# *Banner - University Family Care*
# *Long Term Care Plan*
## Operational Review
## Contract Year 2019

**April 17, 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 Banner - University Family Care Long Term Care Plan (B-UFC LTC) 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 B-UFC LTC from February 4, 2019 through February 6, 2019.

A copy of the draft version of the report was provided to the Contractor on March 20, 2019. B-UFC LTC 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:

- Case Management (CM)
- 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

| Case Management (CM) | CM Standard Area Score = 93% (1944 of 2100) | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |
| **CM 1**<br>The Contractor implements policies and procedures for initial contact, on-site visits, and service initiation. | 100% | None |
| **CM 2**<br>The Contractor implements policies and procedures for initial contact, on-site visits and service initiation. | 97% | None |
| **CM 3**<br>The Contractor implements policies and procedures for conducting placement and service planning. | 100% | None |
| **CM 4**<br>The Contractor implements policies and procedures for conducting discharge planning for members enrolled with the Contractor while in the hospital and for existing members who experience a hospitalization. | 85% | The Contractor must develop a corrective action plan to ensure that appropriate services are in place prior to a member's discharge to his or her own home or to an Alternative HCBS Setting and documented accordingly by the CMs. Additionally, the corrective action must address the AHCCCS requirement that an on-site review be conducted within 10 business days post-discharge from an institutional setting. |
| **CM 5**<br>The Contractor implements policies and procedures for conducting needs assessment and care planning. | 98% | None |
| **CM 6**<br>The Contractor implements policies and procedures for conducting needs assessment and care planning. | 68% | The Contractor must develop a corrective action plan to ensure that all required assessment elements specifically address a members developmental history; justice system involvement; previous living situations; behavioral health (including need for Special Assistance in accordance with AMPM Policy 320-R); social/environmental/cultural factors; existing support system; and health and safety risks (including risks to member and/or others as a result of the member's actions) are addressed as part of the assessment and care planning process. The plan must also address how The Contractor must ensure that the information documented on the Uniform Assessment Tools (UATs) is consistent with all other case file documentation; that HNTs are reviewed/ completed at each review assessment; and that established goals are member specific, progress of goals is well documented. In most cases, |

| Case Management (CM) | CM Standard Area Score = 93% (1944 of 2100) | |
|---|---|---|
| | | goals were selected from a drop-down list incorporated in the Contractor's Assessment Tool. |
| **CM 7**<br>The Contractor implements policies and procedures that meet the Cost Effectiveness Study (CES) Standards. | 98% | None |
| **CM 8**<br>The Contractor implements policies and procedures for placement and service planning. | 84% | The Contractor must develop a corrective action plan that addresses appropriate service placement and that ensures that Service Plans and Contingency/Back-up Plans are completed by CMs accurately and comprehensively. |
| **CM 9**<br>The Contractor implements policies and procedures for Service Plan monitoring and reassessment. | 95% | None |
| **CM 10**<br>The Contractor implements policies and procedures for Service Plan monitoring. | 98% | None |
| **CM 11**<br>The Contractor implements policies and procedures for Service Plan monitoring and reassessment. | 77% | The Contractor must develop a corrective action plan that addresses situations in which CMs may need to develop an action plan and/or conduct more frequent case monitoring when urgent/emergent needs are identified or when a change in a member's condition has occurred which may result in revisions to a member's existing service plan. Additionally, the corrective action plan must address instances in which CMs may be required to conduct emergency visits, particularly when a situation is believed to be urgent or when the CM has reason to believe that a member's well-being may be at risk. |
| **CM 12**<br>The Contractor implements policies and procedures for Service Plan monitoring and reassessment. | 89% | The Contractor must develop a corrective action plan that addresses all instances in which Member Change Reports need to be submitted to AHCCCS and that ensures that member handbooks are reviewed with and provided to members at least annually. |
| **CM 13**<br>The Contractor implements policies and procedures for providing and monitoring behavioral health (BH) services. | 100% | None |
| **CM 14**<br>The Contractor implements policies and procedures for providing and monitoring behavioral health (BH) services. | 94% | The Contractor must develop a corrective action plan that addresses initial and quarterly consultations with the BH professional; documentation of psychotropic medications, including the purpose of the medication and member reported therapeutic effects/adverse reactions; CM engagement |

| **Case Management (CM)** | **CM Standard Area Score = 93% (1944 of 2100)** | |
|---|---|---|
| | | with the BH Professional, BH Consultant and/or prescribing practitioners when medication issues are identified; as well as appropriate documentation of all of these activities. |
| **CM 15**<br>The Contractor implements policies and procedures for providing and monitoring skilled nursing services. | 95% | None |
| **CM 16 (DDD Only)**<br>The Contractor implements policies and procedures for monitoring the cost effectiveness of its members. | N/A | N/A |
| **CM 17**<br>The Contractor implements policies and procedures for reporting abuse and neglect. | 100% | None |
| **CM 18**<br>The Contractor implements policies and procedures for conducting case management staff orientation/training. | 100% | None |
| **CM 19**<br>The Contractor implements policies and procedures for internal monitoring of the case management program on a quarterly basis. | 100% | None |
| **CM 20**<br>The Contractor implements policies and procedures for monitoring case management caseloads for compliance with AHCCCS Standards. | 100% | None |
| **CM 21**<br>The Contractor implements policies and procedures for a comprehensive inter-rater reliability (IRR) process to ensure consistency in member assessments and service authorizations. | 100% | None |
| **CM 22 (DDD Only)**<br>The Contractor implements policies and procedures for monitoring Targeted Case Management services for program compliance. | N/A | N/A |
| **CM 23**<br>The Contractor implements policies and procedures for the timely initiation of services to existing members in an HCBS (own home) setting. | 66% | The Contractor must develop a corrective action plan that addresses how The Contractor must track and monitor services for existing to ensure services are provided within 14 calendar days services are determined to be medically necessary and cost effective. The corrective action plan must also address the Contractor's standardized system for verifying and documenting the delivery of services with the member/ guardian/ |

| Case Management (CM) | CM Standard Area Score = 93% (1944 of 2100) | |
|---|---|---|
| | | designated representative after authorization. |

| Corporate Compliance (CC) | CC Standard Area Score = 100% (500 of 500) | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |
| **CC 1**<br>The Contractor has an operational Corporate Compliance program including a work plan that details compliance activities. | 100% | None |
| **CC 2**<br>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**<br>The Contractor educates staff and the provider network on fraud, waste and abuse. | 100% | None |
| **CC 4**<br>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**<br>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. | 100% | None |

| Claims and Information Systems (CIS) | CIS Standard Area Score = 99% (992 of 1000) | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |
| **CIS 1**<br>The Contractor has a mechanism in place to inform providers of the | 100% | None |

| Claims and Information Systems (CIS) | CIS Standard Area Score = 99% (992 of 1000) | |
|---|---|---|
| appropriate place to send claims. | | |
| **CIS 2**<br>The Contractor's remittance advice to providers contains the minimum required information. | 100% | None |
| **CIS 3**<br>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**<br>The Contractor has AHCCCS compliant policies and procedures for the recoupment of overpayments and adjustments for underpayments. | 100% | None |
| **CIS 5**<br>The Contractor pays applicable interest on all claims, including overturned claim disputes. | 92% | The Contractor must ensure it pays applicable interest on all claims, including overturned claim disputes in a consistent manner. |
| **CIS 6**<br>The Contractor accurately applies quick-pay discounts. | 100% | None |
| **CIS 7**<br>The Contractor processes and pays all overturned claim disputes in a manner consistent with the decision within 15 business days of the decision. | 100% | None |
| **CIS 8**<br>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**<br>Contractor has a process to identify resubmitted claims and a process to adjust claims for data corrections or revised payment. | 100% | None |
| **CIS 10**<br>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 = 87% (1216 of 1400) | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |

| Delivery Systems (DS) | DS Standard Area Score = 87% (1216 of 1400) | |
|---|---|---|
| **DS 1**<br>The Contractor has sufficient staffing in place to ensure providers receive assistance and appropriate, prompt resolution to their problems and inquiries. | 100% | None |
| **DS 2**<br>The Contractor determines, monitors, and adjusts the number of members assigned to each PCP. | 100% | None |
| **DS 3**<br>Provider Services Representatives are adequately trained. | 100% | None |
| **DS 4**<br>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**<br>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**<br>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**<br>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**<br>The Contractor refers members to out of network providers if it is unable to provide requested services in its network. | 50% | The Contractor must ensure its policies regarding out of network provider use appropriately address referrals when the Contractor is unable to provide medically necessary covered services in network. |
| **DS 9**<br>The Contractor develops, distributes and maintains a provider manual, and makes its providers and subcontractors aware of its availability. | 66% | Banner must revise their Provider Manual to adequately address the ACOM 416 requirements. |
| **DS 10**<br>The Contractor has a process for collecting, maintaining, updating and reporting accurate demographic information on its provider network. | 100% | None |

| Delivery Systems (DS) | DS Standard Area Score = 87% (1216 of 1400) | |
|---|---|---|
| **DS 11 (All Plans except CMDP)**<br>The Contractor's network analysis meets AHCCCS requirements for evaluating member geographic access to care. | 50% | The Contractor must use the definitions outlined in ACOM 436 to identify providers, populations and areas for its time and distance calculations. |
| **DS 12**<br>The Contractor has a process for determining if there has been a material change that could affect the adequacy of capacity and services. | 50% | The Contractor's policies should include criteria and/or a methodology to determine if a change in business operations is a material change as defined in ACOM Policy 439. The policy's criteria and/or methodology for a identifying a material business operations change must be consistent with the requirements outlined in ACOM 439. The Contractor should consider revising its policies to more clearly establish a link between its analyses and determining the potential materiality of a loss of a provider or provider group who is the sole provider in a service area, or operates in an area with limited alternate providers. |
| **DS 13 (RBHA Only)**<br>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 | N/A |
| **DS 14 (RBHA Only)**<br>Contractor performed provider block grant monitoring activities and has evidence of the following:<br>• Comprehensive provider SABG and MHBG policies and procedures;<br>• SABG and MHBG activities were monitored to ensure funds were expended for authorized purposes;<br>• Block grant funds tracking, including unexpended funds, for appropriate allocation by category, recoupment and/or return to AHCCCS. | N/A | N/A |
| **DS 15**<br>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. | 100% | None |
| **DS 16** | 100% | None |

| Delivery Systems (DS) | DS Standard Area Score = 87% (1216 of 1400) | |
|---|---|---|
| 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. | | |

| General Administration (GA) | GA Standard Area Score = 100% (300 of 300) | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |
| **GA 1**<br>The Contractor has policies and procedures for the maintenance of records and can provide those records, when requested. | 100% | None |
| **GA 2**<br>The Contractor provides training to all staff on AHCCCS guidelines. | 100% | None |
| **GA 3**<br>The Contractor maintains a policy on policy development. | 100% | None |

| Grievance Systems (GS) | GS Standard Area Score = 99% (1680 of 1700) | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |
| **GS 1**<br>The Contractor issues and carries out appeal decisions within required timeframes. | 100% | None |
| **GS 2**<br>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**<br>The Contractor has a process for the intake and handling of member appeals that are filed orally. | 100% | None |
| **GS 4**<br>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 |
| **GS 5**<br>The Contractor ensures that the individuals who make decisions on | 100% | None |

| Grievance Systems (GS) | GS Standard Area Score = 99% (1680 of 1700) | |
|---|---|---|
| appeals are appropriately qualified. | | |
| **GS 6**<br>The Contractor has a process for internal communication and coordination when an appeal decision is reversed. | 100% | None |
| **GS 7**<br>The Contractor continues or reinstates an enrollee's benefits when an appeal is pending under the appropriate circumstances as required by Federal Regulation. | 100% | None |
| **GS 8**<br>The Contractor issues Notices of Appeal Resolution that includes all information required by AHCCCS. | 100% | None |
| **GS 9**<br>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. | 100% | None |
| **GS 10**<br>The Contractor's member appeal policies allow for, and require notification of the member of, all rights granted under rule. | 100% | None |
| **GS 11**<br>The Contractor maintains claim dispute records. | 100% | None |
| **GS 12**<br>The Contractor logs, registries, or other written records include all the contractually required information. | 100% | None |
| **GS 13**<br>The Contractor confirms all provider claim disputes with a written acknowledgement of receipt. | 100% | None |
| **GS 14**<br>Requests for hearing received by the Contractor follows the timeframe and notice requirements. | 100% | None |
| **GS 15**<br>The Contractor resolves claim disputes and mails written Notice of | 80% | The Contractor must include the "contractual provisions" that specifically applies to the reason for denial. |

| Grievance Systems (GS) | GS Standard Area Score = 99% (1680 of 1700) | |
|---|---|---|
| Decisions no later than 30 days after receipt of the dispute unless an extension is requested or approved by the provider. | | |
| **GS 16**<br>The Contractor's grievance process follows the timeframe and written notice requirements. | 100% | None |
| **GS 17**<br>The Contractor shall have written policies delineating the Grievance System. | 100% | None |
| **GS 18 (ALTCS/EPD Only)**<br>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 | N/A |
| **GS 19 (ALTCS/EPD Only)**<br>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 | N/A |
| **GS 20 (ALTCS/EPD Only)**<br>SMI Grievances: The Contractor drafts an investigation report that describes the investigation and contains findings of fact, conclusions, and recommendations. | N/A | N/A |
| **GS 21 (ALTCS/EPD Only)**<br>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 | N/A |
| **GS 22 (ALTCS/EPD Only)**<br>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 | N/A |
| **GS 23 (ALTCS/EPD Only)**<br>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 | N/A | N/A |

| Grievance Systems (GS) | GS Standard Area Score = 99% (1680 of 1700) | |
|---|---|---|
| be appropriately resolved without investigation, and the resolution. | | |
| **GS 24 (ALTCS/EPD Only)**<br>SMI Grievances: The Contractor maintains a complete grievance investigation case record. | N/A | N/A |
| **GS 25 (ALTCS/EPD Only)**<br>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. | N/A | N/A |
| **GS 26 (ALTCS/EPD Only)**<br>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 | N/A |
| **GS 27 (ALTCS/EPD Only)**<br>SMI Appeals: The Contractor ensures that an authorized decision maker for the issue on appeal attended the informal conference. | N/A | N/A |
| **GS 28 (ALTCS/EPD Only)**<br>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 | N/A |
| **GS 29 (ALTCS/EPD Only)**<br>SMI Appeals: The Contractor shall maintain appeal case records to | N/A | N/A |

| Grievance Systems (GS) | GS Standard Area Score = 99% (1680 of 1700) | |
|---|---|---|
| include copies of all documents generated or acquired through the Appeal process. | | |
| **GS 30 (ALTCS/EPD Only)**<br>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 | N/A |

| Adult, EPSDT and Maternal Child Health (MCH) | MCH Standard Area Score = 72% (1152 of 1600) | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |
| **MCH 1**<br>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 demonstrate 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**<br>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. | 100% | None |
| **MCH 3**<br>The Contractor ensures postpartum care is provided for a period of up to 57 days after delivery. | 100% | None |
| **MCH 4**<br>Family planning services are provided to members who voluntarily choose to delay or prevent pregnancy. | 100% | None |
| **MCH 5**<br>The Contractor provides EPSDT/well-child services according to the AHCCCS EPSDT Periodicity Schedule. | 36% | The Contractor must demonstrate how it informs all primary care providers (PCPs) about EPSDT services, including federal requirements, state regulations, and AHCCCS policy requirements.<br><br>The Contractor must demonstrate that they employ sufficient numbers of appropriately qualified local personnel in order to meet the requirements of the EPSDT program for eligible enrolled members and achieve contractual compliance. As in MCH 1, the Contractor must demonstrate that staff, such as case managers and other personnel who work with the EPSDT |

| Adult, EPSDT and Maternal Child Health (MCH) | MCH Standard Area Score = 72% (1152 of 1600) | |
|---|---|---|
| | | population within the LTC membership, receive training regarding policies and contract compliance that pertain to this unique population.<br><br>The Contractor must demonstrate that they have implemented member outreach activities to increase EPSDT/ well-child participation rates and that the reporting of those activities align across all reporting tools.<br><br>The Contractor must demonstrate that they measure the effectiveness of provider outreach activities and implement process improvement activities as necessary to improve member participation in EPSDT/ well-child services. |
| **MCH 6**<br>The Contractor monitors member compliance with obtaining EPSDT services. | 80% | The Contractor must demonstrate that it distributes outreach material to educate LTC members and their families on the importance of EPSDT services, including childhood obesity and dangers of lead exposure per requirements in Exhibit 400-3. |
| **MCH 7**<br>The Contractor monitors provider compliance with providing EPSDT services. | 84% | The Contractor must demonstrate that they review medical records for provider compliance with completing all the elements of the EPSDT tracking form during each well-child visit. When submitting documentation, the auditing documents must be clear about scoring requirements, results of the audit, and that any compliance issues can be understood from these audit results. |
| **MCH 8**<br>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 how it monitors providers to determine if oral health/dental services are provided according to the AHCCCS Dental Periodicity Schedule.<br><br>The Contractor must demonstrate how it implements processes monitoring interventions of the dental home to ensure members receive care. |
| **MCH 9**<br>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. | 50% | The Contractor must show that they are monitoring providers during the time period and for the population being served (LTC). |
| **MCH 10 (All Plans except RBHAs)**<br>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 | 40% | The Contractor must demonstrate that they 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) Establish effective working relationships to promote healthy outcomes for EPSDT aged members and 2) Increase member utilization |

| Adult, EPSDT and Maternal Child Health (MCH) | MCH Standard Area Score = 72% (1152 of 1600) | |
|---|---|---|
| requirements. | | and provider referrals to the identified programs: WIC, Head Start, and other Home Visiting Programs. |
| **MCH 11 (All Plans except RBHAs)**<br>The Contractor coordinates with Arizona Early Intervention Program (AzEIP) according to federal and state requirements. | 100% | None |
| **MCH 12**<br>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. | 67% | The Contractor must demonstrate that they assist members in navigating the healthcare system to ensure that members receive appropriate services, including notifying members per policy that care coordination is available. |
| **MCH 13**<br>The Contractor monitors, evaluates, and improves utilization of nutritional screenings and appropriate interventions, including medically necessary supplemental nutrition to EPSDT age members. | 80% | The Contractor must demonstrate that it ensures that medical necessity for commercial oral nutritional supplements is determined on an individual basis by the member's PCP or attending physician using: The AHCCCS approved form "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" to obtain PA from the Contractor. |
| **MCH 14**<br>The Contractor ensures that women's preventive care services are provided according to the AHCCCS Medical Policy Manual (AMPM). | 34% | The Contractor must develop and implement a process to monitor provider compliance of delivering well-woman preventative care services as listed in AMPM 411. In addition, the Contractor must develop a process to inform members about women's preventative health services as listed in AMPM 411.<br>The Contractor must develop a process to inform members about women's preventative health services as listed in AMPM 411. |
| **MCH 15**<br>The Contractor ensures that behavioral health medical records requirements are completed in accordance with Policy. | 33% | The Contractor must demonstrate how it ensures that documentation includes a comprehensive review of behavioral health record information by all members of the clinical team.<br><br>The Contractor must develop a process to ensure that a Health Risk Assessment, TB and all EPSDT screenings related to behavioral health needs (Developmental, MCHAT,CASII, and psychotropic medication utilization) are completed. |
| **MCH 16**<br>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. | 100% | None |

| **Medical Management (MM)** | **MM Standard Area Score = 94% (2549 of 2700)** | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |
| **MM 1**<br>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**<br>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. | 100% | None |
| **MM 3**<br>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. | 53% | The Contractor must ensure arrangement of follow-up appointment with the PCP, BHMP and/or specialist within seven days within seven days of discharge. |
| **MM 4**<br>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). | 100% | None |
| **MM 5**<br>The Contractor shall process Prior Authorization requests in accordance with State and Federal requirements. | 74% | The Contractor must communicate services requiring prior authorization to both providers and members upon request. The Contractor must annually review and document in its MM Committee Meeting minutes services that require prior authorization and provides the rationale for changes made. In addition, the Contractor must document the monitoring and reporting of timeliness of service authorization to the MM Committee and act upon any areas requiring improvement. |
| **MM 6**<br>The Contractor has a comprehensive inter-rater reliability (IRR) testing process to ensure consistent application of criteria for clinical decision making. | 100% | None |
| **MM 7**<br>The Contractor conducts retrospective reviews. | 99% | None |
| **MM 8**<br>The Contractor develops or adopts and disseminates clinical practice guidelines for physical and behavioral health services. | 100% | None |

| **Medical Management (MM)** | **MM Standard Area Score = 94% (2549 of 2700)** | |
|---|---|---|
| **MM 9**<br>The Contractor evaluates new technologies and new uses for existing technologies. | 100% | None |
| **MM 10**<br>The Contractor identifies and coordinates care for members with special health care needs. | 100% | None |
| **MM 11 (ACC, RBHA, CMDP, DDD Only)**<br>The Contractor coordinates care for members with qualifying Children's Rehabilitative Services (CRS) conditions | N/A | N/A |
| **MM 12**<br>The Contractor identifies and coordinates care for members who are candidates for stem cell or solid organ transplants. | 100% | None |
| **MM 13**<br>The Contractor promotes health maintenance and coordination of care through Disease/Chronic Care Management Programs. | 100% | None |
| **MM 14**<br>The Contractor has a system and process that outlines a Drug Utilization Review (DUR) Program. | 100% | None |
| **MM 15**<br>The Contractor facilitates coordination of services being provided to member when the member is transitioning between Contractors. | 70% | The Contractor must ensure all sections of the ETI are completed appropriately. If a section is not applicable it must be addressed with an N/A. |
| **MM 16**<br>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**<br>The Contractor ensures that members receive medically necessary behavioral health services | 100% | None |
| **MM 18**<br>The Contractor does not deny emergency services. | 85% | The Contractor must ensure that its policies, procedures and processes do not allow for denial of payment for emergency services or limit emergency services on the basis of a list of diagnoses or symptoms. |
| **MM 19**<br>The Contractor issues a Notice of Adverse Benefits determination | 78% | The Contractor must have policies and procedures for the issuance of Notices of Extension |

| **Medical Management (MM)** | **MM Standard Area Score = 94% (2549 of 2700)** | |
|---|---|---|
| (NOA) to the member when a requested service has been denied, limited, suspended, terminated, or reduced. | | |
| **MM 20**<br>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**<br>The Contractor identifies, monitors, and implements interventions to prevent the misuse of controlled and non-controlled medications. | 100% | None |
| **MM 22**<br>The Contractor shall demonstrate that services are delivered in compliance with Mental Health Parity. | 100% | None |
| **MM 23**<br>The Contractor shall employ care managers to perform Contractor care management functions. | 90% | The Contractor must have policies, procedures and processes to meet the contractual requirements for care management to outreach to service members, veterans and families. |
| **MM 24**<br>The Contractor provides End of Life Care and Advanced Care planning. | 100% | None |
| **MM 25 (ACC, ALTCS/EPD, and RBHA Only)**<br>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. | 100% | None |
| **MM 26 (All except CMDP)**<br>The Contractor establishes processes for ensuring coordination and provision of appropriate services for members transitioning from the justice system | 100% | None |
| **MM 27**<br>The Contractor establishes processes for ensuring coordination and provision of appropriate services for members who are court ordered treatment. | 100% | None |
| **MM 28**<br>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 = 97% (966 of 1000) | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |
| **MI 1**<br>The Contractor's New Member Information Packets meet AHCCCS standards for content and distribution. | 100% | None |
| **MI 2**<br>The Contractor notifies members that they can receive a new member handbook annually. | 100% | None |
| **MI 3**<br>The Contractor assesses PCP capacity and evaluates it prior to assigning new members. | 100% | None |
| **MI 4**<br>The Contractor trains its Member Services Representatives, and appropriately handles and tracks member inquiries and complaints. | 66% | The Contractor must revise its Training Guidelines documentation to remove the time restriction imposed on when members may file a transportation grievance. The Training Guidelines must be resubmitted for AHCCCS' review and approval. The Contractor must also provide evidence of retraining and that it disseminated the revised Training Guidelines to all its Member Services Representatives |
| **MI 5**<br>The Contractor notifies affected members timely when a PCP or frequently utilized provider leaves the network. | 100% | None |
| **MI 6**<br>The Contractor notifies affected members of material changes to network and/or operations at least 30 days before the effective date of the change. | 100% | None |
| **MI 7**<br>The Contractor distributes at a minimum two member newsletters per contract year which contain the required member information. | 100% | None |
| **MI 8**<br>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. | 100% | None |
| **MI 9**<br>The Contractor submits to AHCCCS for approval qualifying member information materials given to its current members, that do not fall | 100% | None |

| **Member Information (MI)** | **MI Standard Area Score = 97% (966 of 1000)** | |
|---|---|---|
| within annual, semi-annual or quarterly required submissions and maintains a log of all member material distributed to its members. | | |
| **MI 10**<br>The Contractor maintains policies on Social Networking. | 100% | None |

| **Quality Management (QM)** | **QM Standard Area Score = 83% (1833 of 2200)** | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |
| **QM 1**<br>The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for member/system resolution. | 69% | 1. Regulatory reporting:<br>The Contractor must develop a plan to ensure referrals made to regulatory entities are documented within the QOC file. The Contractor must revise 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, title, and date of training received. The Contractor must provide at least 5 QOC case files documenting regulatory agency referrals.<br><br>2. QOC's submitted by members/families:<br>For QOC cases submitted by members, the Contractor must develop and submit a plan to ensure that case resolution is appropriately communicated to the member and is documented within the QOC file. Per AMPM 960, "Follow-up with the member that includes, but is not limited to:<br>i. Assistance as needed to ensure that the immediate health care needs are met,<br>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…"<br><br>The Contractor must provide documented evidence of communication to member/family within the QOC file.<br><br>3. QOC versus non-QOC determination:<br>The Contractor must update policies and/or desktop procedures to ensure thorough and complete QOC case documentation is present and reflective |

| Quality Management (QM) | QM Standard Area Score = 83% (1833 of 2200) | |
|---|---|---|
| | | 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.<br><br>The Contractor must submit updated policies and desktop procedures, including evidence of QM Department staff training to the updated procedures. Training documentation is to be submitted to AHCCCS that includes training materials, printed first and last name of QM staff, title, and date of training received. Additionally, the Contractor must submit the tool used to conduct inter-rater reliability audits, as well as 5 QOC case files demonstrating use of the tool, the final outcome, and any interventions resulting from the inter-rater audit.<br><br>4. Reportable versus non-AHCCCS Reportable QOCs:<br>The Contractor must update policies and/or desktop procedures to ensure appropriate assessment, notification to AHCCCS, and case documentation in accordance with the most current AMPM 960. This may occur initially or at any time throughout the QOC review process. As part of action item #3 (above) regarding inter-rater reliability questions, The Contractor must include questions related to identification, notification, and case documentation of cases appropriate for AHCCCS notification. The Contractor must submit updated policies and desktop procedures, including evidence of QM Department staff training to the updated procedures. Training documentation is to be submitted to AHCCCS that includes training materials, printed first and last name of QM staff, title, and date of training received. Additionally, the Contractor must submit the tool used to conduct inter-rater reliability audits, as well as 5 QOC case files demonstrating use of the tool, the final outcome, and any interventions resulting from the inter-rater audit.<br><br>5. Severity Level, Substantiation, and Corrective Action Plans (CAPs):<br>The Contractor must follow the standard definitions of severity leveling and substantiation determination that match the potential or actual harm that has occurred. The Contractor must clearly define QOC cases that require further elevation to the Medical Director, Peer Review, external Peer Review, etc.in order to assess appropriate development of CAPs. |

| Quality Management (QM) | QM Standard Area Score = 83% (1833 of 2200) | |
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| | | The Contractor must submit evidence of QM Department staff training on the above definitions and re-train staff on case elevation. Training documentation is to be submitted to AHCCCS that includes training materials, printed first and last name of QM staff, title, and date of training received. As part of action item #3 (above) regarding inter-rater reliability questions, The Contractor must include questions related to severity leveling and substantiation determination, as well as case elevation. Additionally, the Contractor must submit the tool used to conduct inter-rater reliability audits, as well as 5 QOC case files demonstrating use of the tool, the final outcome, and any interventions resulting from the inter-rater audit.<br><br>6. Additional Findings:<br>The Contractor must update its policy to make clearer that if additional allegations are discovered during the course of the review time period that they are added to the existing case. The Contractor must submit the revised policy and include evidence of QM Department staff training on the updated policy. The Contractor must submit training materials, printed first and last name of QM staff, title, and date of training received. |
| **QM 2**<br>The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for system improvement. | 77% | 1. The Contractor must update its policies and training material to reflect AMPM requirements that QOC concerns are to be referred to the QM team handling QOC issues. The Contractor must submit the updated policy for AHCCCS review.<br><br>The Contractor must also submit an updated Desktop QOC to reflect that transportation issues are to be reviewed by the QM Department for QOC evaluation and then any concerns deemed appropriate for Grievance and Appeals be referred to that department by QM.<br><br>In addition, The Contractor must provide documented clarification to the section of policy QM 6004, 1.3 with regards to responsibility of investigation for member grievances that are deemed to have potential quality of care issues.<br><br>Per AMPM 960, B.2. (page 4 of 14), documents that, “Contractors may not |

| Quality Management (QM) | QM Standard Area Score = 83% (1833 of 2200) | |
|---|---|---|
| | | delegate quality of care investigation processes or onsite quality of care visits. Quality investigations may not be delegated or performed by the staff of the provider agency/facility where the identified health and safety concerns, Immediate Jeopardy, or AHCCCS-requested reviews have occurred."<br><br>2. The Contractor must provide evidence of documented implementation that includes, but is not limited to: the Weekly Veyo meeting notes, the Veyo escalation tracking form, and a copy of the Critical Care Watch List, which the Contractor noted in their document submission response. |
| **QM 3**<br>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. The concerns identified in this area are addressed in Corrective Action Plans in Standards QM 1 and/or QM 2.<br><br>2. The Contractor must ensure confidentiality of all information used to prepare, and carry out functions related to case review under the Peer Review protection.<br><br>The Contractor must submit evidence demonstrating that the confidentiality of all information used to prepare, and carry out functions related to case review under the Peer Review protection is inclusive of all correspondences involving QOC concerns.<br><br>3. The Contractor must submit a policy and procedure/desktop clearly outlining the investigative responsibilities of the QM Department.<br><br>As part of the desktop procedure the Contractor must incorporate an inter-rater reliability process to ensure standardization and consistency of primary source verification prior to making inquiries to the provider involved.<br><br>In addition, the Contractor must submit the tool used to conduct inter-rater reliability audits, as well as 5 QOC case files demonstrating use of the tool, the final outcome, and any interventions resulting from the inter-rater audit.<br><br>4. The concerns identified in this area are being addressed in Corrective Action Plans in Standard QM 1. |

| Quality Management (QM) | QM Standard Area Score = 83% (1833 of 2200) | |
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| | | 5. The concerns identified in this area are being addressed in Corrective Action Plans in Standard QM 7. |
| **QM 4**<br>The Contractor has a structure and process in place to identify and investigate adverse outcomes, including mortalities, for member/system improvement. | 60% | The Contractor must submit a policy that incorporates the following: The Contractor must investigate potential QOC referrals for members without any claims, significant utilization history, or recent utilization history. Additionally, The Contractor must submit training on this policy including staff sign-in sheets/attestations with date, printed first and last name, and title. The Contractor is also to submit 3 member samples demonstrating this process.<br><br>The Contractor must add language related to prescribing issues or failure of the provider to check the CSPMP to Paragraph 6 of L QM4 Mortality Review Desktop. The Contractor must submit this desktop for AHCCCS for review. |
| **QM 5 (ALTCS/EPD and DES/DDD Only)**<br>Contractor ensures that the staff providing attendant care, personal care, homemaker services, and habilitation services are monitored as outlined in Chapter 900. | 99% | None |
| **QM 6**<br>The Contractor ensures that residential settings (including behavioral health residential treatment facilities) are monitored annually in accordance to policy, by qualified staff. | 95% | None |
| **QM 7**<br>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. | 60% | The Contractor must revise L QM7 Policy QM 6004 and L QM7 Policy QM 1326 A to reflect that Health and Safety and Immediate Jeopardy On-sites are to be unannounced and QM staff is to be present and leading on-site visits per AMPM 960.<br><br>The Contractor must revise the onsite audit tools, health and safety forms, and/or visit documents to reflect the above policy revisions.<br><br>Additionally, the Contractor must provide evidence of staff training on revised audit tools, health and safety forms, and/or visit documents, as well as policy revisions. This should also include training materials, staff training |

| Quality Management (QM) | QM Standard Area Score = 83% (1833 of 2200) | |
|---|---|---|
| | | sign-in sheets/attestations with date, printed first and last name, and title. |
| **QM 8**<br>The governing body and the Contractor are accountable for all Quality Management/Performance Improvement (QM/PI) program functions. | 100% | None |
| **QM 9**<br>The Contractor has the appropriate staff employed to carry out Quality Management (QM) and Performance Improvement (PI) Program administrative requirements. | 75% | The Contractor must submit evidence that the Contractor provides training to all staff in how to identify and refer Quality of Care (QOC) concerns/issues to the Quality Management Department.<br><br>The documentation must include sign-in sheets with printed first and last name of the employee, title and department employed in, the date of hire, date due for annual training, completed date of training, final score, and any documentation demonstrating remediation for those employees not passing.<br><br>In addition, The Contractor must submit the training materials and explanation of passing score. |
| **QM 10**<br>The Contractor has a structured Quality Management Program that includes administrative requirements related to policy development. | 90% | The Contractor must ensure that applicable Quality Management/Performance Improvement policies include a clear indication specific to the Arizona Medicaid line(s) of business being reviewed as part of the current Operational Review Process.<br><br>The Contractor must submit a revised policy of QM 6004 to reflect a clear distinction of the Arizona Medicaid line of business as it applies to this policy.<br><br>The Contractor must also to provide supporting documentation that all other policies identified to apply to all lines of business are reviewed to ensure that there is a clear distinction of Arizona Medicaid lines of business where appropriate and applicable. |
| **QM 11**<br>The Contractor has implemented a structured peer review process that includes administrative requirements related to the peer review process. | 35% | 1. The Contractor must provide evidence of Peer Review that includes cases where there is evidence of deficient quality, as stated in their QM Policy 6005 (2.1.2 and 2.1.3.), such as substantiated severity level ratings of 3's or above, and/or a summary of all substantiated cases.<br><br>2. The Contractor must provide all Peer Review minutes related to AHCCCS members as part of the current Operational Review Process. The Contractor must provide AHCCCS ID numbers for identification. |

| Quality Management (QM) | QM Standard Area Score = 83% (1833 of 2200) | |
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| | | 3. The Contractor must submit a copy of revised Policy QM 6005 including specific case types that are appropriate to undergo Peer Review. In addition, The Contractor must provide QM Department staff training to the updated policy and must provide evidence of sign-in sheets/attestations with printed first and last name, title, and date of training received.<br><br>Refer to AM PM 900 for examples of Peer Review case types, such as, but not limited to: High profile cases, adverse outcome cases related to mortalities, inappropriate prescribing patterns (CSPMP), lack of coordinated care, provider suspensions, provider regulatory agency/board referrals, provider corrective actions, etc.<br><br>4. The Contractor must submit 3 samples of non-clinical AHCCCS QOCs in which these were elevated and addressed within the Peer Review process. The Contractor must provide AHCCCS ID numbers for identification, as applicable.<br><br>5. The Contractor must provide evidence to support that each Peer Review attendee (all committee members) had signed a confidentiality and conflict of interest statement for all AHCCCS Peer Review meetings within this current Operational Review cycle. The attendance document is to include printed first and last name, title, and specialty of each committee member.<br><br>6. The Contractor must submit a copy of a revised Purpose under Policy QM 6005, with documentation to include addressing non clinical issues and service concerns. The Contractor must provide QM Department staff training to the revised policy and must provide evidence of sign-in sheets/attestations with printed first and last name, title, and date of training received.<br><br>7. The Contractor must include evidence to demonstrate same specialty reviewer is in attendance for all Peer Review Committees for the case(s)/concerns being reviewed. The Contractor must submit all Peer Review Committee Minutes within the current Operational Review Cycle. |

| Quality Management (QM) | QM Standard Area Score = 83% (1833 of 2200) | |
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| | | The Contractor must provide AHCCCS ID numbers for those members referenced in the submitted Peer Review Committee Meeting Minutes for identification. |
| **QM 12**<br>The Contractor ensures credentialing, re-credentialing, and provisional credentialing of the providers in their contracted provider network. | 100% | None |
| **QM 13**<br>The Contractor has a process to grant provisional credentialing which meets the AHCCCS required timelines. | 97% | None |
| **QM 14**<br>The Contractor ensures the credentialing and recredentialing of providers in the contracted provider network. | 98% | None |
| **QM 15**<br>The Contractor has a process for verifying credentials of all organizational providers. | 98% | None |
| **QM 16**<br>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**<br>The Contractor conducts a new member health risk assessment survey and identifies specific health care needs. | 100% | None |
| **QM 18**<br>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. | 90% | The Contractor must ensure its health information system(s) includes (at a minimum) accurate, complete, and up-to-date data related to member designations. |
| **QM 19**<br>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. | 100% | None |
| **QM 20**<br>The Contractor has written policies and procedures and monitors to | 100% | None |

| Quality Management (QM) | QM Standard Area Score = 83% (1833 of 2200) | |
|---|---|---|
| ensure that providers discuss advance directives with all adult members receiving medical care. | | |
| **QM 21**<br>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. | 90% | The Contractor must utilize proven quality improvement tools when conducting root-cause analysis and problem solving activities specific to Performance Improvement Projects (PIPs)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. |
| **QM 22**<br>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 Activities. | 55% | The Contractor must provide evidence of oversight and validation of data collection, reporting, and analysis specific to administrative Performance Measure rates and calculations conducted by a contracted vendor or Subcontractor.<br><br>The Contractor must conduct aggregate/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.<br><br>Additionally, the Contractor must utilize proven quality improvement tools when conducting root-cause analysis and problem solving activities specific to Performance Measures (PMs) 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. |
| **QM 23**<br>The Contractor participates in applicable community initiatives for each Medicaid line of business. | 45% | The Contractor must participate in applicable community initiatives related to Behavioral Health, Long-Term Care Services and Supports, Home and Community Based Services (HCBS), Justice Population, and Suicide, and implement interventions to address overarching community concerns related to Behavioral Health, Long-Term Care Services and Supports, Home and Community Based Services (HCBS), and Suicide. |

| Reinsurance (RI) | RI Standard Area Score = 100% (400 of 400) | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |
| **RI 1**<br>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**<br>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**<br>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**<br>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 = 100% (800 of 800) | |
|---|---|---|
| **Standard** | **Score** | **Required Corrective Actions** |
| **TPL 1**<br>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. | 100% | None |
| **TPL 2**<br>The Contractor identifies the existence of potentially liable parties through the use of trauma code edits and other procedures. | 100% | None |
| **TPL 3**<br>The Contractor does not pursue recovery on the case unless the case has been referred to the Contractor by AHCCCS, or by the AHCCCS | 100% | None |

| Third Party Liability (TPL) | TPL Standard Area Score = 100% (800 of 800) | |
|---|---|---|
| authorized representative:<br>Restitution Recovery, Motor Vehicle Cases, Other Casualty Cases, Worker's Compensation, and Tortfeasors. | | |
| **TPL 4**<br>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**<br>The Contractor files liens on total plan casualty cases that exceed $250. | 100% | None |
| **TPL 6**<br>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**<br>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**<br>The Contractor shall respond to requests from AHCCCS or AHCCCS' TPL Contractor to provide a list of claims related to the joint or mass tort case within 10 business days of the request. | 100% | None |