CHAPTER 900
QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM

POLICY 900
CHAPTER OVERVIEW

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The standards and requirements included in this Chapter are applicable to AHCCCS Acute Care and Arizona Long Term Care System (ALTCS) Contractors, the Arizona Department of Economic Security, Division of Developmental Disabilities (ADES/DDD), the 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.