

CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

900	<u>CHAPTER OVERVIEW</u>	<u>900-1</u>
	DEFINITIONS	900-2
	REFERENCES	900-6
910	<u>QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM ADMINISTRATIVE REQUIREMENTS.....</u>	<u>910-1</u>
	A. QM/PI PLAN	910-1
	B. WORK PLAN	910-10
	C. QM/PI PROGRAM EVALUATION	910-10
	D. QM/PI PLAN AND EVALUATION.....	910-11
	E. QM/PI DOCUMENTATION.....	910-12
	● EXHIBIT 910-1 AHCCCS QM/PI PROGRAM CHECKLIST	
	● EXHIBIT 910-2 AHCCCS INTEGRATED HEALTH PLAN REPORT CHECKLIST	
920	<u>QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM SCOPE.....</u>	<u>920-1</u>
	A. QM/PI PROGRAM COMPONENTS	920-1
	B. QM/PI PROGRAM MONITORING AND EVALUATION ACTIVITIES	920-3
	C. IMPLEMENTATION OF ACTIONS TO IMPROVE CARE.....	920-10
	● EXHIBIT 920-1 HEALTH CARE ACQUIRED CONDITIONS, OTHER PROVIDER PREVENTABLE CONDITIONS REPORTING TOOL	
	● EXHIBIT 920-2 HEALTH AND SAFETY UPDATE IMMEDIATE JEOPARDY FORM	
	● EXHIBIT 920-3 ORGANIZATIONAL PROVIDERS APPROVED/NOT APPROVED DIRECT CARE WORKER (DCW) TRAINING AND TESTING PROGRAMS	
930	<u>MEMBER RIGHTS AND RESPONSIBILITIES.....</u>	<u>930-1</u>
940	<u>MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION</u>	<u>940-1</u>

CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

950	<u>CREDENTIALING AND RECREDENTIALING PROCESSES</u>	<u>950-1</u>
	A. OVERVIEW	950-1
	B. CREDENTIALING INDIVIDUAL PROVIDERS	950-1
	C. INITIAL CREDENTIALING	950-4
	D. TEMPORARY/PROVISIONAL CREDENTIALING	950-8
	E. RECREDENTIALING INDIVIDUAL PROVIDERS	950-11
	F. INITIAL ASSESSMENT OF ORGANIZATIONAL PROVIDERS	950-12
	G. REASSESSMENT OF ORGANIZATIONAL PROVIDERS	950-16
	H. NOTIFICATION REQUIREMENTS (LIMITED TO PROVIDERS)	950-17
	I. NOTIFICATION REQUIREMENTS (HEALTH CARE PROVIDERS, SUPPLIERS AND PRACTITIONERS).	950-18
	J. TEACHING PHYSICIANS AND TEACHING DENTISTS	950-20
	K. CREDENTIALING TIMELINES	950-21
	● EXHIBIT 950-1 AHCCCS CONTRACTOR QUARTERLY CREDENTIALING REPORT	
960	<u>TRACKING AND TRENDING OF MEMBER AND PROVIDER ISSUES</u>	<u>960-1</u>
	A. OVERVIEW	960-1
	B. DOCUMENTATION RELATED TO QUALITY OF CARE CONCERNS	960-1
	C. PROCESS OF EVALUATION AND RESOLUTION OF QUALITY OF CARE CONCERNS	960-2
	D. TRACKING AND TRENDING OF QUALITY OF CARE ISSUES	960-7
	E. PROVIDER-PREVENTABLE CONDITIONS	960-8
	● EXHIBIT 960-1 AHCCCS CONTRACTOR QUARTERLY QUALITY MANAGEMENT REPORT	
970	<u>PERFORMANCE MEASURES</u>	<u>970-1</u>
	A. OVERVIEW	970-1
	B. QUALITY RATING SYSTEM	970-3
	C. QUALITY MANAGEMENT PERFORMANCE MEASURE REQUIREMENTS	970-4

CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

980	<u>PERFORMANCE IMPROVEMENT PROJECTS (PIPS)</u>	<u>980-1</u>
	A. OVERVIEW	980-1
	B. PERFORMANCE IMPROVEMENT PROJECTS (PIPS) DESIGN.....	980-1
	C. DATA COLLECTION METHODOLOGY	980-2
	D. MEASUREMENT OF DEMONSTRABLE IMPROVEMENT	980-2
	E. PERFORMANCE IMPROVEMENT PROJECTS (PIPS) TIMEFRAMES.....	980-3
	F. PERFORMANCE IMPROVEMENT PROJECTS (PIPS) REPORTING REQUIREMENTS ..	980-4
	● EXHIBIT 980-1 AHCCCS PERFORMANCE IMPROVEMENT PROJECT (PIP) PROTOCOL	
	● EXHIBIT 980-2 AHCCCS PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE	
990	<u>REPORTING REQUIREMENTS</u>	<u>990-1</u>



900 CHAPTER OVERVIEW

REVISION DATES: 10/01/15, 10/01/13, 04/01/12, 02/01/11, 10/01/09, 10/01/08, 02/01/07,
04/01/05, 05/01/04, 08/13/03, 10/01/01, 10/01/97

INITIAL

EFFECTIVE DATE: 10/01/1994

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 Arizona Department of Child Safety (DCS) Comprehensive Medical and Dental Plan (DCS/CMDP), the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS), and the Children's Rehabilitative Services (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 established processes including:
 - a. Monitoring and evaluating the Contractor service delivery system and provider network, as well as its own processes for quality management and performance improvement,
 - b. Implementing actions and activities to correct deficiencies and improve the quality of care and services provided to enrolled members, and
 - c. Initiating performance improvement projects to improve outcomes and systems and to address trends identified through monitoring activities including, but not limited to:
 - i. Complaint reviews
 - ii. Grievance reviews
 - iii. Quality of care reviews
 - iv. Provider credentialing, re-credentialing
 - v. Profiling reviews
 - vi. Utilization management reviews
 - vii. On-site reviews



2. Comply with Federal, State and AHCCCS requirements.
3. Ensure coordination with Federal and State registries and community programs.
4. Ensure the Contractor's executive and management staff actively participates in 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.
6. Ensure that the development and implementation of quality management and performance improvement activities include input from members and their families and/or guardians.
7. Ensure that the development and implementation of quality management and performance improvement activities include input from stakeholders.
8. Identify and implement evidence-based 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. **Adverse Action** - any type of restriction placed on a provider's practice by the Contractor such as but not limited to contract termination, suspension, limitation, continuing education requirement, monitoring or supervision.
2. **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.
3. **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.
4. **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 by the Contractor.
5. **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.

6. **Corrective Action Plan (CAP)** – a written work plan that includes goals and objectives, steps to be taken and methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance QM/PI activities and the outcomes of the activities, or to resolve a deficiency.
7. **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.
8. **Demonstrable Improvement** – the projected percentage of performance improvement submitted as a part of the Contractor’s Performance Improvement Project (PIP) proposal and approved by AHCCCS for the project outcome.
9. **Federally Qualified Health Care Centers (FQHC)** – facilities or programs also known as Community Health Centers, Rural Health Centers (RHC), FQHC Look-Alikes, 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.
10. **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.



11. **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, such as rudeness of a provider or employee, or
 - c. Failure to respect the member’s rights.
12. **Health Care Acquired Conditions (HCAC)** – means a Hospital Acquired Condition (HAC) which occurs in any inpatient hospital setting and is not present on admission (Refer to the current CMS list of Hospital-Acquired Conditions).
13. **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.
14. **High Volume Specialist** – specialist with 50 or more unique member referrals per contract year.
15. **Long Term Supports and Services (LTSS) Providers** – individuals that provide the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.
16. **Measurable** – the ability to determine definitively whether or not a quantifiable objective has been met, or whether progress has been made toward a positive outcome.
17. **Methodology** – the planned documented process, steps, activities or actions taken by a Contractor to achieve a goal or objective, or to progress toward a positive outcome.
18. **Monitoring** – the process of auditing, observing, evaluating, analyzing and conducting follow-up activities, and documenting results via desktop or on-site review.
19. **Objective** – a measurable step, generally one of a series of progressive steps, to achieve a goal.



20. **Peer Review** – evaluating the necessity, quality or utilization of care/service provided by a health care professional/provider. Peer review is conducted by 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.
21. **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.
22. **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 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.
23. **Serious Incident** - care or services that resulted in or had the potential to or resulted in harm or an adverse outcome or was a potential risk to the health and safety of an AHCCCS member.
24. **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.
25. **Work Plan** – addresses all the requirements of Chapter 900, Policy 920-A and AHCCCS-suggested guidelines and supports the Contractor’s QM/PI goals and objectives with measureable goals (SMART), timelines, methodologies and designated staff responsibilities. The work plan must include measureable physical, behavioral and oral 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
4. 42 C.F.R. 438.214 (Credentialing and Recredentialing)
5. SEC. 1128E. (42 U.S.C. 1320 A-7E)
6. 42 C.F.R. 438.230 (Delegation)
7. 42 C.F.R. 438.240 (Quality Assurance and Performance Improvement)
8. 42 C.F.R. 438.242 (Health Information System)
9. 45 C.F.R. Part 164 (Security and Privacy)
10. 42 C.F.R. Part 447.26 (Health Care Acquired Conditions)
11. Arizona Revised Statutes (A.R.S.) § 36-441 (Utilization Committee Materials Not Subject to Discovery with Certain Exceptions)
12. A.R.S. § 36-445 (Physician in Hospital or Centers to Have Committees to Review Professional Practices)
13. 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)
14. A.R.S. §§ 36-2903, 36-2932, 36-2986 (Duties of the Administration)
15. A.R.S. § 36-2917 (Review Committees)
16. Title 9 of the Arizona Administrative Code, Chapter 22 (9 A.A.C. 22), Article 5 (General Provisions and Standards)
17. 9 A.A.C. 22, Article 12 (Behavioral Health, General Provisions and Standards for Service Providers)



18. 9 A.A.C. 28, Article 5 (Program Contractor and Provider Standards, General Provisions and Standards)
19. 9 A.A.C. 28, Article 11 (Behavioral Health Services, General Provisions and Standards for Service Providers)
20. 9 A.A.C. 31, Article 5 (General Provisions and Standards)
21. 9 A.A.C. 31, Article 12 (Behavioral Health Services, General Provisions and Standards for Service Providers)
22. CMS State Medicaid Manual
23. 9 A.A.C. 34 (Grievance System), and
24. AHCCCS Contracts.



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

REVISION DATES: 07/01/16, 10/01/15, 10/01/13, 04/01/12, 02/01/11, 10/01/09, 10/01/08,
02/01/07, 01/01/06, 04/01/05, 08/13/03, 10/01/01, 10/01/97

INITIAL
EFFECTIVE DATE: 10/01/1994

A. QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT PLAN

Each Contractor must develop a written Quality Management/Performance Improvement (QM/PI) Plan that addresses the Contractor's proposed methodology to meet or exceed the standards and requirements of the contract and this Chapter. Contractors that are contracted with AHCCCS for more than one line of business must submit a separate plan for each line of business. The QM/PI plan must describe how program activities will improve the quality of care, service delivery, and satisfaction for enrolled members. The QM/PI Plan, and any subsequent modifications, must be submitted to the 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 include, 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. The governing or policymaking 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, Provider Relations, Grievance and Appeals, Fraud, Waste and Abuse, and Case Management.
 - b. A description of the Contractor's administrative structure for oversight of its QM/PI Program as required by Policy 910, Section C 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 Peer Review Committee
 - v. The Credentialing Committee
 - vi. The Contractor's Executive Management, and



- vii. QM/PI Program staff.
 - c. An organizational chart that shows the reporting relationships for QM/PI activities and the percent of time dedicated to the position for each line of business. This chart must also show direct oversight of QM/PI activities by the local Medical Director and the implemented process for reporting to Executive Management.
 - d. Documentation that the Board of Directors and in the absence of a Board the executive body has reviewed and approved the Plan.
 - e. Documentation that the Board of Directors and in the absence of a Board the executive 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 local (Arizona) 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 local 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, and
 - v. Appropriate clinical representatives.
 - b. The local Medical Director is responsible for implementation of the QM/PI Plan and must have substantial involvement in the implementation, assessment and resulting 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, at a minimum, quarterly or more frequently. The frequency of committee meetings must be sufficient to monitor all program requirements and to monitor any required actions.



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 910

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

- e. The QM/PI Committee must review the QM/PI Program objectives, policies and procedures as specified in contract and must modify or update the policies when processes/activities are changed substantially. 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, utilization data such as performance improvement, prescribing practices, emergency room (ED) utilization, etc.).
 - i. When deficiencies are noted, the QM/PI Committee meeting minutes must clearly document discussions of the following:
 - i. Identified issues
 - ii. Responsible party for interventions or activities
 - iii. Proposed actions
 - iv. Evaluation of the actions taken
 - v. Timelines including 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, both individual and organizational 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 whether delivered in or out of state. 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.
 - 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 case is being reviewed.
- e. Peer Review Committee members shall sign (may be an electronic signature) 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. The Peer Review Committee 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. Adverse actions taken as a result of the Peer Review Committee must be reported to AHCCCS within 24 hours of an adverse decision being made.
- h. The Peer Review Committee is responsible for making appropriate recommendations for the Contractor's Medical Director to make referrals to the Department of Child Safety, Adult Protective Services, the Department of Health Services, Licensure Unit, the appropriate regulatory agency or board and AHCCCS for further investigation or action. Notification must occur when the Peer Review Committee determines care was not provided according to the medical community standards. Initial notification may be verbal but must be followed by a written report to AHCCCS within 24 hours.
- i. Peer Review Committee 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



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 910

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

Committee reports, meetings, minutes, 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.
 - n. Matters appropriate for peer review may include, but are not limited to:
 - i. Cases where there is evidence of deficient quality,
 - ii. An omission of the care or service provided by a participating or non-participating physical health care or behavioral health care provider,
 - iii. Questionable clinical decisions, lack of care and/or substandard care,
 - iv. Inappropriate interpersonal interactions or unethical behavior, physical, psychological, or verbal abuse of a member, family, staff, or other disruptive behavior,
 - v. Allegations of criminal or felonious actions related to practice,
 - vi. Issues that immediately impact the member and that are life threatening or dangerous,
 - vii. Unanticipated death of a member; issues that have the potential for adverse outcome, or
 - viii. Allegations from any source that bring into question the standard of practice.
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 or delegated entities are used. Policies and procedures must demonstrate:
- a. Staff qualifications including education, certifications, experience and training for each QM/PI position.



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 910

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

- b. A current organizational chart which demonstrates the reporting structure, responsibilities, number of full time and part time positions, and their percent of time by line of business for the QM/PI Program.
- c. The Contractor's Quality Management Coordinator must attend AHCCCS Contractor meetings unless attendance is specified as optional 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
 - vi. AHCCCS may require Contractor participation in specific community initiatives and collaborations
 - vii. Long-term care

NOTE: AHCCCS sponsored activities are not considered community initiatives or 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 the Quality Management Unit. This training must be provided during new employee orientation and, at a minimum, 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 910, Sections C, D and E must be met for all delegated functions. Accredited agencies must be included in the Contractor's oversight process.
- 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. Examples 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 allegations of quality of care and



- quality of service issues. Quality of care or service investigation and resolution processes may not be delegated.
- 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,
 - ii. Review of policies and procedures and the implementation of them, and
 - iii. Documented evaluation and determination that the entity is able to effectively perform the delegated activities.
 - d. Prior to delegation, a written contract must be established 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 provided are monitored on an ongoing basis and are annually reviewed by the Contractor. Annually, the Contractor must review a minimum of 30 randomly selected files per line of business 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,
 - iii. Quality of care concerns, and
 - iv. Complaints.
 - 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,
 - iii. Corrective action plans, and
 - iv. Appropriate follow up of the implementation of corrective action plans to ensure quality and compliance with AHCCCS requirements for all delegated activities or functions are met.
6. Chapter 900 Requirements – The Contractor shall have policies and procedures to describe the implementation of the following:
- a. The Contractor's method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with Policy 920, Section B of this chapter.



- b. 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. 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.
- e. The Contractor's process for grievance resolution, tracking and trending that meets standards set in Policy 960 of this Chapter and 42 CFR 438.242 *et seq.*
- f. Documentation of the Contractor's planned activities to meet or exceed AHCCCS-mandated performance measures minimum performance standards 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. 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 transition to an integrated program, and all medication prescribed.
- j. The comprehensive and coordinated delivery of integrated services including administrative and clinical integration of health care service delivery. Integration strategies and activities shall focus on improving individual health outcomes, enhancing care coordination and increasing member satisfaction.



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 910

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

NOTE: The RBHA and CRS Contractors shall submit an Integrated Health Plan Report as specified in Contract. See Exhibit 910-2 for associated checklist.

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 CFR 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, by line of business, to ensure that:
 - a. Information/data received from providers is accurate, timely and complete.
 - b. Reported data is reviewed for accuracy, completeness, logic and consistency, and the review and evaluation processes used are clearly documented.
 - c. Information rejected must be tracked to ensure errors are corrected and the data is resubmitted and accepted.
 - d. All member and provider information protected by Federal and State law, regulations, or policies is kept confidential.
 - e. 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 by line of business that includes all requirements of Policy 920, Section A 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, but not limited to, the following information:

1. A description of all planned goals and objectives for both clinical care and Contractor monitoring of access and availability of covered services. Once a goal has been achieved and sustained, the Contractor must identify new goals based on data, member/provider input, etc.
2. Targeted implementation and completion dates of work plan activities.
3. Methodologies, strategies and specific measurable interventions to accomplish objectives.
4. Measurable behavioral health goals and objectives.
5. Assigned local staff positions responsible and accountable for meeting established goals and objectives.

NOTE: The Contractor must review its work plan at least quarterly. If activities and interventions are not meeting the goals and objectives, the Contractor must revise its work plan and develop new strategies aimed at achieving the goals.

C. QM/PI PROGRAM EVALUATION

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

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



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 910

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

- e. An evaluation of baseline data and outcomes utilizing qualitative and quantitative data which must include a statement describing if goals/objectives were met or not met,
- f. A description of how the sustained goal/objective is incorporated into the Contractor's business practice (institutionalized). The Contractor is expected to develop new goals and objectives once a goal or objective has been sustained,
- g. Actions to be taken for the improvement of Corrective Action Plan (CAP),
- h. Documentation of continued monitoring to evaluate the effectiveness of the actions (interventions) and other follow up activities,
- i. Rationale for changes in the scope of the QM/PI program or documentation indicating if no changes were made.
- j. Necessary follow-up with targeted timelines for revisions made to the QM/PI plan, and
- k. Documentation of QM/PI Committee review, evaluation and approval of any changes to the QM/PI plan.
- l. 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 by line of business, 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,
3. QM/PI Evaluation,
4. Maternity Care Plan and associated work plans and evaluations, as described in Exhibit 400-2,



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 910

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

5. EPSDT Plan and associated work plans and evaluations, as described in Exhibit 400-2,
6. Oral Health Plan and associated work plans and evaluations, as described in Exhibit 400-2
7. PIP Interim Report(s),
8. Quality Management Plan Checklist (see Exhibit 910-1), and
9. 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 Quality Management and Performance Improvement (QM/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. Processes/desktop procedures,
5. Standards,
6. Worksheets,
7. Meeting minutes,
8. Corrective Action Plans (CAPs), and
9. Other information and data appropriate to support changes made to the scope of the QM/PI Plan or Program.

EXHIBIT 910-1

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
QUALITY MANAGEMENT/QUALITY IMPROVEMENT (QM/PI)
PROGRAM CHECKLIST**

EXHIBIT 910-1
QM/PI PLAN PROGRAM CHECKLIST
CONTRACTOR: [CLICK HERE TO ENTER TEXT.](#)

ACUTE ALTCS FIRST ROUND SECOND ROUND

BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
PROGRAM EVALUATION				
Instructions: The Contractor must formally evaluate and document the effectiveness of the QM/PI Program strategy and activities. This QM/PI Program Evaluation must be done at least annually and include the following:				
BBA: 438.240(e)(1)(i) BBA: 438.240(e)(2) AMPM: 910-C-1-k	1. 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.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-C-1-a,b,c,d, f	2. 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 e. Action to be taken for improvement - Corrective Action Plan (CAP)		<input type="checkbox"/>	
BBA: n/a AMPM: 910-C-g	3. Documentation of continued monitoring to evaluate the effectiveness of the actions of interventions and other follow-up activities.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-C-e	4. An evaluation of outcomes utilizing qualitative data, including a statement describing if goals/objectives were met completely, partially or not at all.		<input type="checkbox"/>	
BBA: n/a AMPM: 900-1-c	5. Trends identified through QM/PI activities and resulting actions taken for improvement.		<input type="checkbox"/>	
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).		<input type="checkbox"/>	
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.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-C-1-i	8. Necessary follow-up with targeted timelines for revisions made to the QM/PI Plan. If no changes were made, include a statement that no changes were made.		<input type="checkbox"/>	

**EXHIBIT 910-1
QM/PI PLAN PROGRAM CHECKLIST**

BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
WORK PLAN				
Instructions: The Contractor must develop an annual work plan that supports the Contractor’s QM/PI goals and objectives. This Work Plan must be submitted with the QM/PI Plan and must include the following:				
BBA: n/a AMPM: 910-B-1 AMPM: 920-A-2-a	9. A description of all planned goals and objectives for both clinical care and other covered services.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-B-2 AMPM: 920-A-2-b	10. Targeted implementation and completion dates for QM measurable objectives, activities and PI projects.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-B-3 AMPM: 920-A-2-c	11. Methodologies and activities to accomplish measurable goals and objectives.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-B-4 AMPM: 920-A-2-d	12. The inclusion of behavioral health goals and objectives.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-B-5 AMPM: 920-A-2-e	13. Staff positions responsible and accountable for meeting established goals and objectives.		<input type="checkbox"/>	
BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
PROGRAM DESCRIPTION				
Instructions: The Contractor must develop a written QM/PI Plan that addresses the Contractor’s proposed methodology to meet or exceed the standards and requirements of AMPM Chapter 900. The Program Scope must be comprehensive and demonstrate how the Contractor’s activities will improve the quality of services and the continuum of care in all service sites. The QM/PI Plan must be in paginated detail and include the following: *Note: If the descriptions and processes are only included in referenced QM/PI Plan policies, please include the policies.				
BBA: n/a AMPM: 910-A AMPM: 920-B-2	14. Description of how program activities will improve the quality of care and service delivery for enrolled members.		<input type="checkbox"/>	
BBA: 438.202(b) AMPM: 900-5	15. A description of how the QM/QI Program must include input from employed or affiliated providers and consumers (BBA requirement).		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-1-a	16. A description of how the Contractor will ensure ongoing communication and collaboration between the QM/PI Program and the other functional areas of the organization (such as, but not unlimited to:		<input type="checkbox"/>	

**EXHIBIT 910-1
QM/PI PLAN PROGRAM CHECKLIST**

BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
	medical management, behavioral health, member services and case management).			
BBA: n/a AMPM: 910-A-1	17. 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.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-1-b	18. The roles and responsibilities of the governing body or policy making body, the Medical Director, the QM/PI Committee, the Contractors executive management and the QM/PI Program staff.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-1-c	19. An organizational chart that delineates the reporting channels for QM/PI activities and the relationship to the Contractor Medical Director and Executive Management.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-2-a-(i-v)	20. The membership for the Contractor's QM/PI Committee which must include, at a minimum the: <ul style="list-style-type: none"> a. Medical Director, or the Associate Medical Director when the Medical Director is unable to attend, as the chairperson of the Committee b. QM/PI Manager c. Representation from the functional areas within the organization d. Representation of contracted or affiliated providers serving AHCCCS members e. Appropriate clinical representatives. 		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-2-b	21. A description of how the local Medical Director is responsible for implementation of the QM/PI Plan and how he/she has substantial involvement in the assessment and improvement of QM/PI activities.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-2-d	22. The Contract must have an identifiable, structured QM/PI Committee that is responsible of QM/PI functions and responsibilities. There must be a description of how often the QM/PI Committee will meet. The Committee must meet quarterly or more frequently		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-2-e	23. A description of how the QM/PI Committee will review the QM/PI Program objectives, policies, and procedures at least annually and modify or update them as necessary.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-2-f	24. A description of how the QM/PI Committee will develop procedures for QM/PI responsibilities and the processes of how each QM/PI function and activity will be clearly documented.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-2-g	25. A description of how the QM/PI Committee will develop and implement procedures to ensure that Contractor staff and providers are informed of the most current QM/PI requirements, policies, and procedures.		<input type="checkbox"/>	

**EXHIBIT 910-1
QM/PI PLAN PROGRAM CHECKLIST**

BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
BBA: n/a AMPM: 910-A-2-h	26. A description of how the QM/PI Committee will 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.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-3	27. A description of the Contractor's peer review process of which the purpose is to improve the quality of medical care provided to members by practitioners and providers by analyzing and addressing clinical issues.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-4-e	28. A process to ensure that staff having contact with members or providers such case managers, customer service, provider relations, and 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.		<input type="checkbox"/>	
BBA: n/a AMPM: 920-B-3	29. A description of how information and data gleaned from QM monitoring and evaluation that shows trends in quality of care issues may be used in developing PI projects.		<input type="checkbox"/>	
BBA: n/a AMPM: 920-C-1-(a-b)	30. A description of how the Contractor will develop work plans for taking appropriate actions to improve care if problems are identified. This description must specify: a. The types of problems that require correction action b. The person or body responsible for making the final determination regarding quality issues.			
BBA: n/a AMPM: 920-C-1-c-(i-vi)	31. The work plan must include a description of member/provider action(s) to be taken: education, technical assistance, monitoring, evaluation, change in processes, counseling, termination, referrals, etc. (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	32. Work plan/corrective action plan must include documentation of the assessment and effectiveness of actions taken.			
BBA: n/a AMPM: 920-C-1-(e-f)	33. Detailed methods for internal dissemination of findings and resulting work plans to appropriate staff and/or network providers, and methods of dissemination of pertinent information to AHCCCS Administration and/or regulatory boards and agencies.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-5	34. 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.		<input type="checkbox"/>	

**EXHIBIT 910-1
QM/PI PLAN PROGRAM CHECKLIST**

BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
BBA: n/a AMPM: 960-D-2	35. A description of the process by which the delegated entity or subcontractor reports incidences of healthcare acquired conditions, abuse, neglect, exploitation, injuries, and unexpected death to the Contractor.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-5-b	36. A description of how the Contractor will include information from delegated entities for purposes of tracking, trending, reporting, process improvement, and re-credentialing.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-5-c	37. A description of how the Contractor will evaluate an entity's ability to perform the delegated activities prior to delegation.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-5-e-(i-iii)	38. A process to review and monitor the performance of the entity (including accredited agencies) 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.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-6-a	39. A description of the Contractor's method(s) for monitoring and evaluating its service delivery system and provider network.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-6-d	40. A description of the Contractor's initial credentialing process for individual providers.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-6-d	41. A description of the Contractor's re-credentialing process for individual providers which includes provider profiling.		<input type="checkbox"/>	
BBA: n/a AMPM: 950-B	42. Providers who are not licensed or certified must be included in the credentialing process and profiled.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-6-d	43. A description of the Contractor's initial assessment of organizational providers contracted with the Contractor.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-6-d	44. A description of the Contractor's initial re-assessment of organizational providers contracted with the Contractor.		<input type="checkbox"/>	
BBA: n/a AMPM: 950-F-6	45. A description of how the Contractor will ensure behavioral health residential placement settings are profiling behavioral health technicians and behavioral health paraprofessional staff.			
BBA: n/a AMPM: 910-A-6-d AMPM: 950-D	46. A description of the Contractor's temporary/provisional credentialing process for individual providers. Contractor's must have policies and procedure to address granting of temporary/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.		<input type="checkbox"/>	

**EXHIBIT 910-1
QM/PI PLAN PROGRAM CHECKLIST**

BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
BBA: n/a AMPM: 950-B-3	47. 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.		<input type="checkbox"/>	
BBA: n/a AMPM: 950-B-3	48. The QM/PI committee or other peer review body is responsible for over-site regarding delegated credentialing or re-credentialing decisions.		<input type="checkbox"/>	
BBA: n/a AMPM: 950-B-4-a	49. Policies must reflect the direct responsibility of the Medical Director (or designee) for the oversight of the process and delineate the role of the credentialing committee.		<input type="checkbox"/>	
BBA: n/a AMPM: 950-B-4-b	50. Written policies must indicate the utilization of participating Arizona Medicaid network providers in making credentialing decisions.		<input type="checkbox"/>	
BBA: n/a AMPM: 950-D	51. The Contractor must follow the primary source verification process of initial credentialing when granting temporary/provisional credentialing. Providers working in a Federally Qualified Health Center (FQHC) – or look-a-like, as well as hospital employed physicians must be credentialed using the temporary/provisional credentialing process.		<input type="checkbox"/>	
BBA: n/a AMPM 950-D	52. The Contractor must review and approve that provider through the credentialing committee. The contractor must render a decision regarding temporary/provisional credentialing within 14 calendar days from receipt of a complete application.		<input type="checkbox"/>	
BBA: n/a AMPM: 950-F	53. Description of the process used by the Contractor that ensures that, prior to contracting and credentialing, the subcontractor or delegated entity has established policies and procedures that meet AHCCCS requirements.		<input type="checkbox"/>	
BBA: n/a AMPM: 960-A	54. Each Contractor must develop 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).		<input type="checkbox"/>	
BBA: n/a AMPM: 960-B-1	55. There must be documentation of each concern raised, when and from whom it was received and the projected time frame for resolution.		<input type="checkbox"/>	

**EXHIBIT 910-1
QM/PI PLAN PROGRAM CHECKLIST**

BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
BBA: n/a AMPM: 960-B-2-(a-d)	56. A description of how the Contractor will determine of whether an issue is to be resolved through the Contractor's established <ul style="list-style-type: none"> 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. 		<input type="checkbox"/>	
BBA: n/a AMPM: 960-B-3	57. Acknowledgement of 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.		<input type="checkbox"/>	
BBA: n/a AMPM: 960-B-4	58. Assisting the member or provider as needed in completing forms or taking other necessary steps to obtain resolution of the issue.		<input type="checkbox"/>	
BBA: n/a AMPM: 960-B-5	59. Ensuring confidentiality of all member information.		<input type="checkbox"/>	
BBA: n/a AMPM: 960-B-6	60. Informing the member or provider of all applicable mechanisms for resolving the issue external of the Contractor process		<input type="checkbox"/>	
BBA: n/a AMPM: 960-B-7	61. Documenting all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance and appeal.		<input type="checkbox"/>	
BBA: n/a AMPM: 960-C-1-(a-f)	62. Contractors must develop and implement policies and procedures that address analysis of quality of care issues through: <ul style="list-style-type: none"> a. Identification of the quality of care issue. b. Initial assessment of the severity of the quality of care issues. 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) e. Research, including but not limited to: a review of the log of events, documentation of conversation, and medical record review. f. Quantitative and qualitative analysis of the research. 		<input type="checkbox"/>	

**EXHIBIT 910-1
QM/PI PLAN PROGRAM CHECKLIST**

BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
BBA: n/a AMPM: 960-C-2-(a-e)	63. The Contractor must have a process to assure that action is taken when needed by: <ul style="list-style-type: none"> 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 QM program if successful. e. Assigning new intervention/approaches when necessary. 		<input type="checkbox"/>	
BBA: n/a AMPM: 960-C-3	64. A process to provide resolution of the issue. Member and system resolutions may occur independently from one another.		<input type="checkbox"/>	
BBA: n/a AMPM: 960-C-4	65. A process to determine the level of substantiation and the severity level for each allegation.		<input type="checkbox"/>	
BBA: n/a AMPM: 960-C-5	66. A description of how the Contractor will notify the appropriate regulatory agency and/or AHCCCS of quality of care issues for further research/review or action.		<input type="checkbox"/>	
BBA: n/a AMPM: 960-C-6	67. A process to refer the issue to the Contractor’s peer review committee when appropriate.		<input type="checkbox"/>	
BBA: n/a AMPM: 960-C-7	68. A description of how the Contractor will report to AHCCCS CQM Unit, when adverse action is taken with a provider due to a quality of care concern.		<input type="checkbox"/>	
BBA: n/a AMPM: 960-C-8	69. A process of how the Contractor determines the level of substantiation.		<input type="checkbox"/>	
BBA: n/a AMPM: 960-C-9	70. A process of 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		<input type="checkbox"/>	
BBA: n/a AMPM: 960-C-10-(a-b)	71. A process for documenting the criteria and process for closure of the review including but not limited to: <ul style="list-style-type: none"> a. A description of the problem, 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. 		<input type="checkbox"/>	

**EXHIBIT 910-1
QM/PI PLAN PROGRAM CHECKLIST**

BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
BBA: n/a AMPM: 960-D-1-a	72. A description of how the Contractor will track and trend quality of care issues for quality improvement.		<input type="checkbox"/>	
BBA: 488.242(b)(3) AMPM: 910-A-7	73. 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.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-6-c	74. A description of how the contractor will ensure medical records and communication of clinical information for each member reflect all aspects of member care, including ancillary and behavioral health services.		<input type="checkbox"/>	
BBA: n/a AMPM: 940-2-(a-c)	75. Contractors must implement appropriate policies and procedures to ensure that the organization and its providers have information required for: <ul style="list-style-type: none"> a. Effective and continuous member care through accurate medical record documentation of each member's health status, changes in health status, health care needs and health care services provided. b. Quality review. c. An ongoing program to monitor compliance with those policies and procedures. 		<input type="checkbox"/>	
BBA: n/a AMPM: 940-3-b	76. 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 of each enrolled member, is well organized and kept up to date.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-6-c	77. Policies must address processes for digital (electronic) signatures when electronic documents are utilized.		<input type="checkbox"/>	
BBA: n/a AMPM: 940-3-c	78. A member may have numerous medical records kept by various health care providers however, the Primary Care Provider must maintain a comprehensive record.		<input type="checkbox"/>	
BBA: n/a AMPM: 940-3-d	79. The QM Program implements policies and procedures that include requirements of PCPs referrals to, coordination of care with, and transfer of care to Behavioral Health providers.		<input type="checkbox"/>	
BBA: n/a AMPM: 910-A-6-b	80. A description of how members' rights and responsibilities are defined, implemented, and monitored.		<input type="checkbox"/>	

**EXHIBIT 910-1
QM/PI PLAN PROGRAM CHECKLIST**

BBA AND AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
PERFORMANCE IMPROVEMENT				
BBA: n/a AMPM: 910-A-6-f	81. A description of how the Contractor's planned activities will meet or exceed AHCCCS mandated performance measures and performance improvement project goals.		<input type="checkbox"/>	
BBA: 438.240(e)(1)(i) BBA: 438.240(a) BBA: 438.240(b) BBA: 438.240(c)(1-3) AMPM: 970-B-d-i	82. 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.		<input type="checkbox"/>	
BBA: n/a AMPM: 970-B-1-b-(i-v)	83. 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.		<input type="checkbox"/>	
BBA: 438.240(a)(1) BBA: 438.240(b)(1) BBA: 438.240(d)(1) BBA:438.240(e)(1)(ii) BBA: 438.240(e)(2) AMPM: 970-B-1-(i-vii)	84. 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.		<input type="checkbox"/>	
BBA: 438.240(e)(1) BBA: 438.240(d)(2) AMPM: 980-B-(1-2)	85. 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).		<input type="checkbox"/>	
AMPM: 950-E-3. f.	86. For Contractors that implement Enhanced Payment Models (Value Based Payment Models) will report annually to AHCCCS quality metric results at least annually. The metrics will include number of members , percentage of members impacted by VBPM and bucketed in the following categories: Fee-For-Service; Centers of Excellence including primary care incentives; performance based contracts; Centers of Excellence with bundled/episode payments; and for Accountable Care Programs they will include shared savings; shared risk and capitation plus performance based contracts (PBC).		<input type="checkbox"/>	

EXHIBIT 910-2

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INTEGRATED HEALTH PLAN REPORT CHECKLIST**

**EXHIBIT 910-2
INTEGRATED HEALTH PLAN REPORT CHECKLIST**

CONTRACTOR: [CLICK HERE TO ENTER TEXT](#)

CRS (FULLY INTEGRATED) RBHA FIRST ROUND SECOND ROUND

AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (INTEGRATION)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
PROGRAM EVALUATION				
<p>Instructions: The Contractor must formally evaluate and document their plan for integrated behavioral and physical health care. This annual report must include, but is not limited to:</p>				
Evaluation of Previous Year's Plan				
1. An evaluation of the previous year's activities, including stakeholder interviews and experiences, trends identified through INTEGRATION activities, and resulting actions taken for improvement.		<input type="checkbox"/>		
2. Rationale for changes in the scope of the INTEGRATION Program and Plan (and when reported to AHCCCS).		<input type="checkbox"/>		
Narrative and Work Plan - Current Year				
3. Summary of all INTEGRATION activities: <ul style="list-style-type: none"> a. Title/name of each activity b. Timelines c. Measurable goals and/or objective(s) related to each activity d. Contractor departments or units and staff positions involved in integration activities e. Description of communications and feedback related to INTEGRATION data and activities 		<input type="checkbox"/>		
4. Documentation of continued monitoring to evaluate the effectiveness of integration, including data related to the following member-related system outcomes: <ul style="list-style-type: none"> a. Chronic healthcare needs and/or disease management b. ER visits c. Hospital readmission rates d. Justice involvement e. Homelessness f. SMI Opt-out requests g. SMI Opt-outs accepted h. Access to and utilization of primary and specialty care 		<input type="checkbox"/>		

**EXHIBIT 910-2
INTEGRATED HEALTH PLAN REPORT CHECKLIST**

AMPM SECTION	CHAPTER 900 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (INTEGRATION)	LOCATION, PAGE # & PARAGRAPH	ACCEPTED	EXPLANATION IF NOT ACCEPTED
Narrative and Work Plan - Current Year (continued)				
5. Documentation of continued monitoring to evaluate the effectiveness of integration, including data and/or activities related to the following: <ul style="list-style-type: none"> a. Housing waitlist time b. Employment rates c. Hospital discharge planning and coordination including member outcomes for follow-up care d. Coordinated communication among providers 		<input type="checkbox"/>		
6. Summary and timeline of short-term (6-12 months) and long-term (>13 months) INTEGRATION strategies, including methodologies.		<input type="checkbox"/>		
7. Summary of targeted outreach including but not limited to : <ul style="list-style-type: none"> a. High-risk members b. American Indians members c. Homeless members d. Members with substance use disorders e. Veterans 		<input type="checkbox"/>		



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

REVISION DATES: 10/01/15, 03/01/14, 10/01/13, 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 (Quality Management/Performance Improvement) 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 goals and objectives for both clinical care and other covered services,
 - b. Targeted implementation and completion dates for quality management measurable objectives, activities and performance improvement projects,
 - c. Methodologies and activities to accomplish measurable goals and objectives,
 - d. The inclusion of measurable behavioral health goals and objectives,
 - e. 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. All Contractors are required to conduct a new member health risk assessment. Contractors must develop and implement a process to ensure that a "best effort" attempt has been made to conduct an initial health assessment of each member's health care needs including follow up on unsuccessful attempts to contact a member within 90 days of the effective date of enrollment. Documentation of each attempt must be documented. Contractors must develop processes to utilize



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 920

QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM

SCOPE

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).

- 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 Behavioral Health Contractors/providers must have first contact with referred or enrolled members.
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) who is formally designated as having primary responsibility for coordinating the member's overall health care. The PCP must coordinate care for the member including coordination with the behavioral health medical professional,
 - 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, 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
 - 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 but not limited to, other Contractors/insurers 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).
7. Contractors are required to maintain records and documentation as required under State and Federal law.

B. QM/PI PROGRAM MONITORING AND EVALUATION ACTIVITIES

1. If collaborative opportunities exist to coordinate organizational monitoring, the lead Contractor must coordinate and ensure that all requirements in the collaborative arrangement are met.
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, injuries (e.g. falls and fractures),



exploitation, healthcare acquired conditions, and or unexpected death as soon as the providers are aware of the incident.

5. The Contractor must report all incidents of abuse, neglect, exploitation, and unexpected deaths to the AHCCCS Clinical Quality Management Unit as soon as the Contractor is aware of the incident. Contractors are expected to investigate and report case findings, including identification of organizational providers, individual providers, paid caregivers, or the specific individual rendering the service.
6. Contractors must report identified quality of care, reportable incidents and/or service trends to the AHCCCS Clinical Quality Management Unit immediately upon identification of the trend, including trend specifications such as providers, facilities, services, and allegation types.
7. Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC) must be reported to the AHCCCS Clinical Quality Management Unit on a quarterly basis utilizing the template in Exhibit 920-1. Contractors are expected to investigate and maintain case files that contain findings.
8. Contractors must incorporate the ADHS licensure and certification reports and other publicly reported data in their monitoring process, as applicable.
9. Contractor quality of care trend reports must be incorporated into monitoring and evaluation activities. Policies and procedures must be adopted to explain how the process is routinely completed.
10. Contractors are responsible for ensuring health and safety of members in placement settings or service sites 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 placement settings or service sites that have been identified through the Licensure Survey process or other mechanisms 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. Contractors must be active participants in both individual and coordinated efforts to improve the quality of care in facilities placement settings or service sites that have been identified by AHCCCS as an Immediate Care Need. Based on 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 placement setting or service sites compliance with ADHS Licensure and/or AHCCCS requirements.
 - c. Participate in scheduled and unscheduled monitoring of placement setting or service sites that are in an Immediate Jeopardy status or have serious identified deficiencies that may affect health and safety of members (Immediate Care Needs).
 - d. Assist in the identification of technical assistance resources focused on achieving and sustaining licensure compliance.
 - e. Monitoring placement setting or service sites upon completion of the activities and interventions to ensure that compliance is sustained.
11. The following services and service sites must be monitored at a minimum annually by Contractor Quality Management staff 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 ● Marriage/Family Counseling ● Substance Abuse Treatment ● 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 	<ul style="list-style-type: none"> ● Behavioral Health Outpatient Clinics ● Behavioral Health Therapeutic Home (Adults and Children) ● Independent Clinic ● Federally Qualified Health Center ● Community Mental Health Center ● Community/Rural Health Clinic (or Center) ● Crisis Service Provider ● Community Service Agency* ● Hospital (if it includes a distinct behavioral health or detoxification unit) ● Inpatient Behavioral Health Facility ● Behavioral Health Residential Facility ● Residential Treatment Center ● Psychiatric Hospital ● Substance Abuse Transitional Center ● Unclassified Facility ● Integrated Behavioral Health and Medical Facility ● Individual Respite Homes



<ul style="list-style-type: none"> • 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 	
--	--

12. The following services and service sites must be monitored at a minimum every three years by Contractors, 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 • Individual Respite Homes



13. The following services and service sites must be monitored by Arizona Long Term Care System (ALTC) 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 Services † * ● Directed Care Services ††* ● 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* ● Individual Respite Homes*
<p>* These services must be reviewed annually. † defined in ARS §36-401(36) †† defined in ARS §36-401(15)</p>	



14. Arizona Long Term Care System (ALTCS) Contractors must implement policies and procedures for the annual monitoring of attendant care, homemaker services, personal care services, respite services and habilitation services. When deficiencies or potential deficiencies are identified, they must be addressed from a member and from a system perspective.
15. 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 Contractor network. A collaborative process must be utilized in urban counties (Maricopa and Pima) and in rural counties when more than one Contractor is contracted with and utilizes the facility.
16. The Contractor (or the lead Contractor if Contractor collaborative monitoring was completed) must submit results to AHCCCS CQM annually by December 15. Additionally, a standardized and agreed upon tool must be used and include 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 or competencies to provide care
 - (d) Evidence that the agency contacted at least three references, **one** of which must be a former employer. Results of the contacts must be documented in the employee's personnel record.
 - b. Specific quality monitoring requirements are as follows:
 - i. Direct Care Services (Attendant care, Personal care and Homemaker services) monitoring (refer to AHCCCS Medical Policy Manual (AMPM) [Chapter 1200](#), Policy 1240-A, *Direct Care Services*, for detailed information) must include verification and documentation of the following::
 - (a) Verification of the monitoring and documentation of the following:



- (i) Mandated written agreement between the member and or member representative and the Direct Care Worker (DCW) which delineates the responsibilities of each,
 - (ii) Evaluation of the appropriateness of allowing the member's immediate relatives to provide attendant care, and
 - (iii) Compliance with ensuring DCWs meet competencies to provide care including training, testing, verifying and sharing testing records of DCWs. Additionally, a provider's compliance with continuing education standards (refer to AMPM Chapter 1200, Policy 1240-A, *Direct Care Services* and AHCCCS Contractor Operations Manual Chapter 400, Policy 429, *Direct Care Worker Training and Testing Program*). Contractors must incorporate testing results into monitoring tools for organizational providers that are and are not Approved DCW Training and Testing Programs.
 - (iv) Timeliness and content of supervisory visitations as outlined in AMPM Chapter 1200, Policy 1240-A.
- ii. 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).
- iii. Contractors must monitor that the services that a member receiving Long Term Services and Supports (LTSS) has obtained align with those that were documented in the member's LTSS treatment plan (§ 438.330(a)(2)(ii)).
- iv. Contractors must have mechanisms to assess the quality and appropriateness of care provided to members receiving LTSS services including between settings of care and as compared to the member's service plan (438.330).
- v. Contractors may also consider incorporating the use of surveys to assess the experience of members receiving LTSS as a key component of the Contractor's LTSS assessment process (§ 438.330(a)(2)(ii)).



C. IMPLEMENTATION OF ACTIONS TO IMPROVE CARE

1. Contractors must develop corrective action plans for taking appropriate actions to improve care if problems are identified. The corrective action plans should address the following:
 - a. Specified type(s) of problem(s) that requires corrective action. Examples include, but are not limited to
 - i. Abuse, neglect, and exploitation,
 - ii. Healthcare acquired conditions,
 - iii. Unexpected death,
 - iv. Isolated systemic issues,
 - v. Trends
 - vi. Health and safety issues, Immediate Jeopardy and Immediate Care Need situations
 - vii. Lack of coordination,
 - viii. Inappropriate blanket authorizations for specific ongoing care needs, and
 - ix. High profile/media events
 - 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 for 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, Section C, Item 4.
 - c. Type(s) of member/provider action(s) to be taken including, but not limited to:
 - 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, suspension or limitation of the provider (if an adverse action is taken with a provider the Contractor must report the adverse action to the AHCCCS Clinical Quality Management Unit within one business day), and/or
 - vi. Referrals to regulatory agencies.
 - d. Documentation of assessment of the effectiveness of actions taken.
 - e. Method(s) for internal dissemination of findings and resulting corrective action plans to appropriate staff and/or network providers, and



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 920

QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM

SCOPE

- 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 Board of Pharmacy, Arizona State Board of Nursing).
2. Contractors must maintain documentation that confirms the implementation of corrective actions.

EXHIBIT 920-1

**HEALTH CARE ACQUIRED CONDITIONS
OTHER PROVIDER PREVENTABLE CONDITIONS
REPORTING TOOL**

EXHIBIT 920-2

**HEALTH AND SAFETY UPDATE
IMMEDIATE JEOPARDY/IMMEDIATE CARE NEED FORM**

EXHIBIT 920-3

**ORGANIZATIONAL PROVIDERS APPROVED/NOT APPROVED
DIRECT CARE WORKER (DCW) TRAINING AND TESTING PROGRAMS**

EXHIBIT 920-3
ORGANIZATIONAL PROVIDERS APPROVED/NOT APPROVED
DIRECT CARE WORKER (DCW) TRAINING AND TESTING PROGRAMS

ORGANIZATIONAL PROVIDERS <u>NOT APPROVED</u> DCW TRAINING AND TESTING PROGRAMS		
STANDARD	DOCUMENTATION	INSTRUCTIONAL COMMENTS/NOTES
CONTRACTS OR AGREEMENTS	Contractor shall verify the organizational provider has a contract(s) or agreement(s) with at least one Approved DCW Training and Testing Program to train and test DCWs.	The Approved DCW Training and Testing Programs must be on the listing provided on the AHCCCS website (www.azahcccs.gov/dcw).
INDIVIDUAL RECORDS	<p>Contractor shall verify individual training and testing records include the following information:</p> <ol style="list-style-type: none"> 1. Identifies the services provided by the DCW. 2. Identifies if the DCW is exempt from the training requirement 3. Documentation of the hire date and when the training period concluded 4. Form used to obtain permission from employees to access testing records in the online database 5. Testing transcript sent by an Approved Program that outlines testing modules and scores or completed Verification of Direct Care Worker Testing form sent by previous employer. <ol style="list-style-type: none"> a. Test type b. Test Date(s) c. Test Modules d. Test Scores (written and skills) 6. Continuing Education <ol style="list-style-type: none"> a. Annual timeframe for continuing education b. Hours c. Topics d. Delivery method 	<ol style="list-style-type: none"> 1. DCW must pass competency tests within 90 days of hire. 2. If the test was a challenge test, the employer must document the educational and work experience that makes the DCW eligible for a challenge test. 3. For individuals who were employed prior to 9/30/12, the annual timeframe is October 1 – September 30. The annual timeframe for individuals hired on or after 10/01/12, is the date of hire to anniversary date. The training completed in the first year to become a qualified DCW can be counted towards the required six hours of continuing education during the first year of hire.
DCW DATABASE	<p>Contractor shall verify the organizational provider has:</p> <ol style="list-style-type: none"> 1. Procedures for maintaining a list of organizational users of the online database and notifications sent to AHCCCS requesting a user account must be terminated or suspended. 2. Procedures for adding employees into the employee listing who will be or have been sent by the employer for training/testing including updating status changes of employees (hired, terminated, resigned) within 30 days of the status change. 3. Procedures for, in the event testing records are not yet available in the online database, sharing current/former employee testing results upon request from another organization using <i>Verification of Direct Care Worker Testing</i> form. 	<ol style="list-style-type: none"> 1. Contractor shall verify the employee listing in the online database is consistent with the number of individuals employed by the agency. Additionally, the Contractor shall pull a sampling of employee records to verify the information in the database is consistent with hard copy personnel records. 2. The organizational provider should retain copies of testing verification requests from other agencies. The Contractor shall ask to view copies of the completed requests.

EXHIBIT 920-3
ORGANIZATIONAL PROVIDERS APPROVED/NOT APPROVED
DIRECT CARE WORKER (DCW) TRAINING AND TESTING PROGRAMS

ORGANIZATIONAL PROVIDERS <u>APPROVED</u> DCW TRAINING AND TESTING PROGRAMS		
STANDARD	DOCUMENTATION	INSTRUCTIONAL COMMENTS/NOTES
INDIVIDUAL RECORDS	<ol style="list-style-type: none"> 1. Continuing Education <ol style="list-style-type: none"> a. Annual timeframe for continuing education b. Hours c. Topics d. Delivery method 	<p>For individuals who were employed prior to 9/30/12, the annual timeframe is October 1 – September 30. The annual timeframe for individuals hired on or after 10/01/12, is the date of hire to anniversary date. The training completed in the first year to become a qualified DCW can be counted towards the required six hours of continuing education during the first year of hire.</p>



930 MEMBER RIGHTS AND RESPONSIBILITIES

REVISION DATES: 10/01/15, 10/01/13, 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, service 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, gender, age, age, behavioral health condition (intellectual) or physical disability, sexual preference, 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.
- d. Be provided with information about formulating Advance Directives (the Contractor must ensure 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]).
- e. For members in a HCBS or a behavioral health residential setting that have completed an Advance Directive, the document must be kept confidential but be readily available. For example: in a sealed envelope attached to the refrigerator.
- f. 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 Primary Care Provider.
 - 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 but may not require a specific form be used.
 - 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 contracted 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 contracted providers.
- 3. AHCCCS has implemented 12 Principles meant to maintain the integrity of the best practices and approaches to providing behavioral health services for children. Contractors are required to consider and integrate these principles for in the provision of behavioral health services for members under the age of 18 years. For a complete list of the principles please refer to [Policy 310-B](#), Behavioral Health Services.
- 4. 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 Primary Care Provider,
 - a. Scheduling appointments during office hours whenever possible instead of using urgent care facilities and/or emergency rooms,
 - b. Arriving for appointments on time,



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 930

MEMBER RIGHTS AND RESPONSIBILITIES

- c. Notifying the provider in advance when it is not possible to keep an appointment, and
 - d. Bringing immunization records to every appointment for children 18 years of age or younger.
5. 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.
6. 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: 10/01/15, 03/01/14, 10/01/13, 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 (physical and behavioral health) records and for use of an health information exchange (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,
 - c. Coordination of care, and
 - d. 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).



3. Contractors must implement policies and procedures for initial and on-going monitoring of medical records for all contracted primary care physicians (PCPs), Obstetrician/Gynecologists (OB/GYNs), licensed behavioral health professionals, oral health providers and high volume specialist (50 or more referrals per contract year by Contractor). The sample of files chosen for medical record review must be reflective of Geographical Service Area (GSA) served by the Contractor and the AHCCCS Contractor's lines of business. These requirements also apply to professionals employed by or affiliated with a contracted provider such as an Accountable Care Organization (ACO). Review of medical records must be conducted every three years.
4. The Contractors must:
 - a. Conduct Medical Record Reviews using a standardized tool that has been reviewed by AHCCCS.
 - b. Conduct medical records reviews at a minimum of every 3 years.
 - c. Utilize a collaborative approach that will result in only one AHCCCS Contractor conducting the "routine" medical record review for each provider.
 - d. Ensure results of the medical record review will be made available to all Contractors that contract with that provider.
 - e. Ensure samples are by provider, not by provider group.
 - f. Utilize a sample size of 30 records. If the first eight records reviewed are 100 percent in compliance, the review stops at the eight records. If deficiencies or variances are found in any of the first eight records reviewed, the full 30 records must then be reviewed.
 - g. Ensure that identified deficiencies are shared with all Contractors contracted with the provider.
5. The lead Contractor that conducted the medical record review shall be responsible for working with the provider on corrective actions. However, other Contractor input into those corrective actions may be necessary and appropriate.
6. If quality-of-care issues are identified during the medical record review process, it is expected that Contractors that contract with that provider be notified promptly of the results in order to conduct an independent on-site provider audit. It is also expected that the Contractor will address noted areas of non-compliance, despite a provider obtaining an overall passing score, to include subsequent follow-up



measures taken and/or a corrective action plan required to address the noted deficiency.

7. Each Contractor must implement policies and procedures that address paper and electronic health records, and the methodologies to be used by the organization to:
 - a. Ensure that contracted providers maintain a legible medical record (including electronic health record/medical record) for each enrolled member who has been seen for medical or behavioral health 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. Ensure providers, in multi-provider offices, have the treating provider sign his or her treatment notes after each appointment and/or procedure.
 - c. Ensure the medical record contains documentation of referrals to other providers, coordination of care activities, and transfer of care to behavioral health and other providers.
 - d. Make certain the medical record is legible, kept up-to-date, is well organized and comprehensive with sufficient detail to promote effective patient care, quality review, and identifies the treating or consulting provider. A member may have more than one medical record kept by various health care providers that have rendered services to the member. However, the PCP 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.
 - 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. Documentation of review of the Controlled Substances Prescription Monitoring Program (CSPMP) data base prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances
 - xi. Current and complete EPSDT forms (required for all members age 0 through 20 years)
 - xii. Developmental screening tools for children ages 9, 18 and 24 months
 - xiii. 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 an Integrated Regional Behavioral Health Authority (Integrated RBHA) or Regional Behavioral Health Authority (RBHA) behavioral health provider who is also treating the member.
 - xiv. Documentation as to whether or not an adult member has completed advance directives and the location of the document.
 - xv. Documentation that the provider responds to behavioral health provider information requests 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.
- xvi. Documentation related to requests for release of information and subsequent releases, and
 - xvii. 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 Gynecologists [ACOG]). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines.
 - e. Ensure that PCPs utilized AHCCCS approved developmental screening tools.
 - f. Ensure each organizational provider of services (e.g., hospitals, nursing facilities, rehabilitation clinics, transportation, 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.
 - g. Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines.
 - h. Ensure the Contractor has an implemented process to assess and improve the content, legibility, organization, and completeness of member health records when concerns are identified, and
 - i. 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 or para professionals provide services.



8. 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.
 - 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.
9. 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.



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 940

MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

- 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 timely with behavioral health providers for members with ongoing care needs or changes in health status.
10. 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.
11. 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.*
12. 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.
13. Contractors may request approval to discontinue conducting medical record reviews. Prior to receiving approval to discontinue 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, family planning, maternity and behavioral health services.
 - 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 will utilize 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 Advanced Directives for adult members.



950 CREDENTIALING AND RECREDENTIALING PROCESSES

REVISION DATES: 10/01/15, 09/01/14, 04/01/14, 10/01/13, 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 temporary/provisional credentialing, 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, 30 days after the end of the quarter, 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 credentialing and recredentialing policy addresses all the providers, including Long Term Service and Support (LTSS) providers, for all provider types for covered services provided by such providers § 438.214(b)(1).

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

1. Credentialing and recredentialing must be conducted and documented for all providers providing care and services to AHCCCS members, including those that are employed by an organizational provider. Credentialing and recredentialing must be completed for at least the following provider types:
 - a. Physicians (Medical Doctor [MD]),
 - b. Doctor of Osteopathic Medicine [DO],
 - c. Doctor of Podiatric Medicine (DPM),
 - d. Nurse practitioners,
 - e. Physician Assistants,



- f. Certified Nurse Midwives acting as primary care providers, including prenatal care/delivering providers,
- g. Dentists (Doctor of Dental Surgery [DDS] and Doctor of Medical Dentistry [DMD]),
- h. Affiliated Practice Dental Hygienists,
- i. Psychologists,
- j. Optometrist,
- k. Certified Registered Nurse Anesthetist,
- l. Occupational Therapist,
- m. Speech and Language Pathologist,
- n. Physical Therapists,
- o. Independent behavioral health professionals who contract directly with the Contractor and other non-licensed or certified providers that provide behavioral health services including:
 - i. Licensed Baccalaureate Social Workers (LBSW)
 - ii. Licensed Clinical Social Worker (LCSW)
 - iii. Licensed Professional Counselor (LPC)
 - iv. Licensed Associate Counselor (LAC)
 - v. Licensed Marriage/Family Therapist (LMFT)
 - vi. Licensed Associate Marriage/Family Therapist (LAMFT)
 - vii. Licensed Substance Abuse Technician (LSAT)
 - viii. Licensed Associate Substance Abuse Counselor (LASAC)
 - ix. Licensed Independent Substance Abuse Counselor (LISAC)
- p. Board Certified Behavioral Analysts (BCBAs)
- q. Any non-contracted provider that is rendering services and sees 50 or more of the Contractor's members per contract year, and
- r. Covering or substitute providers that provide care and services to Contractor's members while providing coverage or acting as a substitute during an absence of the contracted provider. Covering or substitute providers must indicate on the claim form that they are the rendering provider of the care or service.



2. The Contractor must ensure:
 - a. The credentialing and recredentialing processes do not discriminate against:
 - i. 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 or that employ individuals or entities that are excluded from participation.
3. If the Contractor delegates to another entity any of the responsibilities of credentialing/recredentialing that are required by this Chapter, it must retain the right and implement a process to approve, suspend, or terminate any provider selected by that entity and meet the requirements of Policy 910 of this Chapter regarding delegation. The Contractor's Credentialing Committee is responsible for making an independent decision regarding including a provider approved through a delegated credentialing process into its network. The Contractor must have a process to include information in B. 5. a, b, c. and d in recredentialing decisions of providers recredentialed through delegated agreements.
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 in the absence of the local Medical Director, other local designated physician to:
 - i. Act as the Chair of the Credentialing Committee,
 - ii. Implement the decisions made by the Credentialing Committee, and
 - iii. Oversee the credentialing process.
 - b. Indicate the use of participating Arizona Medicaid network providers in making credentialing decisions, and
 - c. Describe the methodology to be used by Contractor staff and the local Contractor Medical Director to provide documentation that each credentialing or recredentialing file was completed and reviewed, as per B.1. above, prior to presentation to the Credentialing Committee for evaluation.



5. Contractors must maintain an individual electronic or hard copy 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 the signature on the application,
 - b. Information gained through credentialing and recredentialing queries,
 - c. Utilization data, quality of care concerns, grievances, performance measure rates, value based purchasing results 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. Credentialed providers must be entered/loaded into the Contractor's claims payment system with an effective date no later than the date the provider was approved by the Credentialing Committee.
7. For Locum Tenens, it is each Contractor's responsibility to verify the status of the physician with the Arizona Medical Board and national databases.

C. INITIAL CREDENTIALING

Contractors are required to utilize the Arizona Health Plan Association's Credential Verification Organization (CVO) as part of the credentialing process. At a minimum, policies and procedures for the initial credentialing of physicians, other licensed health care providers, behavioral health providers, and Board Certified Behavioral Analysts 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
 - 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,



- 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), and
 - g. Minimum five year work history or total work history if less than five years.
2. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification, if a prescriber
 3. Verification from primary sources of:
 - a. Licensure or certification
 - b. Board certification, if applicable, or highest level of credentials attained
 - c. For credentialing of Independent Masters Level Behavioral Health Licensed Professionals, including:
 - i. Licensed Clinical Social Worker (LCSW)
 - ii. Licensed Professional Counselor (LPC)
 - iii. Licensed Marriage and Family Therapist (LMFT), and
 - iv. Licensed Independent Substance Abuse Counselor (LISAC).
 - d. Primary source verification of:
 - i. Licensure by Arizona Board of Behavioral Health Examiners (AZBBHE), and
 - ii. A review of complaints received and disciplinary status through AZBBHE.
 - e. For credentialing of Licensed Board Certified Behavioral Health Analysts, primary source verification of:
 - i. Licensure by the Arizona Board of Psychologist Examiners, and
 - ii. A review of complaints received, board and disciplinary status through the Arizona Board of Psychologist Examiners.
 - iii. Continuing Education requirements
 - (a) BCBA's credentialed under a 3-Year Cycle: 36 hours every 3 years (3 hours in ethics and professional behavior)
 - (b) BCBA's credentialed under a 2-Year Cycle: 32 hours every 2 years (4 hours in ethics for all certificates; 3 hours in supervision for supervisors)
 - iv. Continuing Education Courses
 - (a) BCBA's providing supervision of individuals pursuing BACB certification or the ongoing practice of BCaBAs or RBTs will be



CHAPTER 900
QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 950
CREDENTIALING AND RECREDENTIALING PROCESSES

required to obtain specific training in order to do so. These individuals will also be required to obtain 3 CEUs on supervision in every certification cycle.

- (b) Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined in the BACB's Experience Standards (in particular, the "Nature of Supervision" section) and the BACB Supervisor Training Curriculum Outline.

TYPE	DESCRIPTION	LIMIT	CEUs
1	College or university coursework	None – all CE can come from this type	1 hour of instruction = 1 CEU
2	CE issued by approved continuing education (ACE) providers	None – all CE can come from this type	50 minutes of instruction = 1 CEU
3	Non-approved events	25% can come from this type*	1 hour = 1 CEU
4	Instruction of Type 1 or Type 2	50% can come from this type*	1 hour of instruction = 1 CEU
5	CE issued by the BACB directly	25% can come from this type*	Determined by BACB
6	Take and pass the certification exam again	All CE will be fulfilled by this activity	Passing the exam equals 100% of your required CE, except for supervision
7	Scholarly Activities	25% can come from this type*	One publication = 8 CEUs One review = 1 CEU

**A maximum of 75% of the total required CE may come from categories 3, 4, 5 and 7. At least 25% must come from Type 1 or Type 2. Passing the examination (Type 6) meets all CE requirements except for supervision.*

BCBAs providing supervision of individuals pursuing BACB certification or the ongoing practice of BCaBAs or RBTs will be required to obtain specific training in order to supervise. These individuals will also be required to obtain three CEUs on supervision in every certification cycle. Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined in the BACB's [Experience Standards](#) (in particular, the "Nature of Supervision" section) and the BACB [Supervisor Training Curriculum Outline](#).

- f. For credentialing of Licensed Substance Abuse Technician (LSAT) primary source verification of:
- i. Bachelor's degree in a behavioral science with an emphasis on counseling, as determined by the Credentialing Committee of the Arizona Board of Behavioral Health Examiners, and
 - ii. Passing of the exam approved by the Credentialing Committee of the Arizona Board of Behavioral Health Examiners.
 - iii. Direct Supervision
 - iv. A review of complaints received and disciplinary



- g. Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training. A print out of license from the applicable Board's official website denoting that the license is active with no restrictions is acceptable.
- h. National Provider Databank (NPDB),
- i. Verification of the following:
 - 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 exclusions, and terminations for cause
 - iv. State sanctions or limitations of licensure.
- 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 and the identity of the provider must be disclosed to AHCCCS/OIG immediately in accordance with the AHCCCS ACOM Policy 103.
 - i. Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) <http://oig.hhs.gov/fraud/exclusions.asp>, and
 - ii. The System of Award Management (SAM) www.sam.gov formerly known as the General Services Administration (GSA)
- 6. Behavioral health providers, Board Certified Behavioral Analysts and affiliated practice dental hygienists may request a copy of their transcript or proof of education from their educational institution and submit it directly, in a sealed envelope from the educational institution.
- 7. Affiliated practice dental hygienists must provide documentation of the affiliation agreement with an AHCCCS registered dentist.
- 8. 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
- 9. Contractors must ensure that network providers have capabilities to ensure physical access, accommodations, and accessible equipment for members with



physical and mental disabilities. In addition, the accommodations must be reasonable and providers must ensure culturally competent communications with members. Contractors must also ensure that providers are able to communicate limited English proficient members in their preferred § 438.206(c)(3), 438.203(2) and § 438.68(c)(1)(viii).

10. The Contractor must conduct timely verification of information, as evidenced by approval (or denial) of a provider within 90 days of a receipt of complete application. The Contractor must send a notification to the provider and load all required information in to Contractor's system in order to allow payment to the provider for services, effective no later than the date of the Credentialing Committee decision.
11. 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).
12. Contracted providers including licensed or certified behavioral health providers who are a part of the Integrated Regional Behavioral Health Authority (RBHA), Regional Behavioral Authority (RBHA), or Tribal/Regional Behavioral Health Authority (T/RBHA) network may be subject to an initial site visit as part of the credentialing process.

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),



4. Providers needed in medically underserved areas,
5. Providers joining an existing, contracted oral health provider group, and
6. Covering or substitute providers providing services to the Contractor's members during a provider's absence from the practice.

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.

In situations where a covering or substitute provider must be utilized by a contracted provider and is approved through the temporary/provisional credentialing process, the Contractor must ensure that its system allows payments to the covering/substitute provider effective the date notification was received from the provider of the need for a covering or substitute provider. Covering or substitute providers must also meet the following requirements:

1. Licensure: Provider and employees rendering services to Members shall be appropriately licensed in Arizona to render such services as required by state or federal law or regulatory agencies, and such licenses shall be maintained in good standing.
2. Restriction of Licensure: Provider shall notify the Contractor within two (2) business days of the loss or restriction of his/her DEA permit or license or any other action that limits or restricts the Provider's ability to practice or provide services.
3. Professional Training: Provider and all employees rendering services to Members shall possess the education, skills, training, physical and mental health status, and other qualifications necessary to provide quality care and services to Members.
4. Professional Standards: Provider and employees rendering services to Members shall provide care and services which meets or exceeds the standard of care and shall comply with all standards of care established by state or federal law.
5. Continuing education: Provider and employees rendering care or services to Members shall comply with continuing education standards as required by state or federal law or regulatory agencies.



6. Regulatory compliance: Provider must meet the minimum requirements for participating in the Medicaid program as specified by the State.

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,
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 the past five years or total work history if less than 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 print out of license from the applicable Boards' official website denoting that the license is active with no restrictions is acceptable.
2. Board certification, if applicable, or the highest level of credential attained, and
3. National Provider Data Bank (NPDB) query including 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. State sanctions or limitations of licenses, and



- d. Medicare/Medicaid sanctions, exclusions, and terminations for cause.

The local 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 Credential Committee review, as outlined in this Section, must 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 or certified 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 as discussed in the Initial Credentialing Section of this Policy.
3. Verification of continuing education requirements being met.
4. A process for monitoring health care providers 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, if applicable
 - e. Quality of care issues (including trend data). If an adverse action is taken with a provider, including non-renewal of a contract the Contractor must report the adverse action and include the reason for the adverse action to the AHCCCS Clinical Quality Management Unit within one business day.
 - f. Pay for performance and value driven health care data/outcomes, if applicable.



- g. Evidence that the provider's policies and procedures meet AHCCCS requirements.
- h. Timely approval (or denial) by the Contractor's Credentialing Committee within 90 days of recredentialing being initiated.

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, including policies and procedures for credentialing and recredentialing if delegated to the organizational provider. The requirements described in this section must be met for all organizational providers included in its network including, but not limited to:

1. Hospitals,
2. Home health agencies,
3. Attendant care agencies,
4. Habilitation Providers,
5. Group homes,
6. Nursing facilities,
7. Dialysis centers,
8. Dental and medical schools,
9. Freestanding surgical centers,
10. Intermediate Care Facilities,
11. State or local public health clinics,
12. Community/Rural Health Clinics (or Centers),
13. Air Transportation,
14. Non-emergency transportation vendor,
15. Laboratories,
16. Pharmacies,
17. Respite Homes/Providers,
18. Behavioral health facilities, including but not limited to:
 - a. Independent Clinics,
 - b. Federally Qualified Health Centers,
 - c. Community Mental Health Centers,
 - d. Level 1 Sub-Acute Facility,
 - e. Level 1 Sub-Acute Intermediate Care Facility,
 - f. Level 1 Residential Treatment Center (secure and non-secure),
 - g. Community Service Agency,
 - h. Crisis Services Provider/Agency,
 - i. Behavioral Health Residential Facility,
 - j. Behavioral Health Outpatient Clinic,
 - k. Integrated Clinic,
 - l. Rural Substance Abuse Transitional Agency),



- m. Behavioral Health Therapeutic Home,
- n. Respite Homes/Providers
- o. Specialized Assisted Living Centers
- p. Specialized Assisted Living Homes

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 the 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 that is in compliance with federal requirements,
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 that must include, but is not limited to, confirmation that the organizational provider has the following:
 - a. A process for ensuring that the organizational provider credentials its providers for all employed and contracted providers included in Section 950,
 - 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 documentation when the Contractor has documented that they have reviewed and approved the CMS criteria and they meet the Contractor's standards.
 - e. In addition, Community Service Agencies must also have a:
 - i. Signed relationship agreement with the RBHA whose members they are serving,
 - ii. Approved application with the RBHA,



- iii. Signed contract with a RBHA contracted network provider,
 - iv. Description of the services provided that matches the services approved on the Title XIX Certificate,
 - v. Fire inspection reports,
 - vi. Occupancy permits,
 - vii. Tuberculosis testing,
 - viii. CPR certification,
 - ix. First Aid certification, and
 - x. Respite providers must provide and maintain consistently a signed agreement with an Outpatient Treatment Center.
4. Review and approve the organizational provider and the providers credentialed by the organizational provider through the Contractor's Credentialing Committee.
 5. For transportation vendors, a maintenance schedule for vehicles used to transport AHCCCS members and the availability of age appropriate car seats when transporting children.
 6. For behavioral health providers that utilize behavioral health technicians and behavioral health paraprofessional staff, the Contractor must review the following:
 - a. Personnel files to document:
 - i. Specific skills and services by classification of staff;
 - ii. Qualifications of staff including education and training;
 - iii. Supervision of staff and required documentation of direct supervision/clinical oversight as required in R9-10-114.
 - b. Completed written application including the following:
 - i. Reasons for any inability to perform the essential functions of the position, with or without accommodation,
 - ii. Lack of present illegal drug use,
 - iii. History of any disciplinary actions taken by the Board of Behavioral Health Examiners or any convictions,
 - iv. History of loss or limitation of scope of services or disciplinary action, if applicable,
 - v. Work history for the past five years or total work history if less than five years, and
 - vi. 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).
 - c. Behavioral health technicians and paraprofessionals must have:
 - i. Arizona Finger print clearance card if working with children,
 - ii. Documentation of cardio-pulmonary resuscitation



- iii. Documentation of first aid training,
- iv. Documentation of crisis prevention and intervention (CPI) training,
- v. Documentation of required training for orientation to the facility as stated in the facility's policies and procedures,
- vi. Initial Training must be at least 80 hours completed within the first six months of employment and must include the following topics:
 - (a) Ethics and professional conduct,
 - (b) Documentation and patient confidentiality,
 - (c) Maintaining client and personal safety,
 - (d) Clinical competence including medications, and
 - (e) Mandatory reporting and cultural competency.
- vii. Initial training does not prohibit a behavioral health paraprofessional or technician from providing services during training,
- viii. Documentation that personnel member's skills, training and proficiency are verified before providing any services and re-verified at least every 12 months,
- ix. Evidence of freedom of infectious tuberculosis as specified in R9-10-112,
- x. Each facility must have documentation of direct supervision for behavioral health paraprofessionals and clinical oversight for behavioral health technician (R9-10-114) consisting of 80 hours initially. One hour of continuing supervision and/or oversight will be completed for every forty hours of full time work after the initial orientation. Documentation of all or part of the initial clinical oversight for behavioral health technicians and supervision for behavioral health paraprofessionals are transferrable at the discretion of the hiring organization,
- xi. Documentation of work experience and/or training relevant to the population with which the individual staff is working,
- xii. In-service/continuing education requirements for personnel of a minimum of one hour per month documented in personnel file,
- xiii. A minimum of a high school diploma or high school equivalency diploma or higher, and
- xiv. Personnel member must be at least 21 years of age.

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. Review of the following:
- a. The most current review conducted by the Arizona Department of Health Services (ADHS) and/or summary of findings (date of ADHS review must be documented). 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.
 - c. Supervision of staff and required documentation of direct supervision/clinical oversight as required in R9-10-114. This process must include a review of a valid sample of clinical charts.
 - d. Most recent audit results of the organizational provider.
 - e. Confirmation that the service delivery address is verified as correct.
 - f. Review of staff to verify credentials, and that the staff person meets the credentialing requirements.
3. Evaluate organizational provider specific information including, but not limited to, the following:
- a. Member concerns which include grievances (complaints),
 - b. Utilization management information,
 - c. Performance improvement and monitoring,
 - d. Quality of care issues,
 - e. Onsite assessment, and



- f. If an adverse credentialing, recredentialing or organizational credentialing decision is made, the Contractor must report the adverse action to the AHCCCS Clinical Quality Management Unit within one business day.
4. Review and approval by the Contractor's Credentialing Committee with formal documentation that includes 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

The Contractor must have procedures for prompt reporting in writing to appropriate authorities including the AHCCCS Clinical Quality Management Unit, the provider's regulatory Board or Agency, the Arizona Department of Health Services Licensure Division, and the Office of the Attorney General. The Contractor must report within one business day to the AHCCCS Clinical Quality Management Unit issue/quality deficiencies that result in a provider's suspension or termination from the Contractor's network. If the issue is determined to have criminal implications, including allegations of abuse or neglect, a law enforcement agency must also be promptly notified as well as Adult Protective Services or the Department of Child Safety. Contractors must have an implemented process to report providers to licensing and other regulatory entities all allegations of inappropriate or misuse of prescribing including allegations of adverse outcomes that may have been avoided should the provider have reviewed the CSPMP and coordinated care with other prescribers.

The Contractor must report to the AHCCCS Clinical Quality Management Unit all credentialing, provisional credentialing, recredentialing and organizational credentialing denials.

The Contractor shall indicate in its notification to AHCCCS the reason or cause of the adverse/denial decision and when restrictions are placed on the provider's contract, including, but not limited to denials or restrictions which are the result of, licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. The AHCCCS Clinical Quality Management Unit shall refer cases, as appropriate, to the AHCCCS Office of the Inspector General (AHCCCS-OIG), in accordance with 42 CFR 455.14. The AHCCCS-OIG shall conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation. [42 CFR 455.14] [42 CFR 455.17][42 CFR 455.1(a)(1)].

1. The Contractor must maintain documentation of implementation of the procedures,



2. The Contractor must have an appeal process for instances in which the Contractor places restrictions on the provider's contract based on issues of quality of care and/or service,
3. The Contractor must inform the provider of the Quality Management (QM) dispute process through the QM Department, and
4. The Contractor must notify the AHCCCS Clinical Quality Management (CQM) within one business day for all reported events.

I. NOTIFICATION REQUIREMENTS

The Contractor must have procedures for reporting to the AHCCCS Clinical Quality Management Unit in writing any final adverse action for any reason, taken against a health care provider, supplier/vendor, or practitioner. A "final adverse action" does not include an action with respect to a malpractice notice or settlements in which no findings or liability has been made.

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, and
 - 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 restriction, 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 42 CFR 455 Subpart B and sections 1128B(f) and 1128(H), respectively), and
 - v. Any other adjudicated actions or decisions that the Secretary shall establish by regulation.
- d. Any adverse credentialing, provisional credentialing, recredentialing or organizational credentialing decision or any adverse action from a quality or peer review process, that results in denial of a provider to participate in the Contractor's network, provider termination, provider suspension or an action that limits or restricts a provider.

Notice of a Contractor's final adverse action should be sent to CQM within one business day of the notice.

3. In accordance with A.R.S. §36-2918.01, §36-2932, §36-2905.04 and ACOM Policy 103, the Contractor, its subcontractors and providers are required to immediately notify the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding any allegation of fraud, waste or abuse of the AHCCCS Program. Notification to AHCCCS-OIG shall be in accordance with ACOM Policy 103 and as specified in Attachment F3, Contractor Chart of Deliverables. This shall include allegations of fraud, waste or abuse that were resolved internally but involved AHCCCS funds. The Contractor must also report to AHCCCS, as specified in Attachment F3, Contractor Chart of Deliverables, any credentialing denials issued by the Credential Verification Organization including, but not limited to those which are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. In accordance with 42 CFR 455.14, AHCCCS-OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation. [42 CFR 455.17][42 CFR 455.1(a)(1)]
4. The Contractor must report, within one business day, 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, and
- 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 and the identity of the provider must be disclosed to AHCCCS/OIG immediately in accordance with the AHCCCS ACOM Policy 103:
 - i. The System of Award Management (SAM) www.sam.gov formerly known as the Excluded Parties List System (EPLS)
 - ii. The Social Security Administration's Death Master File
 - iii. The National Plan and Provider Enumeration System (NPPES)
 - iv. The List of Excluded Individuals (LEIE)
 - v. Any other databases directed by AHCCCS or CMS

J. TEACHING PHYSICIANS AND TEACHING DENTISTS

1. 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 are met, medical residents may provide low-level evaluation and management services to members in designated settings without the presence of the teaching physician.
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.

K. CREDENTIALING TIMELINESS

The Contractor is required to process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing a Contractor shall divide the number of complete applications processed (approved/denied) during the time period per category by the number of complete applications that were received during the time period per category, please reference Exhibit 950-1,



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 950

CREDENTIALING AND RECREDENTIALING PROCESSES

1. The standards for processing are listed by category below:

Type of Credentialing	14 days	30 days	60 days	90 days
Provisional	100%			
Initial		50%	75%	100%
Recredentialing		50%	75%	100%
Organizational Credentialing		50%	75%	100%

EXHIBIT 950-1

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

Exhibit 950-1 AHCCCS Contractor Quarterly Credentialing Report

AHCCCS CONTRACTOR: _____

ADDRESS: _____

QUARTER: _____ DATE OF SUBMISSION _____

PERSON SUBMITTING REPORT: _____

CONTACT TELEPHONE NUMBER: _____

CATEGORY <i>Include data for health providers who completed credentialing within the quarter.</i>	NUMBER OF NEW APPLICATIONS RECEIVED ¹	NUMBER OF PROVIDERS CREDENTIALLED WITHIN THE REPORTED QUARTER ²	SHORTEST TIME FOR DETERMINATION ³	LONGEST TIME FOR DETERMINATION ³	AVERAGE TIME FOR DETERMINATION ³	SHORTEST TIME TO LOAD PROVIDER ID IN CLAIMS SYSTEM ⁴	LONGEST TIME TO LOAD PROVIDER ID IN CLAIMS SYSTEM ⁴	AVERAGE LENGTH OF TIME TO LOAD PROVIDER ID INTO CLAIMS SYSTEM ⁴
INITIAL CREDENTIALING								
RE-CREDENTIALING								
PROVISIONAL CREDENTIALING								
ORGANIZATIONAL CREDENTIALING								

¹The number of new applications received during the quarter but not necessarily completed the credentialing process

²Includes providers that have completed the credentialing process (approved and denied)

³Begin from receipt of completed application

⁴Begin from date of approval

⁵Includes provisionally credentialed providers who completed the initial credentialing process

TYPE OF CREDENTIALING	14 DAYS	30 DAYS	60 DAYS	90 DAYS
PROVISIONAL				
INITIAL				
RE-CREDENTIALING				
ORGANIZATIONAL				

COMMENTS (INCLUDE DESCRIPTION FOR AREAS OF NON-COMPLIANCE AND CORRECTIVE ACTIONS TAKEN)

Exhibit 950-1 AHCCCS Contractor Quarterly Credentialing Report

AHCCCS CONTRACTOR: _____

ADDRESS: _____

QUARTER: _____

DATE OF SUBMISSION _____

PERSON SUBMITTING REPORT: _____

CONTACT TELEPHONE NUMBER: _____

CATEGORY <i>Include data for oral health providers who completed credentialing within the quarter.</i>	NUMBER OF NEW APPLICATIONS RECEIVED ¹	NUMBER OF PROVIDERS CREDENTIALLED WITHIN THE REPORTED QUARTER ²	SHORTEST TIME FOR DETERMINATION ³	LONGEST TIME FOR DETERMINATION ³	AVERAGE TIME FOR DETERMINATION ³	SHORTEST TIME TO LOAD PROVIDER ID IN CLAIMS SYSTEM ⁴	LONGEST TIME TO LOAD PROVIDER ID IN CLAIMS SYSTEM ⁴	AVERAGE LENGTH OF TIME TO LOAD PROVIDER ID INTO CLAIMS SYSTEM ⁴
INITIAL CREDENTIALING								
RE-CREDENTIALING								
PROVISIONAL CREDENTIALING								
ORGANIZATIONAL CREDENTIALING								

¹The number of new applications received during the quarter but not necessarily completed the credentialing process

²Includes providers that have completed the credentialing process (approved and denied)

³Begin from receipt of completed application

⁴Begin from date of approval

⁵Includes provisionally credentialed providers who completed the initial credentialing process

TYPE OF CREDENTIALING	14 DAYS	30 DAYS	60 DAYS	90 DAYS
PROVISIONAL				
INITIAL				
RE-CREDENTIALING				
ORGANIZATIONAL				

COMMENTS (INCLUDE DESCRIPTION FOR AREAS OF NON-COMPLIANCE AND CORRECTIVE ACTIONS TAKEN)



960 TRACKING AND TRENDING OF MEMBER AND PROVIDER ISSUES

REVISION DATES: 10/01/15, 10/01/13, 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 to review, evaluate and resolve quality of care and service issues raised by enrolled members, contracted providers and stakeholders. 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. Document each issue raised, when and from whom it was received, and the projected time frame for resolution.
2. Determine promptly 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 on coverage and payment issues,
or
 - d. Process for resolving disputed initial determinations.
3. Acknowledge receipt of the issue and explain to the member or provider the process that will be followed to resolve his or her issue through written correspondence.



4. Assist the member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.
5. Ensure confidentiality of all member information.
6. Inform the member or provider of all applicable mechanisms for resolving the issue external to the Contractor processes.
7. Document all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each complaint, grievance or 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.
 - 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.
 - e. Referral to the Contractor's compliance department and/or AHCCCS Office of the Inspector General.

(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 AND SERVICE 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/service concern process must be a stand alone process completed through the quality management unit. The process shall not be combined with other agency meetings or processes. Work units outside of the quality



management unit will not have the authority to conduct quality of care investigations but may provide subject matter expertise throughout the investigative process.

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, 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.
 - g. Direct interviews of members, direct care staff, and witness to a reportable event; when applicable and appropriate.
2. Onsite visits must be conducted by the Contractor's Quality Management staff when there are identified health and safety concerns, immediate jeopardy or serious incident situations, or at the direction of AHCCCS. Subject matter experts outside the Quality Management unit may participate in the onsite visit but may not take the place of Quality Management staff during reviews.
3. Member health, welfare and safety is an important tenet in a program providing Long Term Services and Supports (LTSS). Contractors are required to participate in efforts to prevent, detect, and remediate all critical incidents including those that are self-identified, or when notified by AHCCCS of incidents or concerns identified by ADHS Licensure or by AHCCCS. (§ 438.330(b)(6)).
4. Contractors may not delegate quality of care investigation processes or onsite quality of care visits.



5. 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. Implementing new interventions/approaches when necessary.
6. The Contractor must develop a process to ensure resolution of the issue. Member and system resolutions may occur independently from one another.
7. The Contractor must develop a process to determine the level of severity of the quality of care issue.
8. The Contractor must develop a process to refer/report the issue to the appropriate regulatory agency including the Department of Child Safety or Adult Protective Services, Arizona Department of Health Services (ADHS), the Attorney General's Office, law enforcement and AHCCCS for further research/review or action. Initial reporting may be made verbally, but must be followed by a written report within one business day.
9. The Contractor must have a process to refer the issue to the Contractor's Peer Review Committee when appropriate. Referral to the Peer Review Committee is not a substitute for implementing interventions aimed at individual and systemic quality improvement.
10. If an adverse action is taken with a provider for any reason including those related to quality of care concern, the Contractor must report the adverse action to the AHCCCS Clinical Quality Management Unit within 24 hours of the determination to take an adverse action as well as to the National Practitioner Data Bank.
11. The Contractor must have a process to determine the level of substantiation of the quality of care or service issue.



12. 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 its network is suspended or terminated for any reason, including those related to quality of care issues, and
13. The Contractor must have a process to document the criteria and process for closure of the review or investigation including, but not limited to the following:
 - a. A description of the problems, including new allegations identified during the investigation/review process, and the substantiation and severity level for each allegation as well as the case overall.
 - b. Written response from or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or Medical Examiner.
14. Investigations that identify an adverse outcome, including mortalities, due to prescribing issues or failure of the provider to check the CSPMP, to coordinate care with other prescribers, refer for substance use treatment or pain management, the Contractor shall notify AHCCCS CQM, take appropriate action with the provider including suspension or corrective action plans and referrals to appropriate regulatory Boards including the Pharmacy Board. The case findings shall be taken to the Contractor's Peer Review Committee for discussion and review.

Requests for Copies of Death Certificates:

As part of the quality of care investigation process, AHCCCS Contractors may request copies of member death certificates from the ADHS Office of Vital Statistics. The following process must be followed:

- AHCCCS Contractors must send a letter, on Contractor letterhead, providing one or two names of employees who are authorized to make a request for a copy of the death certificate. The request should be someone at a manager or supervisory level position with the Contractor.
- The letter must be sent to:

**Arizona Department of Health Services
Office of Vital Records
Office Chief
P.O Box 3887
Phoenix, Arizona 85030**



- The letter will be kept on file with the Office of Vital Records. Only those individual(s) listed on the letter are eligible to apply/request a copy of the death certificate.
- The following information will be needed from the Contractor, submitted on Contractor letterhead, when making the request for a copy of the death certificate:
 - The decedent's (member's) name
 - Date of death
 - Purpose of request (i.e. quality of care investigation process)
 - Signature of the authorized employee
 - Requests must be mailed with original ink signatures
 - Documentation showing that decedent was a member of the Contractor making the request (copy of an eligibility screen with the Contractor's name, member's name and date of eligibility is acceptable)
- A fee of \$5.00 for each copy requested in the form of a business check, money order or credit card.
- All requests should be sent to:

**Office of Vital Records
Attention: Office Chief
P.O. Box 3887
Phoenix, Arizona 85030**

Contractors must notify the ADHS Office of Vital Statistics in writing of any termination of employment of those listed on the original letter. Included in the notification should be the name of the replacement managerial or supervisory staff person. These changes should be mailed to:

**Operations Section Manager
Arizona Department of Health Services
Office of Vital Records
Operations Section Manager
P.O. Box 3887
Phoenix, Arizona 85030**



D. TRACKING AND TRENDING OF QUALITY OF CARE ISSUES

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

1. The Contractor must develop and implement a system to document, track, trend and evaluate complaints and allegations received from members and providers or as directed by AHCCCS, inclusive of quality of care, quality of service, and immediate care need 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/Division of Health Care Management/Clinical Quality Management (AHCCCS/DHCM/CQM) utilizing the Quarterly Quality Management Report (Exhibit 960-1). The report is due 45 days after the end of each quarter, reported separately by line of business 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 developing performance improvement activities focused on the topic area to improve the issue resolution process itself, and to make improvements that address other system issues raised during the resolution process.

- d. The Contractor must submit to AHCCCS CQM all pertinent information regarding an incident of abuse, neglect, exploitation, serious incident and unexpected death (including all unexpected transplant deaths) as soon as the Contractor is aware of the incident, and no later than 24 hours. Pertinent information must not be limited to autopsy results, and must include a broad



review of all issues and possible areas of concern. Delays in receipt of autopsy results shall not result in a delay in the Contractor's investigation of a quality of care concern. Delayed autopsy results shall be used by the Contractor to confirm the Contractor's resolution of the quality of care concern.

2. The Contractor must ensure that member health records are available and accessible to authorized staff of its organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care/service or investigating member or provider quality of care concerns, complaints, allegations of abuse, neglect, exploitation, serious incidents, grievances, Provider Preventable Conditions 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 its contract with AHCCCS, the Contractor must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program, also referred to as the Challenging Member 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, including AHCCCS, for assistance.

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 Conditions (HCAC) – means a Hospital Acquired Condition (HAC) under the Medicare program which occurs in any inpatient hospital setting and



is not present on admission (Refer to the current CMS list of Hospital-Acquired Conditions).

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

AHCCCS CONTRACTOR QUARTERLY MANAGEMENT REPORT

EXHIBIT 960-1
AHCCCS CONTRACTOR QUARTERLY MANAGEMENT REPORT

Contractor:		Acute: <input type="checkbox"/>	ALTCS: <input type="checkbox"/>	Date Submitted:	
Address:			Quarter: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>		
Person Submitting Report:			Contact Phone Number:		
Category	Number of Cases Closed:	<u>Substantiated:</u>	<u>Unsubstantiated</u>	<u>Unable to Substantiate</u>	
Abuse:					
Availability, Accessibility, Adequacy (AAA):					
Denial, Decrease, Discontinuance of Covered Benefits (DDD):					
Effectiveness, Appropriateness of Care (E/A):					
Exploitation:					
Fraud, Member or Provider (Fraud):					
Health Care Acquired Condition (HAC):					
Member Rights/Respect and Caring (MR):					
Neglect:					
Other Provider Preventable Conditions (OPPC):					
Safety/Risk Management (Safety):					
Unexpected Death:					
Non-Quality of Care (Non-QOC):					
Total:					
Quality of Care Intervention Status (Substantiated Cases Only)	Number of Interventions Implemented:	Identified issues, trends by provider type or facility and any other additional information to share:			
Advocacy:					
Care Conference:					
Counseling (Member):					
Education/Training (Provider):					
Legal:					
Member Contracts:					
Peer Review:					
Placement Change:					
Policy/Procedural Change:					
Provider Change:					
Referral (CPS, APS, AG, Licensure, Certification, OPI, AHCCCS):					
Resolution Monitoring:					
Service Plan/Treatment Change:					
Termination/Suspension:					
Total:					



970 PERFORMANCE MEASURES

REVISION DATES: 10/01/15, 03/01/14, 10/01/13, 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 has developed and implemented performance metrics to monitor the compliance of its Contractors in meeting contractual requirements related to the delivery of care and services to its members. In developing the metric performance measure set, attention was paid to the goals coined by the Institute for Health Improvement (IHI) and adopted by the Centers for Medicare and Medicaid Services, which is called the “Triple Aim”. IHI defines the Triple Aim as “a framework for optimizing health system performance.” There are three components to the Triple Aim:

1. Improve the experience of care
2. Improve the health of populations
3. Reduce the per capita costs of healthcare

The components of the Triple Aim must be balanced in order to reach the overarching goal of optimizing the healthcare system. In order to achieve the Triple Aim, an accurate, reliable and valid health information system is necessary and required. The health information analytics system must be able to aggregate and analyze clinical, service, financial, and patient experience of care data in order to standardize best practices, implement targeted interventions and track improvement over time. Examples of how the three components of the Triple Aim may be implemented include:

1. Improve the Experience of Care
 - a. Offer incentives and penalties to improve the experience of care, such as:
 - i. Meeting the Value-Based Payment (VBP) patient satisfaction goals
 - ii. The Consumer Assessment of Healthcare Providers and Services (CAHPS)
 - iii. Supplying patient portals



2. Improve the Health of Populations

- a. Provide payment based on quality, such as:
 - i. Achieving quality metrics, and
 - ii. Meeting pay-for-performance/quality or value based purchasing metrics

- b. Establish opportunities for clinically integrated care, such as:
 - i. Implementation/use of the Health Information Exchange
 - ii. Increased use of electronic health records
 - iii. Creating disease registries
 - iv. Providing clinician and member portals
 - v. Offering Patient Centered Medical Homes
 - vi. Utilizing Accountable Care Organizations
 - vii. Providing population health initiatives that
 - (a) Support and encourage patient engagement
 - (b) Incorporate mobile applications for patients achieving health goals

3. Reduce the cost of health care

- a. Reform delivery and payment systems to provide better care in a cost-efficient manner by:
 - i. Structuring payment based on quality
 - ii. Rewarding increased access to care
 - iii. Develop methods to utilize electronic health records for care coordination and quality improvement

AHCCCS Performance Measures are based off of the Centers for Medicare and Medicaid Services (CMS) Core/Measure Sets Healthcare Effectiveness Data and Information Set (HEDIS-like) developed by the National Committee for Quality Assurance (NCQA), or other methodologies, and are integral to each Contractor's Quality Management/Performance Improvement (QM/PI) program. Examples of areas that may be measured include maternal and child health services, wellness and screening services, disease management processes, readmissions, utilization of services, and non-clinical areas such as access to care, placement at appropriate level of care, supervision of providers, provider turnover, interpreter services, and cultural competency.

Contractors that provide Long Term Service Supports (LTSS) will also include LTSS-specific, performance measures that examine, at a minimum, members' quality of life and the Contractor's rebalancing and community integration outcomes. Performance



measures specific to member's selecting a self-directed option may also be developed. The measures will consider underlying performance, performance gaps, reliability and validity, feasibility, and alignment. The measures will support and align with a Contractor's quality assessment and performance improvement program (§ 438.330(c)(4)).

The performance measures are used to evaluate whether Contractors are fulfilling key contractual obligations. Such performance measures established or adopted by AHCCCS are also 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 such as in its report cards and rating systems, and through other means, such as sharing of data with state agencies and other community organizations and stakeholders. Contractor performance is compared to AHCCCS requirements and to national Medicaid and commercial health plan means as well as goal established by the Centers for Medicare and Medicaid Services.

The Centers for Medicare and Medicaid Services (CMS) may, in consultation with states and other stakeholders, specify standardized performance measures and topics for performance improvement projects (PIPs) for inclusion alongside state- specified measures and topics in state contracts (§ 438.330(a)(2)). Contractors are required to participate in performance measures and performance improvement projects that are mandated by CMS.

Performance Measures must be reported to AHCCCS CQM on a quarterly basis (refer to [Appendix A](#), *EPSDT and Adult Quarterly Monitoring Report Instructions & Templates*). Performance measures must be analyzed and reported separately, by line of business Acute, E/PD, DDD, BHS (Acute and SMI populations, DDD and CMDP), and CRS (CMDP and DDD). 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 an Integrated RBHA or 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 RATING SYSTEM

AHCCCS will develop a Contractor quality rating system. The quality rating system will measure and report on performance data collected from each Contractor on a standardized set of measures that will be determined by CMS as well as state identified measures. The components of the rating system will be based on three summary indicators: (1) Clinical quality management, (2) Member experience, and (3) Plan efficiency, affordability, and management (§ 438.334(a) (1) and (2) and (3)).



C. QUALITY MANAGEMENT PERFORMANCE MEASURE REQUIREMENTS

The Contractor shall comply with AHCCCS quality management requirements to improve performance in all AHCCCS established performance measures. Descriptions of the AHCCCS Clinical Quality Performance Measures can be found in the most recently published reports of Acute Care Performance Measures located on the AHCCCS website. The EPSDT Participation performance measure description utilizes the methodology established in CMS “Form 416” which can also be found on the [AHCCCS Performance Measures website](#). Contractors are responsible for applying the correct performance measure methodologies including the CMS-416 methodology as developed by CMS for its internal monitoring of performance measure results.

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.
- c. 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.
- d. Contractors are responsible for monitoring and reporting to AHCCCS the status of and any discrepancies identified in encounters submitted to and received by AHCCCS including paid, denied and pended encounters for purposes of Performance Measure monitoring. Contractors are responsible for monitoring encounter submission by its subcontractors.
 - e. Show demonstrable improvement from year to year, which is sustained over time, in order to meet goals for performance established by AHCCCS.
 - f. 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. Contractor calculated and/or reported rates will be used strictly for monitoring the effectiveness of Contractor actions/interventions and will not be used by AHCCCS for official reporting or for corrective action purposes.
 - 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.
 - iii. A Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. AHCCCS may impose sanctions on Contractors that do not show statistically



significant improvement in a measure rate as calculated by AHCCCS. Sanctions may also be imposed for statistically significant declines of rates even if they meet or exceed the MPS, for any rate that does not meet the AHCCCS MPS, or a rate that has a significant impact to the aggregate rate for the State. AHCCCS may require the Contractor to demonstrate that they are allocating increased administrative resources to improving rates for a particular measure or service area. AHCCCS also may require a corrective action plan for measures that are below the MPS or that show a statistically significant decrease in its rate even if it meets or exceeds the MPS.

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

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.

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.



980 PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

REVISION DATES: 07/01/16, 10/01/15, 10/01/08, 02/01/07, 04/01/05, 08/13/03, 10/01/01, 10/01/97

REVIEW DATE: 10/01/13, 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. When developing quality assessment and performance improvement projects, AHCCCS and its Contractors must consider all populations and services covered (42 CFR §438.330).

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

The Centers for Medicare and Medicaid Services (CMS) may, in consultation with states and other stakeholders, specify standardized performance measures and topics for performance improvement projects (PIPs) for inclusion alongside state-specified measures and topics in state contracts (42 CFR §438.330(a)(2)). Contractors are required to participate in performance measures and performance improvement projects that are mandated by CMS.

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.
- e. Behavioral Health topics may include:
- i. A change in behavioral health status or functional status, and
 - ii. A change in member satisfaction.
2. PIP methodologies are developed according to 42 CFR 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 re-measurement 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.
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.

EXHIBIT 980-1

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

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)	
2.1 State study question(s) for each PIP clearly in writing.	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.
STEP 3: STUDY INDICATOR(S)	
3.1 Develop objective, clearly defined, measurable indicators.	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.
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>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 Contractor 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 re-measurements after the first re-measurement 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**

EXHIBIT 980-2
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
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	
Re-measurement 1							
Re-measurement 2							
Re-measurement 3							
Re-measurement 4							
Re-measurement 5							

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

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

EXHIBIT 980-2
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
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	
Re-measurement 1							
Re-measurement 2							
Re-measurement 3							
Re-measurement 4							
Re-measurement 5							

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

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

EXHIBIT 980-2
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
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	
Re-measurement 1							
Re-measurement 2							
Re-measurement 3							
Re-measurement 4							
Re-measurement 5							

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

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

EXHIBIT 980-2
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
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							
Re-measurement 1							
Re-measurement 2							
Re-measurement 3							
Re-measurement 4							
Re-measurement 5							

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

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

EXHIBIT 980-2
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
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.

EXHIBIT 980-2
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE

ASSESSMENT OF IMPROVEMENT

IF DEMONSTRABLE IMPROVEMENT IN STUDY INDICATORS IS ACHIEVED FROM BASELINE TO RE-MEASUREMENT: 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 RE-MEASUREMENT: 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.

EXHIBIT 980-2
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PERFORMANCE IMPROVEMENT PROJECT (PIP) REPORTING TEMPLATE

ASSESSMENT OF IMPROVEMENT

IF THIS IS A FINAL RE-MEASUREMENT 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.



990 REPORTING REQUIREMENTS

REVISION DATES: 10/01/15, 10/01/13, 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 Performance Monitoring Report (for each applicable population served). (Appendix A)	15 days after the end of each quarter	DHCM/CQM
Quarterly Credentialing Report (Exhibit 950-1)	30 days after end of quarter	DHCM/CQM
Quarterly QM Report (Exhibit 960-1)	45 days after end of quarter	DHCM/CQM
Health Care Acquired Conditions/Provider Preventable Conditions Report (Exhibit 920-1)	45 days after end of quarter	DHCM/CQM
Performance Improvement Project (PIP) Re-measurement Report (Standardized format to be utilized). (Exhibit 980-2)	Annually on December 15 following initial year of the PIP	DHCM/CQM
Performance Improvement Project Final Report (Standardized format to be utilized). (Exhibit 980-2)	By March 31 after the contract year in which the PIP was completed	DHCM/CQM



CHAPTER 900

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 990

REPORTING REQUIREMENTS

REPORT	DUE DATE	REPORTS DIRECTED TO
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
Reports for Alternative Residential Placement Setting and Nursing Care Institutions Collaboration Projects	Annually by December 15	DHCM/CQM

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.

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 Medical Management.