DFSMQualityAssurance@azahcccs.gov

Date

Facility Administrator/Owner Signature

Printed Name and Title

Date

Overseeing BHP Signature

Printed Name and Credentials

Date

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Provider Responsibilities

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First Step

- **Timely and Formal Acceptance:**
  - Providers must formally acknowledge receipt of the CAP **within 5 business days.**
  - The acknowledgment must include signatures from both the Administrator/Owner **and** the Overseeing Behavioral Health Professional (BHP) for applicable Behavioral Health provider types.
- **Why These Signatures Matter:**
  - The Administrator/Owner's signature confirms acceptance of the deficiencies outlined in the CAP and agreement to the timeframes for demonstrating compliance.
  - The Overseeing BHP's signature ensures they are aware of the clinical deficiencies and are actively involved in implementing strategies to enhance clinical oversight and prevent recurrence.

Review the CAP Letter Thoroughly

- **Read Every Section:** Carefully read the entire CAP letter, including the provider info, context of the review, and each allegation.
- **Understand Citations:** Pay close attention to the specific AHCCCS policies and regulations cited to guide internal policy updates and staff training. These are the standards you are expected to meet.
- **Assess Allegations & Severity:** Note each deficiency (“allegation”) and its severity level. This shows how serious each issue is and the potential impact on member safety.

Examine the Evidence Section

- **Read the Evidence Carefully:** For each allegation, review the paragraph or bullet points that describe what was found deficient during the Quality Management (QM) review.
- **Understand the Details:** Evidence may include member initials, dates, or descriptions of missing or incomplete documentation (e.g., progress notes, assessments, signatures).
    - Note: The evidence section does not include screenshots or protected health information—just enough detail to clarify the deficiency. Please reference your Provider Records Request Letter for full member names.
- **Use Evidence to Guide Corrections:** Base your corrective actions on the specific findings, addressing each cited issue and its underlying cause.

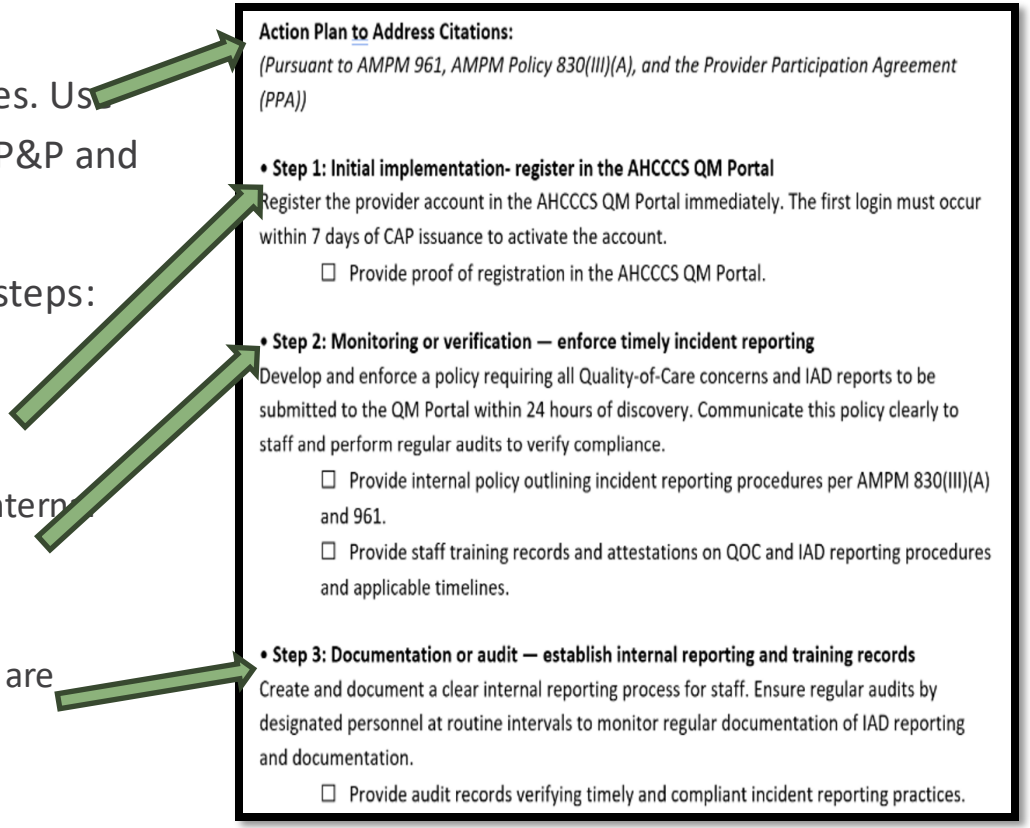
What is the Necessary Action Section?

- This part of your CAP letter lists the specific steps you must take to correct each deficiency. Actions are tailored to the citation.
- **Read Each Action Carefully:** Each action is linked to a specific AHCCCS policy or federal and state law, rule and/or regulation.
- **Understand What's Requested:** Actions may include updating internal policies, retraining staff, and formulating an audit plan.

Tip: If you're unsure about any required action, reach out to DFSM QA for clarification or support. Following the necessary actions precisely is key to resolving your CAP and maintaining compliance.

Necessary Action Example

- Begin by reviewing the applicable policies. Use them to guide updates to your internal P&P and staff training.
- The action plan typically includes three steps:
  - Initial Implementation: First steps to demonstrate compliance.
  - Monitoring/Verification: Establish an internal policy and provide staff training.
  - Documentation/Audit: Conduct regular audits to ensure these changes are maintained long-term.



Action Plan to Address Citations:

(Pursuant to AMPM 961, AMPM Policy 830(III)(A), and the Provider Participation Agreement (PPA))

• Step 1: Initial implementation- register in the AHCCCS QM Portal

Register the provider account in the AHCCCS QM Portal immediately. The first login must occur within 7 days of CAP issuance to activate the account.

☐ Provide proof of registration in the AHCCCS QM Portal.

• Step 2: Monitoring or verification — enforce timely incident reporting

Develop and enforce a policy requiring all Quality-of-Care concerns and IAD reports to be submitted to the QM Portal within 24 hours of discovery. Communicate this policy clearly to staff and perform regular audits to verify compliance.

☐ Provide internal policy outlining incident reporting procedures per AMPM 830(III)(A) and 961.

☐ Provide staff training records and attestations on QOC and IAD reporting procedures and applicable timelines.

• Step 3: Documentation or audit — establish internal reporting and training records

Create and document a clear internal reporting process for staff. Ensure regular audits by designated personnel at routine intervals to monitor regular documentation of IAD reporting and documentation.

☐ Provide audit records verifying timely and compliant incident reporting practices.

Global Program Changes

Developing/Updating Internal Policies

- Review and revise internal policies to align with AHCCCS policy, federal and state laws, rules and regulations.
- Ensure policies are accessible and communicated to all staff.

Conducting Staff Training

- Train staff on updated policies and procedures. Document training sessions and ensure staff understand their roles in maintaining compliance.

- Submit training materials, with staff attestations that include signatures with credentials of all who attended the training.

Creating an Audit Plan

- Develop an audit plan to monitor identified issues.
- Monitoring and evaluation should occur, at a minimum, on a quarterly basis to ensure ongoing compliance and improvement.

Maintaining Compliance

- Stay informed of AHCCCS updates and training opportunities. Subscribe to Claims Clues and other e-news from DFSM/AHCCCS. www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/claimsclues.html

Extension Request Process

- **When is an Extension Appropriate?**
  - Providers may request an extension if additional time is needed to submit a Corrective Action Plan (CAP) or respond to a Memo of Concern (MOC) due to unforeseen circumstances or complexity of corrective actions.

How to Request an Extension

1. When to Request an Extension
    - Providers must submit an extension request prior to the current CAP due date listed in the notification from DFSM Quality Assurance.
    - Requests submitted after the due date may not be considered.
2. How to Submit an Extension Request
    - Providers must submit extension requests via email to: DFSMQualityAssurance@azahcccs.gov.
    - The subject line should include: “Extension Request – [Provider Name & Provider ID]”

How to Request an Extension

3. Required Information in the Request Email:

   The request must include all of the following:

   a. **Proposed New Completion Date:** Provide a realistic, specific date by which all corrective actions will be fully completed.

   b. **Current Status Update:** Brief summary of actions that have been completed to date. Any work already underway.

   c. **Barriers to Completion:** Description of the circumstances preventing completion by the current deadline.

   d. **Plan to Ensure Completion:** Outline the steps the provider will take to complete the CAP within the requested extension window.

How to Request an Extension

4. DFSM Review and Response
    a. DFSM Quality Assurance will review the request and may approve, deny, or request additional information.
    b. The provider will receive a written response via email with the decision.
    c. Until an approval is issued, the original due date remains in effect.
5. Limitations
    a. Extensions are not guaranteed and are reviewed on a case-by-case basis.
    b. Repeated extension requests may result in additional oversight, follow-up, and/ or escalation.

QA CAP Closure and Reaudit

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CAP Closure Expectations:

- **CAP Closure:** Your Corrective Action Plan will only be closed once all required global program changes have been successfully submitted and accepted.
- **Ongoing Oversight:** The closure letter will confirm that AHCCCS DFSM retains the right to conduct unannounced oversight audits at your facility to monitor ongoing compliance with your corrective action plan.
- Continued compliance is essential, even after your CAP is closed, DFSM QA may conduct future audits to ensure standards are maintained.

What to Expect at Reaudit:

- **CAP Reaudit:** DFSM QA will conduct an unscheduled reaudit to assess the effectiveness of your corrective actions. The reaudit may be in-person or virtual.
- **What Happens During the Reaudit:** We will request recent member records and supporting documentation. Our team will review your documentation to ensure your updated policies, training records, and audit results have positively improved the initial deficiencies. The focus is on the specific deficiencies cited in your CAP.
- **Our Approach:** We are not looking for perfection, we understand everyone is human. The goal is to see meaningful improvement and progress toward compliance.

What Happens if the Deficiencies Remain?

If deficiencies are still present after the CAP and reaudit:

- Active & Engaged Providers: If you have been responsive and eager to improve, DFSM QA will:
  - Clearly explain which deficiencies remain.
  - Offer additional support, including a video call for technical assistance if needed.
  - May require an additional audit to review compliance.
- Poorly Responsive Providers: If you have not responded to outreach or continue to be deficient after all attempts:
  - The CAP will be escalated for further review.
  - This may result in termination of your Provider Participation Agreement (PPA).

Common CAP Issues & Submission Deficiencies

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Documentation Submission Problems

- Submitting files that are not labeled by facility and/or PID make it difficult for DFSM to verify which documentation belongs to which location, especially for providers with multiple facilities.
- **Tips:**
  - Always label each document clearly with the correct facility name and PID.
  - Send necessary action documentation in an organized manner ensuring that each is labeled with the corresponding allegation or citation.

Sending More Documentation Than Requested

- Providing excessive or unrelated documentation slows down the review process and can lead to an extended CAP. Submitting only what is requested ensures a faster and more efficient review.

- **Tips:**
  - Only send the specific documents requested in your CAP letter. Avoid adding extra materials unless explicitly asked.
  - Clearly label each document according to the CAP requirements. This helps reviewers quickly verify compliance.
  - If the review team asks for additional information, provide it quickly and in the requested format.

Common Provider Documentation Issues

- **Incomplete Documentation:** Missing required forms, signatures, or supporting evidence. Not including all pages or sections of a record (e.g., missing progress notes, incomplete treatment plans).
- **Incorrect File Formats:** Submitting files in formats that are not accepted (e.g., images instead of PDFs or Word documents). Scanned documents that are illegible or poorly formatted.
- **Unorganized or Unsorted Files:** Uploading documents in bulk without clear organization. Not grouping records by member, date, or deficiency, making review difficult.

Common Provider Documentation Issues

- **Duplicate Submissions:** Submitting the same document more than once, resulting in confusion and delays in review.
- **Outdated Documentation:** Providing superseded versions of policies, procedures, or training records rather than current documents with effective dates and authorized signatures.
- **Missing Required Identifiers:** Omitting essential information, such as member names, AHCCCS IDs, dates of birth, or facility identifiers, on each page, which impedes the audit process.
- **Lack of Audit Trails:** Failing to supply documentation of internal audits or monitoring activities.

Common Provider Documentation Issues

- **Inconsistent Naming Conventions:** Using inconsistent or unclear file names, making it hard to match documents to specific deficiencies or facilities.

- **Delayed Submission:** Waiting until after the deadline to submit documentation, risking non-compliance.

- **Failure to Adhere to Instructions:** Not following the explicit directions outlined in the CAP letter regarding required submissions, proper labeling, or designated submission methods.

Quality Assurance + Providers = Partnership for Better Care

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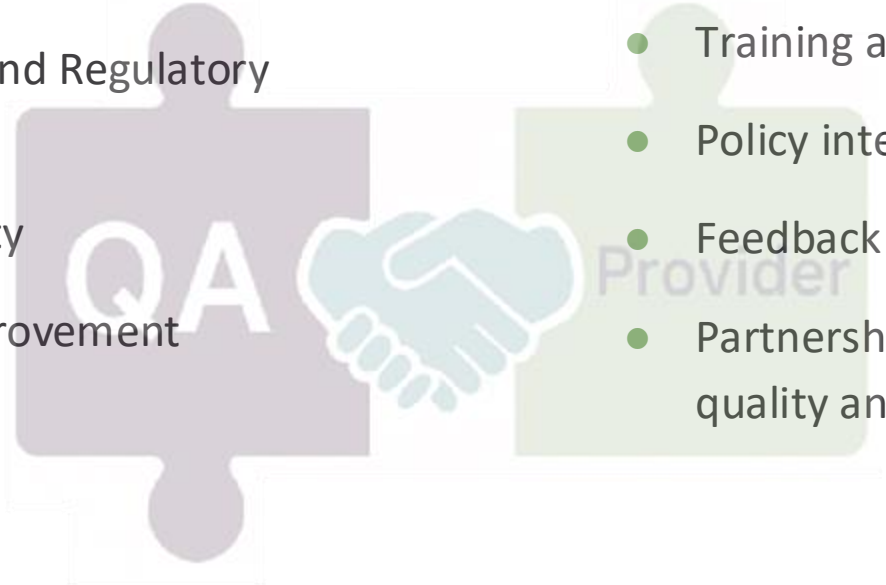
Our Shared Goals

- Member safety, respect, and dignity
- AHCCCS Policy and Regulatory compliance
- Program integrity
- Continuous improvement



How QA Supports Providers

- Clear CAP guidance and support
- Training and education resources
- Policy interpretation support
- Feedback and collaboration
- Partnership on improving care quality and outcomes

Be Our Partner!

- We are dedicated to building a true partnership with providers, working side by side to achieve our shared goals.
- By fostering open communication, mutual respect, and ongoing collaboration, we can ensure that every AHCCCS member receives safe, effective, and compliant care.
- Together, we support continuous improvement and uphold the highest standards of quality and integrity in service delivery.

Growing Together

- Every Compliance and Monitoring Plan is an opportunity for growth.
- Each audit is a step toward higher quality and safer care.
- Our partnership is the foundation for continuous improvement and success. We are committed to supporting you every step of the way.
- Thank you for your dedication to quality and for partnering with us to ensure the best outcomes for AHCCCS members.

Thank you!

Questions?

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