Department of Child Safety – Comprehensive Medical and Dental Program

Operational Review
Contract Year 2019

September 25, 2019

Conducted by the Arizona Health Care Cost Containment System

INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) has served Arizona's most needy since 1982. The Agency's vision is "to shape tomorrow's managed care… from today's experience, quality and innovation." As a component of achieving this vision, AHCCCS regularly reviews its Contractors to ensure that their operations and performance are in compliance with Federal and State law; rules and regulations; and the AHCCCS Contract. The reviewers use a process approved by the Centers for Medicare and Medicaid Services (CMS) based upon the terms of the contract with AHCCCS.

The primary objectives of the Department of Child Safety – Comprehensive Medical and Dental Program (CMDP) CY 2019 Operational Review are to:

- Determine if the Contractor satisfactorily meets AHCCCS' requirements as specified in Contract, AHCCCS policies, Arizona Revised Statute, the Arizona Administrative Code and 42 CFR Part 438, Managed Care,
- Increase AHCCCS knowledge of the Contractor's operational encounter processing procedures,
- Provide technical assistance and identify areas where improvements can be made; as well as identifying areas of noteworthy performance and accomplishments,
- Review progress in implementing recommendations made during prior reviews,
- Determine if the Contractor is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures,
- Perform Contractor oversight as required by the CMS in accordance with AHCCCS' 1115 waiver, and
- Provide information to an External Quality Review Organization (EQRO) for its use as described in 42 CFR 438.364.

AHCCCS conducted an onsite review of CMDP from July 15, 2019 through July 17, 2019, and July 22, 2019.

A copy of the draft version of this report was provided to the Contractor on August 28, 2019. CMDP was given a period of one week in which to file a challenge to any findings it did not feel were accurate based on the evidence available at the time of review. This final report represents any changes made as a result of this request.

Upon issuance of the report, the Contractor is required to maintain the confidentiality of the information, including the standard criteria and findings of the Review Team until such time as AHCCCS determines; in order to maintain the integrity of the process until all Contractors have been reviewed.

SCORING METHODOLOGY

The CY 2019 Operational Review is organized into Standard Areas. Depending on the program contracts awarded, the Contractor may be evaluated in up to twelve Standard Areas. For the CY 2019 Operational Review, these Standard Areas are:

- Corporate Compliance (CC)
- Claims and Information Systems (CIS)
- Delivery Systems (DS)
- General Administration (GA)
- Grievance Systems (GS)
- Adult, EPSDT and Maternal Child Health (MCH)
- Medical Management (MM)
- Member Information (MI)
- Quality Management (QM)
- Reinsurance (RI)
- Third Party Liability (TPL)

Each Standard Area consists of several Standards designed to measure the Contractor's performance. A Contractor may receive up to a maximum possible score of 100 percent for each Standard measured in the CY 2019 Operational Review. Within each Standard are specific scoring detail criteria worth a defined percentage of the total possible score. AHCCCS totals the percentages awarded for each scoring detail into the Standard's total score. Using the sum of all applicable Standard total scores, AHCCCS then developed an overall Standard Area Score.

In addition, a Standard may be scored Not Applicable (N/A) if it does not apply to the Contractor and/or there were no instances in which the requirement applied.

Contractors must complete a Corrective Action Plan (CAP) for any Standard where the total score is less than 95 percent.

Based on the findings of the review, one of three Required Corrective Action statements were made:

The Contractor must…	This indicates critical non-compliance in an area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
The Contractor should…	This indicates non-compliance in an area that must be corrected to be in compliance with the AHCCCS contract, but is not critical to the everyday operation of the Contractor.
The Contractor should consider…	This is a suggestion by the Review Team to improve operations of the Contractor, although it is not directly related to contract compliance.

SUMMARY OF FINDINGS

Corporate Compliance (CC)	CC Standard Area Score = 92% (460 of 500)	
Standard	**Score**	**Required Corrective Actions**
CC 1 The Contractor has an operational Corporate Compliance program including a work plan that details compliance activities.	100%	None
CC 2 The Contractor and its subcontractors have a process for identifying suspected cases of FWA and for reporting all the suspected fraud, waste and abuse referrals to AHCCCS OIG following the established mechanisms.	100%	None
CC 3 The Contractor educates staff and the provider network on fraud, waste and abuse.	100%	None
CC 4 The Contractor audits its providers through its claims payment system or any other data analytics system for accuracy and to identify billing inconsistencies and potential instances of fraud, waste or abuse.	100%	None
CC 5 The Contractor collects required information for all persons with an ownership or control interest in the Contractor and its fiscal agents and determines on a monthly basis, whether such individuals have been convicted of a criminal offense related to any program under Medicare, Medicaid or the Title XX services program.	60%	The Contractor must ensure that information regarding ownership and control, e.g. the name, address, date of birth and social security number of any managing employees is collected.

Claims and Information Systems (CIS)	CIS Standard Area Score = 91% (906 of 1000)	
Standard	**Score**	**Required Corrective Actions**
CIS 1 The Contractor has a mechanism in place to inform providers of the appropriate place to send claims.	100%	None
CIS 2 The Contractor's remittance advice to providers contains the minimum required information.	100%	None

Claims and Information Systems (CIS)	CIS Standard Area Score = 91% (906 of 1000)	
CIS 3 The Contractor has a process to identify claims where the Contractor is or may be a secondary payor prior to payment.	100%	None
CIS 4 The Contractor has AHCCCS compliant policies and procedures for the recoupment of overpayments and adjustments for underpayments.	100%	None
CIS 5 The Contractor pays applicable interest on all claims, including overturned claim disputes.	62%	The Contractor must ensure it pays applicable interest on all claims, including claim disputes.
CIS 6 The Contractor accurately applies quick-pay discounts.	50%	The Contractor must ensure it applies quick pay discounts to claims.
CIS 7 The Contractor processes and pays all overturned claim disputes in a manner consistent with the decision within 15 business days of the decision.	94%	The Contractor must ensure it processes and pays all overturned claim disputes in a manner consistent with the decision within 15 business days of the decision.
CIS 8 The Contractor ensures that the parties responsible for the processing of claims have been trained on the specific rules and methodology for the processing of claims for the applicable AHCCCS line of business.	100%	None
CIS 9 Contractor has a process to identify resubmitted claims and a process to adjust claims for data corrections or revised payment.	100%	None
CIS 10 The Contractor has a process to ensure that all contracts/agreements are loaded accurately and timely and pays non-contracted providers as outlined in statute.	100%	None

Delivery Systems (DS)	DS Standard Area Score = 95% (946 of 1000)	
Standard	**Score**	**Required Corrective Actions**
DS 1 The Contractor has sufficient staffing in place to ensure providers receive assistance and appropriate, prompt resolution to their problems and inquiries.	100%	None

Delivery Systems (DS)	DS Standard Area Score = 95% (946 of 1000)	
DS 2 The Contractor determines, monitors, and adjusts the number of members assigned to each PCP.	100%	None
DS 3 Provider Services Representatives are adequately trained.	80%	The Contractor's provider manual must ensure it correctly addresses claims dispute and appeal time frames.
DS 4 The Contractor provides the following information via written or electronic communication to contracted providers: Exclusion from the Network, Material Changes, Policy/Procedure Change, Subcontract Updates, Termination of Contract, and Disease/Chronic Care Management Information.	100%	None
DS 5 The Contractor's Provider Selection Policy and Procedure prohibits discrimination against providers who serve high-risk populations or that specialize in conditions that result in costly treatment.	100%	None
DS 6 The Contractor does not prohibit or otherwise restrict a provider from advising or advocating on behalf of a member who is his/her patient.	100%	None
DS 7 The Contractor has a mechanism for tracking and trending provider inquiries that includes timely acknowledgement and resolution and taking systemic action as appropriate.	100%	None
DS 8 The Contractor refers members to out of network providers if it is unable to provide requested services in its network.	N/A	None
DS 9 The Contractor develops, distributes and maintains a provider manual, and makes its providers and subcontractors aware of its availability.	66%	The Contractor's Provider Manual must address the noted deficiencies as well as ensure it includes all applicable information as required in the AHCCCS Contractor Operations Manual (ACOM) Policy 416, Provider Information.
DS 10 The Contractor has a process for collecting, maintaining, updating and reporting accurate demographic information on its provider network.	100%	None
DS 11 (All Plans except CMDP) The Contractor's network analysis meets AHCCCS requirements for evaluating member geographic access to care.	N/A	None

Delivery Systems (DS)	DS Standard Area Score = 95% (946 of 1000)	
DS 12 The Contractor has a process for determining if there has been a material change that could affect the adequacy of capacity and services.	100%	None
DS 13 (RBHA Only) The Contractor has comprehensive policies and procedures and has provided evidence that they actively monitored their own and the provider's operations to ensure they have properly adhered to the requirements of 2 CFR Part 200 to include block grant funding requirement notifications, communication to providers of prohibited uses of block grant funding, tracking of provider audits, including Single Audits, and follow-up on findings.	N/A	None
DS 14 (RBHA Only) Contractor performed provider block grant monitoring activities and has evidence of the following: • Comprehensive provider SABG and MHBG policies and procedures; • SABG and MHBG activities were monitored to ensure funds were expended for authorized purposes; • Block grant funds tracking, including unexpended funds, for appropriate allocation by category, recoupment and/or return to AHCCCS.	N/A	None
DS 15 (All Plans except CMDP) The Contractor has identified the means to ensure any Peer/Recovery Support Specialists, employed within their network, have adequate access to continuing education specific to the practice of peer support.	N/A	None
DS 16(All Plans except CMDP) The Contractor has identified the means to ensure any supervisors of Peer/Recovery Support Specialists, employed within their network, have adequate access to ongoing education specific to the practice of peer support.	N/A	None

General Administration (GA)	GA Standard Area Score = 89% (267 of 300)	
Standard	**Score**	**Required Corrective Actions**
GA 1 The Contractor has policies and procedures for the maintenance of records and can provide those records, when requested.	100%	None
GA 2 The Contractor provides training to all staff on AHCCCS guidelines.	100%	None
GA 3 The Contractor maintains a policy on policy development.	67%	The Contractor must ensure that all policies and procedures are reviewed annually.

Grievance Systems (GS)	GS Standard Area Score = 68% (1157 of 1700)	
Standard	**Score**	**Required Corrective Actions**
GS 1 The Contractor issues and carries out appeal decisions within required timeframes.	40%	The Contractor must review the Code of Federal Regulations (42 CFR 438.10; 42 CFR 438.404; 42 CFR 438.406; 42 CFR 438.408; 42 CFR 438.410; and 42 CFR 438.414) and AHCCCS Contract to ensure: 1. The Grievance and Appeal policy stipulates that the Contractor transfers denied expedited appeal requests to the standard appeal review process. 2. The Grievance and Appeal policy stipulates a written notice be issued to the enrollee when an extension to the standard appeal review process is taken. 3. The Grievance and Appeal policy stipulates that the Contractor provides oral notification of an expedited appeal resolution decision.
GS 2 Contractor policies for appeal allow for providers to file on behalf of a member if the member has given their consent.	100%	None
GS 3 The Contractor has a process for the intake and handling of member appeals that are filed orally.	100%	None
GS 4 The Contractor ensures that the individuals who make decisions on appeals were not involved in any previous level of review or decision making.	100%	None

Grievance Systems (GS)	GS Standard Area Score = 68% (1157 of 1700)	
GS 5 The Contractor ensures that the individuals who make decisions on appeals are appropriately qualified.	100%	None
GS 6 The Contractor has a process for internal communication and coordination when an appeal decision is reversed.	0%	The Contractor must review 42 CFR 438.424 and AHCCCS Contract to ensure that the Grievance and Appeal policy has a process for internal communication and coordination when an appeal decision is reversed.
GS 7 The Contractor continues or reinstates an enrollee's benefits when an appeal is pending under the appropriate circumstances as required by Federal Regulation.	80%	The Contractor must ensure that the enrollee's benefits are reinstated or continued when an appeal is pending under the appropriate circumstances as required by the Arizona Administrative Code (AAC R9-34-224) and Code of Federal Regulations (42 CFR 438.420). The Contractor must also ensure that the Chapter 10 Provider Manual states the language from 42 CFR 438.420. "The services were ordered by an authorized provider."
GS 8 The Contractor issues Notices of Appeal Resolution that includes all information required by AHCCCS.	75%	The Contractor must ensure that the Grievance and Appeal policy, CMDP Provider Manual, and the Contractor's notices stipulate all the required information in the Notice of Appeal Resolution in accordance with AHCCCS Contract, A.A.C. R9-34-216 and 42 CFR 438.408(e).
GS 9 If the Contractor or Director's Decision reverses a decision to deny, limit, or delay services that were not furnished while an appeal or hearing was pending, the Contractor authorizes or provides the appealed services promptly and as expeditiously as the member's health condition requires. If an appeal is upheld the Contractor may recover the cost of services received by the enrollee during the appeal process.	0%	The Contractor must ensure that the Contractor's policies require the prompt, or as expeditiously as the member's condition requires, authorization or provision of services should the initial determination to deny, limit, or delay a service is reversed by appeal or Director's Decision in accordance with 42 CFR 438.420(d.) and 42 CFR 438.424; and AAC R9-34-225. In addition, the Contractor must have policies that allow recovering the cost of services provided during the appeal process when the denial is upheld in accordance with 42 CFR 438.420(d.) and 42 CFR 438.424; and AAC R9-34-225.
GS 10 The Contractor's member appeal policies allow for, and require notification of the member of, all rights granted under rule.	0%	The Contractor must have policies that require assisting the enrollee with the filing process, including toll free numbers that an enrollee can use to file an appeal, per 42 CFR 406(b), AAC R9-34-210; and AAC R9-34-211. The Contractor must have policies that require the member is given reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing, per 42 CFR 406(b), AAC R9-34-210; and AAC R9-34-211. The Contractor must have policies that require the member and/or their representative is given the opportunity before and during the appeal

Grievance Systems (GS)	GS Standard Area Score = 68% (1157 of 1700)	
		process to review the case file, including medical records, and any other documents and records considered during the appeal process, per 42 CFR 406(b), AAC R9-34-210; and AAC R9-34-211. The Contractor must have policies that require the enrollee and/or his representative or legal representative is included as a party to the appeal, per 42 CFR 406(b), AAC R9-34-210; and AAC R9-34-211.
GS 11 The Contractor maintains claim dispute records.	100%	None
GS 12 The Contractor logs, registries, or other written records include all the contractually required information.	100%	None
GS 13 The Contractor confirms all provider claim disputes with a written acknowledgement of receipt.	100%	None
GS 14 Requests for hearing received by the Contractor follows the timeframe and notice requirements.	30%	The Contractor must have a written request for hearing policy, per the AHCCCS Contract. Additionally, the Contractor must include the following with every request for hearing file: cover letter; written request for hearing; copy of entire file, including pertinent records; copy of the Contractor's decision Notice; and other information relevant to the Contractor's decision Notice, per the AHCCCS Contract.
GS 15 The Contractor resolves claim disputes and mails written Notice of Decisions no later than 30 days after receipt of the dispute unless an extension is requested or approved by the provider.	80%	The Contractor must specify in policy when extension letters are issued when the Contractor requires additional time to make a decision or the provider requests additional time to provide supporting documentation/testimony and maintains evidence of the provider's acknowledgement or approval when an extension is taken, per AAC R9-34.405 and the AHCCCS Contract.
GS 16 The Contractor's grievance process follows the timeframe and written notice requirements.	100%	None
GS 17 The Contractor shall have written policies delineating the Grievance System.	52%	The Contractor must have written policies addressing expedited and standard appeals, per 42 CFR 438.400 et al, AAC R9-34-201 et seq, and AHCCCS Contract. The Contractor must provide AHCCCS documentation on how the Contractor complies with providing a copy of the Claim Dispute Policy to providers at the time of contract. In addition, the Contractor must

Grievance Systems (GS)	**GS Standard Area Score = 68% (1157 of 1700)**	
		provide AHCCCS documentation demonstrating how the Contractor complies with providing a copy of the Claim Dispute Policy to non-contracted providers with remittance advice.
GS 18 (ALTCS/EPD Only) SMI Grievances: The Contractor appoints an investigator within seven days of the receipt of the grievance or request for investigation, a written dated decision which explains the essential facts as to why the matter may be appropriately resolved without investigation, and the resolution.	N/A	None
GS 19 (ALTCS/EPD Only) SMI Grievances: The Contractor completes the investigation report within 30 calendar days from the date of the investigator's appointment, or obtains and documents an extension.	N/A	None
GS 20 (ALTCS/EPD Only) SMI Grievances: The Contractor drafts an investigation report that describes the investigation and contains findings of fact, conclusions, and recommendations.	N/A	None
GS 21 (ALTCS/EPD Only) SMI Grievances: The Contractor, within five days of receipt of the investigator’s report, reviews the investigation case record and the report, and issues a written, dated decision.	N/A	None
GS 22 (ALTCS/EPD Only) SMI Grievances: The Contractor, in the decision letter, includes a notice of the right to request an appeal of the decision within 30 days from the date of receipt of the decision.	N/A	None
GS 23 (ALTCS/EPD Only) SMI Grievances: The Contractor maintains a database containing data that matches the information contained in the grievance investigation case record and was entered into the database within three (3) business days, including the essential facts as to why the matter may be appropriately resolved without investigation, and the resolution.	N/A	None
GS 24 (ALTCS/EPD Only) SMI Grievances: The Contractor maintains a complete grievance investigation case record.	N/A	None
GS 25 (ALTCS/EPD Only)	N/A	None

Grievance Systems (GS)	GS Standard Area Score = 68% (1157 of 1700)	
SMI Appeals: The contractor informs the client in writing that the appeal has been received and of the procedures that shall be followed during the appeal, within five days of receipt of an appeal. The Contractor shall hold an informal conference with the client, any designated representative and/or guardian, the case manager and representatives of the clinical team, and a representative of the service provider, if appropriate, within seven days of receipt of the notice of appeal.		
GS 26 (ALTCS/EPD Only) SMI Appeals: The Contractor continues the service pending the resolution of the appeal if appropriately requested by the member, and the appeal relates to the modification or termination of a behavioral health service unless a Qualified Clinician determines that the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the person or another individual, or the person or guardian, if applicable, agrees in writing to the modification or termination.	N/A	None
GS 27 (ALTCS/EPD Only) SMI Appeals: The Contractor ensures that an authorized decision maker for the issue on appeal attended the informal conference.	N/A	None
GS 28 (ALTCS/EPD Only) SMI Appeals: The Contractor ensures that if the issues in dispute are not resolved to the satisfaction of the appellant and the issues in dispute do not relate to the appellant's eligibility for behavioral health services, the appellant is informed that the matter will be forwarded for further Appeal to AHCCCS for informal conference, and of the procedure for requesting a waiver of the AHCCCS informal conference.	N/A	None
GS 29 (ALTCS/EPD Only) SMI Appeals: The Contractor shall maintain appeal case records to include copies of all documents generated or acquired through the Appeal process.	N/A	None
GS 30 (ALTCS/EPD Only) SMI Appeals: The Contractor maintains a database containing data that matches the information contained in the appeal case record and was entered into the database within 3 business days.	N/A	None

AHCCCS OPERATIONAL REVIEW
EXECUTIVE SUMMARY
CY 2019

Adult, EPSDT and Maternal Child Health (MCH)	MCH Standard Area Score = 76% (1058 of 1400)	
Standard	**Score**	**Required Corrective Actions**
MCH 1 The Contractor has established a maternity care program that operates with goals directed at achieving optimal birth outcomes that meet AHCCCS minimum requirements.	82%	The Contractor must develop a policy and procedure to ensure that it employs sufficient numbers of appropriately qualified local personnel in order to meet the requirements of the maternity care program for eligible enrolled members and achieve contractual compliance.
MCH 2 The Contractor ensures that pregnant members obtain initial prenatal care appointments and return visits, in accordance with ACOG standards, along with ensuring members receive appointments according to the AHCCCS Contractor Operations Manual (ACOM) Maternity Care Appointment Standards.	75%	The Contractor must develop and implement a process to monitor provider compliance of perinatal/postpartum depression screenings being conducted at least once during the pregnancy and then again at the postpartum visit, with appropriate counseling and referrals made, if a positive screening is obtained.
MCH 3 The Contractor ensures postpartum care is provided for a period of up to 57 days after delivery.	67%	The Contractor must develop and implement a process to identify postpartum depression, refer members to the appropriate health care providers and ensure the member is connected to care.
MCH 4 Family planning services are provided to members who voluntarily choose to delay or prevent pregnancy.	100%	None
MCH 5 The Contractor provides EPSDT/well-child services according to the AHCCCS EPSDT Periodicity Schedule.	84%	The Contractor must demonstrate that it employs sufficient numbers of appropriately qualified local personnel to meet the requirements of the EPSDT program for eligible enrolled members and achieve contractual compliance.
MCH 6 The Contractor monitors member compliance with obtaining EPSDT services.	80%	The Contractor must demonstrate that they identify and provide targeted outreach to members who miss/no-show their EPSDT appointments. This includes all EPSDT members who miss appointments, not just case management for the CRS population.
MCH 7 The Contractor monitors provider compliance with providing EPSDT services.	50%	1. The Contractor must demonstrate that it monitors, tracks, and evaluates provider compliance with providing EPSDT/well-child services to all eligible members according to the most current periodicity schedule. 2. The Contractor must demonstrate that it measures, monitors, and implements activities to improve member participation rates for age appropriate screenings, according to the most current periodicity schedule. This shall include, but is not limited to targeted blood lead

Adult, EPSDT and Maternal Child Health (MCH)	MCH Standard Area Score = 76% (1058 of 1400)	
		screening/testing and developmental/behavioral assessments.
MCH 8 The Contractor ensures that oral health/dental services are provided according to the AHCCCS Medical Policy Manual and the AHCCCS Dental Periodicity Schedule.	66%	The Contractor must demonstrate that it monitors providers to determine if oral health/dental services are provided according to the AHCCCS Dental Periodicity Schedule. In addition, the Contractor must demonstrate that it has implemented member outreach activities to increase utilization of oral health/dental services.
MCH 9 The Contractor ensures providers participate with the Arizona State Immunization Information System (ASIIS) and Vaccine for Children (VFC) programs according to the state and federal requirements.	100%	None
MCH 10 (All Plans except RBHAs) The Contractor coordinates with appropriate agencies and programs including but not limited to VFC, WIC, and Head Start, and provides education, assists in referrals, and connects eligible EPSDT members with appropriate agencies, according to federal and state requirements.	20%	The Contractor must coordinate with appropriate agencies and programs, as well as provide education, assist in referrals and connect eligible EPSDT members with these agencies and services to: 1. Increase provider referrals to WIC. 2. Increase member utilization of VFC. 3. Increase provider referrals to Head Start. 4. Increase member utilization of Home Visiting Programs.
MCH 11 (All Plans except RBHAs) The Contractor coordinates with Arizona Early Intervention Program (AzEIP) according to federal and state requirements.	100%	None
MCH 12 The Contractor has policies and procedures to identify the needs of EPSDT age members, coordinate their care, conduct adequate follow up to verify that members receive timely and appropriate treatment.	100%	None
MCH 13 The Contractor monitors, evaluates, and improves utilization of nutritional screenings and appropriate interventions, including medically necessary supplemental nutrition to EPSDT age members.	100%	None
MCH 14 The Contractor ensures that women's preventive care services are provided according to the AHCCCS Medical Policy Manual (AMPM).	34%	The Contractor must demonstrate that it monitors provider compliance of delivering well-woman preventative care services as listed in AMPM 411. In addition, the Contractor must have a process to inform members about women's preventative health services as listed in AMPM 411.
MCH 15 The Contractor ensures that behavioral health medical records requirements are completed in accordance with Policy.	N/A	None

Adult, EPSDT and Maternal Child Health (MCH)	MCH Standard Area Score = 76% (1058 of 1400)	
MCH 16 The Contractor ensures that a current treatment/assessment/service plan has been completed within the previous 365 days and is part of the behavioral health medical record.	N/A	None

Medical Management (MM)	MM Standard Area Score = 85% (2047 of 2400)	
Standard	**Score**	**Required Corrective Actions**
MM 1 The Contractor shall have mechanisms to evaluate utilization data analysis and data management, including both underutilization and overutilization of services and implement changes if appropriate.	100%	None
MM 2 The Contractor has an effective concurrent review process which includes a component for reviewing the medical necessity of institutional stays, including but not limited to Institution for Mental Disease (IMD), Behavioral Health Institutional Setting and Nursing Facilities.	70%	The Contractor must ensure concurrent review is done within 1 business day of notification per the Contractor's policy.
MM 3 The Contractor conducts proactive discharge planning and coordination of services for members between settings of care for short-term and long-term hospital and institutional stays.	35%	The Contractor must ensure arrangement of a follow-up appointment with the PCP and/or specialist within seven days of discharge; a post discharge telephone call is placed within three days of discharge and proactive discharge planning occurs upon notification of admission.
MM 4 The Contractor collaborates with the Arizona State Hospital prior to member discharge and members who are conditionally released under the authority of the Psychiatric Security Review Board (PSRB).	N/A	None
MM 5 The Contractor shall process Prior Authorization requests in accordance with State and Federal requirements.	95%	None
MM 6 The Contractor has a comprehensive inter-rater reliability (IRR) testing process to ensure consistent application of criteria for clinical decision making.	60%	The Contractor must provide IRR scores for each staff member.
MM 7 The Contractor conducts retrospective reviews.	100%	None

Medical Management (MM)	**MM Standard Area Score = 85% (2047 of 2400)**	
MM 8 The Contractor develops or adopts and disseminates clinical practice guidelines for physical and behavioral health services.	100%	None
MM 9 The Contractor evaluates new technologies and new uses for existing technologies.	100%	None
MM 10 The Contractor identifies and coordinates care for members with special health care needs.	100%	None
MM 11 (ACC, RBHA, CMDP, DDD Only) The Contractor coordinates care for members with qualifying Children's Rehabilitative Services (CRS) conditions	100%	None
MM 12 The Contractor identifies and coordinates care for members who are candidates for stem cell or solid organ transplants.	100%	None
MM 13 The Contractor promotes health maintenance and coordination of care through Disease/Chronic Care Management Programs.	100%	None
MM 14 The Contractor has a system and process that outlines a Drug Utilization Review (DUR) Program.	80%	The Contractor must have a process for prospective review for all drugs prior to dispensing in order to identify potential drug interactions, drug-pregnancy conflicts, therapeutic duplication, drug-age conflicts and non-formulary drug requests.
MM 15 The Contractor facilitates coordination of services being provided to member when the member is transitioning between Contractors.	100%	None
MM 16 The Contractor allows primary care providers to provide behavioral health services within their scope of practice including but not limited to substance use disorders, anxiety, depression and Attention Deficit Hyperactivity Disorder (ADHD) for the purpose of medication management.	100%	None
MM 17 The Contractor ensures that members receive medically necessary behavioral health services	80%	The Contractor must inform PCPs of the ability and process to directly refer members with suspected diagnoses of autism directly to a specialized Autism Spectrum Disorder (ASD) diagnosing provider.
MM 18	100%	None

Medical Management (MM)	**MM Standard Area Score = 85% (2047 of 2400)**	
The Contractor does not deny emergency services.		
MM 19 The Contractor issues a Notice of Adverse Benefits determination (NOA) to the member when a requested service has been denied, limited, suspended, terminated, or reduced.	92%	The Contractor must ensure NOAs are written in compliance with State and Federal Regulations and as outlined in AHCCCS Policy ACOM 414.
MM 20 The Contractor's MM program includes administrative requirements for oversight and accountability for all MM functions and responsibilities that are delegated to other entities.	100%	None
MM 21 The Contractor identifies, monitors, and implements interventions to prevent the misuse of controlled and non-controlled medications.	85%	The Contractor must assign members who meet the AHCCCS established parameters to an exclusive pharmacy and/or single prescriber for up to a 12-month period and provide members with information on how to address emergencies when members are assigned to an exclusive pharmacy and or prescriber (i.e. Out of stock medication, pharmacy closed).
MM 22 The Contractor shall demonstrate that services are delivered in compliance with Mental Health Parity.	100%	None
MM 23 The Contractor shall employ care managers to perform Contractor care management functions.	50%	The Contractor shall identify and coordinate care for members with Opioid Use Disorders.
MM 24 The Contractor provides End of Life Care and Advanced Care planning.	0%	The Contractor must have policies and procedures for the provision of End of Life Care and Advanced Care planning; as well as ensure providers and their staffs are educated in the concepts of EOL care and Advance Care Planning.
MM 25 (ACC, ALTCS/EPD, and RBHA Only) The Contractor maintains collaborative relationships with other government entities that deliver services to members and their families, ensures access to services, and coordinates care with consistent quality.	N/A	None
MM 26 (All except CMDP) The Contractor establishes processes for ensuring coordination and provision of appropriate services for members transitioning from the justice system	N/A	None
MM 27 The Contractor establishes processes for ensuring coordination and	N/A	None

Medical Management (MM)	MM Standard Area Score = 85% (2047 of 2400)	
provision of appropriate services for members who are court ordered treatment.		
MM 28 The Contractor has a process to monitor members and services provided to members in an out of state placement settings.	100%	None

Member Information (MI)	MI Standard Area Score = 78% (625 of 800)	
Standard	**Score**	**Required Corrective Actions**
MI 1 The Contractor's New Member Information Packets meet AHCCCS standards for content and distribution.	100%	None
MI 2 The Contractor notifies members that they can receive a new member handbook annually.	100%	None
MI 3 The Contractor assesses PCP capacity and evaluates it prior to assigning new members.	100%	None
MI 4 The Contractor trains its Member Services Representatives, and appropriately handles and tracks member inquiries and complaints.	33%	The Contractor must develop and implement a process, including training materials that specifically focuses on and ensures Member Service Representatives are trained to appropriately identify, document, refer and respond to member inquiries and grievances. Additionally, the Contractor must monitor phone inquiries to ensure members are assisted according to its policy.
MI 5 The Contractor notifies affected members timely when a PCP or frequently utilized provider leaves the network.	67%	The Contractor must provide a written notice to its members within 15 days of the date of receipt of a provider's termination notice.
MI 6 The Contractor notifies affected members of material changes to network and/or operations at least 30 days before the effective date of the change.	N/A	None
MI 7 The Contractor distributes at a minimum two member newsletters per contract year which contain the required member information.	75%	The Contractor must distribute a minimum of two member newsletters per contract year which contain the required member information.

Member Information (MI)	MI Standard Area Score = 78% (625 of 800)	
MI 8 The Contractor's Member Services, Transportation, and Prior Authorization staff has access to, and utilizes, appropriate mapping search engines and/or applications when scheduling appointments and/or referring members to services or service providers.	50%	The Plan must develop and implement a Desk Reference and/or training materials that contain information on use of mapping services/applications.
MI 9 The Contractor submits to AHCCCS for approval qualifying member information materials given to its current members, that do not fall within annual, semi-annual or quarterly required submissions and maintains a log of all member material distributed to its members.	100%	None
MI 10 The Contractor maintains policies on Social Networking.	N/A	None

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
Standard	**Score**	**Required Corrective Actions**
QM 1 The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for member/system resolution.	23%	1. **QOC Process:** a. **Triage/Referral** The Contractor must submit an updated policy and procedure/desktop that clearly outlines the triage process from referral receipt including but not limited to identification of the potential QOC, assessment of the initial severity level of the QOC, and author(s) of the assessment of the triage process. All elements of the triage process shall be clearly documented. This must be a stand-alone process that is completed within the Quality Management Unit. Per AMPM 960, "Work units outside of the Quality Management Unit do not have the authority to conduct quality of care investigations but may provide subject matter expertise throughout the investigative process." As part of the desktop procedure the Contractor must incorporate an inter-rater reliability process to ensure standardization and consistency of the triage process.

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
		The Contractor must develop and submit a tool that will be used to conduct inter-rater reliability auditing of the triage process. The Contractor must submit evidence of QM Department staff training on the updated policy, procedure, and desktops. The Contractor must submit training materials, printed first and last name of QM staff, title, and date of training received. In addition, the Contractor must submit 5 QOC case files demonstrating the use of the IRR audit tool, the results of the completed audits, and any interventions resulting from the inter-rater audit. The Contractor must update the work flow diagram titled A QM4 Quality AHCCCS Notification Process, to broaden the sources of incoming potential QOCs to the QM department. Examples of incoming referral sources may encompass administrative data sources, other agencies and entities internal or external to the QM department, as well as members and/or their representatives. However, the process must include notification scenarios of AHCCCS reportable QOCs from non-AHCCCS initiated referral sources. All notifications to AHCCCS for AHCCCS reportable case types shall be completed within 24 hours. The Contractor must submit the updated workflow diagram above for AHCCCS review. In addition, the Contractor must provide a process to allow for direct method, phone and email, for members/representatives or others external to the Contractor to contact and speak with QM staff directly for potential QOC concerns. The Contractor must provide documented evidence of communication to member/family within the QOC file. The Contractor shall, upon discovery of potential AHCCCS reportable

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
		QOCs, notify AHCCCS prior to completion of the QOC investigation. The case should carry the label of a QOC regardless of the outcome of the investigation substantiation, for example, substantiated QOC or unsubstantiated QOC. With the exception of the notification to AHCCCS, this principle should also apply to AHCCCS non-reportable QOCs. The Contractor must submit an updated policy and procedure/desktop of the above QOC process. Furthermore, the Contractor must update policies and procedures and desktops, existing and/or newly created, of their Mortality Review process in order to incorporate administrative data, other than internal and external notifications. The Contractor must submit updated policies and procedures and desktops of their Mortality Review process for AHCCCS review, including any evidence to demonstrate that administrative data was incorporated. The Contractor must submit 3 mortality case files representing the steps from the administrative referral source, through triage, to complete resolution. The QM portal shall be utilized for all documentation. b. **Regulatory Referral** Due to mandatory reporting, third party reporting should not be accepted unless there is documented evidence of the first and last name of the regulatory agency employee/staff member, including the date and time the regulatory agency was contacted , name of the agency, and other pertinent information such as confirmation numbers. The Contractor must develop a plan to ensure referrals made to

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
		regulatory entities are documented within the QOC file. The Contractor shall submit revision to current policy to reflect these process changes. In addition, the Contractor must provide staff training to its QM Department for the revised policy and must provide evidence of sign-in sheets/attestations with printed first and last name of QM staff, and date of training received. The Contractor must provide at least 5 QOC case files documenting regulatory agency referrals. c. **Medical Record Requested Timely** Case turnaround time cannot be established without basic referral dates, medical record request dates, medical record received dates, etc. The Contractor must update policies and procedures/desktops on the medical record request process to ensure timely progress of QOC case investigations. The process must include documentation of the QM staff submitting the request, date of the request, name of the recipient (organization/provider, etc.) of the request, as well as the date received in relation to the QOC referral. Any related QOC investigations are a stand-alone process, which involves the medical record review process and tracking. This is completed within the Quality Management Unit and cannot be delegated to non-QM staff. d. **Case Analysis Focused on QOC** The Contractor must submit a policy and procedure/desktop that clearly outlines the investigative responsibilities of the QM Department in the QOC process. As part of the desktop procedure the Contractor must outline the steps of the QOC investigative process and incorporate an inter-rater

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
		reliability process to ensure standardization and consistency of QOC case investigations. The Contractor must develop and submit a tool that will be used to conduct inter-rater reliability auditing of the QOC investigative process. The Contractor must submit evidence of QM Department staff training on the updated policy, procedure, and desktops. The Contractor must submit training materials, printed first and last name of QM staff, and date of training received. In addition, the Contractor must submit 5 QOC case files demonstrating use of the IRR audit tool, the results of the completed audits, and any interventions resulting from the implementation of the inter-rater audit process. The Contractor must also include evidence of incorporating this QOC investigative process with the QM portal. e. **Mortality Review: Case Analysis** See section "A" above with regards to Mortality Reviews and Corrective Action Plan. f. **Case Progresses According to Time Lines** Refer to sections "A" and "C" above with regards to Corrective Action Plan. g. **High Acuity Complex Cases, Repeat Issues or Trends are Elevated** Review of policy A QM2 HS-QM-03 Quality of Care Review – 2018, documented that "The CMDP Chief Medical Officer (CMO) reviews and evaluates all QOC issues during and after the investigation has been completed. The CMO makes the final determination on substantiation, severity level and category of each concern and

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
		determines the need for corrective action." The Contractor must follow the policy as described above. The Contractor shall document this process utilizing the QM portal. In addition, the Contactor must retrain staff on the above policy and documentation procedure within the QM portal. Training documentation must be submitted to AHCCCS demonstrating this retraining. Training documentation shall include training materials, printed first and last name of QM staff, and date of training received. h. **Final Severity Level** The Contractor must update policies and/or desktop procedures to ensure thorough and complete QOC case documentation is present and reflective for the entire QOC process (initiation to resolution). As part of the desktop procedure the Contractor must incorporate an inter-rater reliability process to ensure standardization and consistency of case documentation, which includes severity level determination. The Contractor must submit updated policies and desktop procedures, including evidence of QM Department staff training to the updated procedures. Training documentation must be submitted to AHCCCS that includes training materials, printed first and last name of QM staff, and date of training received. Additionally, the Contractor must submit the tool used to conduct inter-rater reliability audits. In addition, the Contractor must submit 5 QOC case files demonstrating use of the IRR audit tool, the results of the completed audits, and any interventions resulting from the implementation of the

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
		inter-rater audit process. The Contractor must also include evidence of incorporating this QOC investigative process with the QM portal. i. **Final Quality Indicator** The Contractor must incorporate use of an audit tool for inter-rater reliability amongst QM staff to assure that Clinical Quality Indicators are clearly identified and documented for each allegation and/or initial and final indicators upon investigation. The Contractor shall apply methods consistently with each investigation and in accordance with any updated policies and procedures. The Contractor must submit 5 QOC case files demonstrating compliance with the above. The Contractor must also include evidence of incorporating this QOC investigative process with the QM portal. j. **Final Case Substantiation is Congruent with Final Severity Level** The Contractor must incorporate use of an audit tool for inter-rater reliability amongst QM staff to assure that final case substantiation is congruent with final severity level and appropriately documented. The Contractor shall apply methods consistently with each investigation and in accordance with any updated policies and procedures. The Contractor is must submit 5 QOC case files demonstrating compliance with the above. The Contractor must also include evidence of incorporating this QOC investigative process with the QM portal. k. **Cases Referred and Presented to Peer Review Committee** Please refer to the above CAPs for QOC framework including escalation to Peer Review committee. In addition, review of the Contractor's policy, A QM2 HS-QM-03

Quality Management (QM)		QM Standard Area Score = 62% (1121 of 1800)
		Quality of Care Review – 2018, revealed that "Immediately following the Credentialing Review meeting where a case is identified as having a quality deficiency, Provider Services investigates the issue and compile a Peer Review file for the case within 7 days." The Contractor must submit for AHCCCS review an update of the policy above to reflect AMPM policies in that the QOC process is a stand-alone process that cannot be delegated. Work units outside of the Quality Management Unit do not have the authority to conduct quality of care investigations but may provide subject matter expertise throughout the investigative process. l. **Corrective Action Addresses All Gaps in Care** As part of the framework for completing a QOC investigation, the Contractor must update policies and procedure/desktops to delineate the Contractor's role in navigating a case from initiation to full resolution with corrective action plans addressing substantiated cases with severity levels 1-4. The Contractor must submit updated policies and procedures/desktops for AHCCCS review. The Contactor must train staff on the above policy and documentation procedure within the QM portal. Training documentation is to be submitted to AHCCCS demonstrating this training. Training documentation must include training materials, printed first and last name of QM staff, and date of training received. m. **CAPs are Completed Prior to CAP Closure** As part of the CAP process within the QOC framework, the Contractor must update policies and procedure/desktops to include that CAPs are completed prior to CAP closure. The Contractor is to must submit updated policies and

Quality Management (QM)	**QM Standard Area Score = 62% (1121 of 1800)**	
		procedures/desktops for AHCCCS review. The Contactor is to train staff on the above policy. Training documentation must be submitted to AHCCCS demonstrating this training. Training documentation shall include training materials, printed first and last name of QM staff, and date of training received. n. **CAP Monitoring and Progression** The Contractor must update policies and procedure/desktops to include CAP monitoring and elevation to the Contractor's Medical Director or designee for CAPs that are not progressing. The Contractor must submit updated policies and procedures/desktops for AHCCCS review. The Contactor must train staff on the above policy. Training documentation must be submitted to AHCCCS demonstrating this training. Training documentation shall include training materials, printed first and last name of QM staff, and date of training received.
QM 2 The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for system improvement.	66%	The Contractor must submit updated flow charts/diagrams clearly relaying that incidents/quality-of-care complaints received anywhere in the organization are referred to Quality Management for investigation and resolution. Additionally, the Contractor must submit documentation demonstrating use of the forms titled A QM2 Concern Assessment Form and A QM2 #1 QOC Notification. The Contractor must submit policy and procedure/desktops addressing the process in which the Contractor incorporates successful interventions into the Quality Management (QM) program or assigns new interventions/approaches when necessary. In addition, the Contractor must provide documentation demonstrating implementation of this process. The Contractor must submit policy and procedure/desktops to assess, prioritize, and review Incident Accident Death (IAD)/Internal Referral (IRF) reports and identify quality of care concerns received from the QM Portal.

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
		In addition, the Contractor must also submit documentation of training to QM staff of the above policy and procedure/desktops. Training documentation must be submitted to AHCCCS that includes training materials, printed first and last name of QM staff and date of training received.
QM 3 Contractor Quality Management staff are able to speak to requirements of the QM Program and describe day-to-day work processes to support compliance with Contract, Policy, and Program requirements.	N/A	*1.* ***QOC Process:*** a. *Triage/Referral* - Refer to QM 1 Action Item #1a for this corrective action plan. b. *Regulatory Referral* - Refer to QM 1 Action Item #1b for this corrective action plan c. *Medical Record Requested Timely* - Refer to QM 1 Action Item #1c for this corrective action plan. d. *Case Analysis Focused on QOC* - Refer to QM 1 Action Item #1d for this corrective action plan. e. *Mortality Review: Case Analysis* - Refer to QM 1 Action Item #1e with regards to Mortality Reviews and Corrective Action Plan. f. *Case Progresses According to Time Lines* - Refer to QM 1 Action Item #1a and #1c for these corrective action plans g. *High Acuity Complex Cases, Repeat Issues or Trends are Elevated* - Refer to QM 1 Action Item #1g for this corrective action plan. h. *Final Severity Level* - Refer to QM 1 Action Item #1h for this corrective action plan. i. *Final Quality Indicator* - Refer to QM 1 Action Item #1i for this corrective action plan. j. *Final Case Substantiation is Congruent with Final Severity Level* - Refer to QM 1 Action Item #1j for this corrective action plan. k. *Cases Referred and Presented to Peer Review Committee* - Refer to QM 1 Action Item #1k for this corrective action plan. l. *Corrective Action Addresses All Gaps in Care* - Refer to QM 1 Action Item #1l for this corrective action plan. m. *CAPs are Completed Prior to CAP Closure* - Refer to QM 1 Action Item #1m for this corrective action plan. n. *CAP Monitoring and Progression* - Refer to QM 1 Action Item #1n for this corrective action plan.
QM 4 The Contractor has a structure and process in place to identify and	20%	The Contractor must develop processes, update policies, procedures and desktops and submit to AHCCCS for review, for the following clinical

Quality Management (QM)	**QM Standard Area Score = 62% (1121 of 1800)**	
investigate adverse outcomes, including mortalities, for member/system improvement.		quality areas of focus: 1. **Mortality Review**: A process for identifying mortality cases and process them as potential QOC's through the QOC Investigative framework mentioned in QM 1. 2. **Mortality Reviews Identified and Referred to the QM Unit for investigation and resolution:** Refer to QOC Investigative Framework mentioned in QM 1. Updates will be necessary to the Contractor's policy HS-QM-03. 3. **QOC Investigations with Deficiencies in Care Have Corrective Actions Plans**: The Contractor utilizes the quality management process to correct deficiencies and or opportunities for improvement, including but not limited to Medical Director Reviews, Peer Review Executive Sessions, External Peer Review, Health and Safety Committee Meetings, etc. Refer to QOC Investigative Framework mentioned in QM 1. 4. **QOC Case findings are taken to the Contractor's Peer Review Committee.** Updates will be necessary to the Contractor's policy HS-QM-03. Refer to AMPM 910.
QM 5 (ALTCS/EPD and DES/DDD Only) Contractor ensures that the staff providing attendant care, personal care, homemaker services, and habilitation services are monitored as outlined in Chapter 900.	N/A	None
QM 6 The Contractor ensures that residential settings (including behavioral health residential treatment facilities) are monitored annually in accordance to policy, by qualified staff.	N/A	None
QM 7 The Contractor has implemented a process to complete on-site quality management monitoring and investigations when potential quality of care concerns are identified, including health and safety concerns and Immediate Jeopardy.	0%	The Contractor must provide policies, procedures, and desktops that address the following elements of an onsite Clinical Quality Health and Safety visit, but is not limited to: • Onsite visits must be conducted by the Contractor's Quality Management clinical staff when there are identified health and safety

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
		concerns. ○ Per AMPM 960, "Subject matter experts (SMEs) outside the Quality Management Unit may participate in the onsite visit but may not take the place of Quality Management clinical staff during reviews. SMEs may arrive on site first if they are closer to the site, however, a clinical QM staff member must be the lead for the review/investigation and participate in the onsite visits…Contractors may not delegate quality of care investigation processes or onsite quality of care visits." • Onsite Health and Safety visits are unscheduled and unannounced • Documentation related to Unscheduled and Unannounced On-site Audits & Monitoring by QM Staff for Immediate Jeopardy and Serious Concerns. ○ audit tools, health and safety forms, and/or visit documents reflecting monitoring and assessments conducted during onsite monitoring • Timely notification and transition of services for members when an immediate jeopardy status or other serious deficiency is identified (such as, but not limited to, closure of a provider's practice) and documentation reflecting such. • Process on Corrective Action Plans, as well as ongoing monitoring upon completion of the activities and interventions to ensure that compliance is sustained. • Process to document follow-up monitoring if on Corrective Action Plan • If interventions were not sustained, the process to elevate the issues to the QM Medical Director or Designee for resolution The Contractor must submit evidence of QM Department staff training on the above policy, procedure, and desktops. The Contractor must submit training materials, printed first and last name of QM staff, title, and date of training received. The Contractor must also submit a sample of an audit tool used during

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
		Health and Safety Checks.
QM 8 The governing body and the Contractor are accountable for all Quality Management/Performance Improvement (QM/PI) program functions.	100%	None
QM 9 The Contractor has the appropriate staff employed to carry out Quality Management (QM) and Performance Improvement (PI) Program administrative requirements.	25%	Staff qualifications for education, experience, and training shall be based upon AHCCCS contractual requirements for all QM and PI positions. The Contractor must employ sufficient QM and PI personnel to carry out the functions and responsibilities specified in Contract and AMPM Policies 910 through 980, in a timely and knowledgeable manner. The Contractor must provide training to all staff in how to identify and refer Quality of Care (QOC) concerns/issues to the Quality Management Department at the time of hire and annually thereafter. The Contractor must submit clear documentation that includes first and last name, title, department, training date, and date of hire or date of last annual training.
QM 10 The Contractor has a structured Quality Management Program that includes administrative requirements related to policy development.	60%	The Contractor must implement a process to ensure that all policies are reviewed and/or revised at least annually as indicated. Additionally, the Contractor must implement a process for ensuring medical and quality management policies are approved and signed by the Contractor's local Medical Director/Chief Medical officer as indicated.
QM 11 The Contractor has implemented a structured peer review process that includes administrative requirements related to the peer review process.	55%	The Contractor must develop processes, update policies, procedures and desktops and submit to AHCCCS for review, for the following clinical quality areas of focus: 1. <u>Peer Review for Cases with Clinical Deficiencies:</u> The Contractor must develop a process to identify and refer high risk case types to the Peer Review Committee. Refer to AMPM 910 for details. 2. <u>Peer Review Committee Activities:</u> The Contractor must develop a process to identify and refer high risk case types to Peer Review for actions and/or recommendations to be carried out under the Peer Review Committee Executive Sessions. Refer to AMPM 910 and 960 for details. 3. <u>Peer Review Attendance of Same or Similar Specialty:</u> The Contractor must develop a process to demonstrate compliance with the peer review requirement for participation of at least one provider of the

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
		same or similar specialty type for the issue under review. 4. <u>Peer Review Documents Made Available to AHCCCS:</u> The Contractor must develop a policy and procedure to demonstrate that they make peer review documentation available to AHCCCS when requested for purposes of quality management, monitoring and oversight.
QM 12 The Contractor ensures credentialing, re-credentialing, and provisional credentialing of the providers in their contracted provider network.	51%	The Contractor must submit for AHCCCS review documentation of the following process, including associated policies and procedures for: • The Contractor's Credentialing Committee's responsibility in making an independent decision regarding including a provider approved through a delegated credentialing process into its network • The Contractor retains the right and develops a process to approve, suspend or terminate any provider in their network if any portion of credentialing is delegated. • During the re-credentialing decision making process for providers, the Contractor must include information from identified adverse events (risk management/ sentinel events) to its performance monitoring data. • The Contractor must ensure providers who are not licensed or certified are included in the credentialing process and profiled.
QM 13 The Contractor has a process to grant provisional credentialing which meets the AHCCCS required timelines.	N/A	None
QM 14 The Contractor ensures the credentialing and recredentialing of providers in the contracted provider network.	95%	None
QM 15 The Contractor has a process for verifying credentials of all organizational providers.	N/A	None
QM 16 The Contractor has a structured Quality Management Program that includes administrative requirements for oversight and accountability for all functions and responsibilities described in AMPM Chapter 900 that are delegated to other entities.	100%	None
QM 17 The Contractor conducts a new member health risk assessment	100%	None

Quality Management (QM)	**QM Standard Area Score = 62% (1121 of 1800)**	
survey and identifies specific health care needs.		
QM 18 The Contractor's health information system(s) include accurate and timely data essential in meeting the data collection requirements specific to Quality Management/Performance Improvement (QM/PI) Program requirements and expectations.	100%	None
QM 19 The Contractor maintains the integrity of data within its health information system(s) that is utilized to collect, integrate, analyze, and report data necessary in implementing its Quality Management/Performance Improvement (QM/PI) Program.	81%	The Contractor must implement internal corrective actions when deficiencies or concerns are identified as a result of the Contractor's review, analysis, reporting, and evaluation of its health information system(s).
QM 20 The Contractor has written policies and procedures and monitors to ensure that providers discuss advance directives with all adult members receiving medical care.	100%	None
QM 21 The Contractor conducts AHCCCS-mandated as well as Contractor-selected Performance Improvement Projects (PIPs) when determined to be appropriate to assess the quality/appropriateness of its' service provision and improve overall performance.	35%	• The Contractor must provide a documented process to ensure ongoing data collection is accurate, valid, and reliable. • The Contractor must identify the staff or entity collecting and analyzing PIP related data reported by the Contractor and ensures qualified personnel are utilized in the process of collecting and analyzing this data. • The Contractor must utilize proven quality improvement tools when conducting root-cause analysis and problem solving activities including, but not limited to, Cause and Effect Diagrams; Failure Modes and Effects Analysis (FMEA) Tools; Flowcharts; Pareto Charts; Run Charts; Control Charts, and/or Driver Diagrams specific to Performance Improvement Projects. • The Contractor must utilize a documented process to determine and implement recognized "Best Practices" related to selected and/or mandated PIP focus areas.
QM 22 The Contractor has implemented a process to measure and report to the State its performance utilizing standard measures required by the State as well as other Contractor-selected metrics specific to its Quality Management/ Performance Improvement (QM/PI) Program	40%	• The Contractor must provide evidence that it uses qualified personnel to collect, report, and analyze data for administrative and hybrid Performance Measures. • The Contractor must implement a documented process to ensure

Quality Management (QM)	QM Standard Area Score = 62% (1121 of 1800)	
Activities.		inter-rater reliability, when more than one person is collecting and entering data for hybrid performance measure reviews. • The Contractor must conduct aggregate and subpopulation data analysis (inclusive of members with special health care needs including, but not limited to: EPSDT, Maternal, Behavioral Health and CRS Designated members) and implement targeted interventions to address any noted disparities identified as part of the Contractor's data analysis efforts. • The Contractor must provide a process to determine and implement recognized "Best Practices" related to Performance Measures and the achievement of the Minimum Performance Standard.
QM 23 The Contractor participates in applicable community initiatives for each Medicaid line of business.	70%	The Contractor must implement interventions related to Opioid & Substance Use and Suicide.

Reinsurance (RI)	RI Standard Area Score = 100% (400 of 400)	
Standard	**Score**	**Required Corrective Actions**
RI 1 The Contractor has policies, desk level procedures, and appropriate training of personnel for the processing and submission of transplant reinsurance cases to AHCCCS for reimbursement.	100%	None
RI 2 The Contractor has policies and procedures for auditing of reinsurance cases to determine 1) the appropriate payment due on the case and 2) the service was encountered correctly.	100%	None
RI 3 The Contractor has identified a process for advising AHCCCS of reinsurance overpayments against associated reinsurance encounters within 30 days of identification. This process includes open or closed contract years and open or closed reinsurance cases.	100%	None
RI 4 The Contractor has policies and procedures for monitoring the appropriateness of the reinsurance revenue received against paid claims data.	100%	None

Third Party Liability (TPL)	TPL Standard Area Score = 86% (600 of 700)	
Standard	**Score**	**Required Corrective Actions**
TPL 1 If the Contractor discovers the probable existence of a liable party that is not known to AHCCCS, the Contractor reports that information to the AHCCCS contracted vendor not later than 10 days from the date of discovery.	0%	The Contractor must submit documentation demonstrating that it is submitting member insurance updates to AHCCCS within 10 days from the date of discovery.
TPL 2 The Contractor identifies the existence of potentially liable parties through the use of trauma code edits and other procedures.	100%	None
TPL 3 The Contractor does not pursue recovery on the case unless the case has been referred to the Contractor by AHCCCS, or by the AHCCCS authorized representative: Restitution Recovery, Motor Vehicle Cases, Other Casualty Cases, Worker's Compensation, and Tortfeasors.	100%	None
TPL 4 The Contractor notifies the AHCCCS authorized representative upon the identification of reinsurance or fee-for-service payments made by AHCCCS on a total plan case.	100%	None
TPL 5 The Contractor files liens on total plan casualty cases that exceed $250.	100%	None
TPL 6 Prior to negotiating a settlement on a total plan case, the Contractor shall notify AHCCCS to ensure that no reinsurance or fee-for-service payments have been made by AHCCCS.	100%	None
TPL 7 The Contractor shall submit complete settlement information to AHCCCS, using the AHCCCS approved casualty recovery Notification of Settlement form within 10 business days from the settlement date, or on an AHCCCS-approved electronic file by the 20th of each month.	100%	None
TPL 8 The Contractor shall respond to requests from AHCCCS or AHCCCS'	N/A	None

Third Party Liability (TPL)	**TPL Standard Area Score = 86% (600 of 700)**	
TPL Contractor to provide a list of claims related to the joint or mass tort case within 10 business days of the request.		