[UnitedHealthCare Community Plan – Long Term Care

Operational Review
Contract Year Ending 2016

May 4, 2016

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 UnitedHealthcare Community Plan - Long Term Care (UHCCP LTC) CYE 2016 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 UHCCP LTC from February 22, 2016 to February 24, 2016.

A copy of the draft version of this report was provided to the Contractor on April 6, 2016. UHCCP 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 CYE 2016 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 CYE 2016 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 CYE 2016 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 = 97% (1753 of 1800)**	
Standard	**Score**	**Required Corrective Actions**
CM 1 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for initial contact, onsite visits and service initiation.	100%	None
CM 2 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for initial contact, onsite visits and service initiation.	100%	None
CM 3 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for conducting needs assessment and care planning.	100%	None
CM 4 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for conducting needs assessment and care planning.	96%	None
CM 5 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures that meet the Cost Effectiveness Study (CES) Standards.	96%	None
CM 6 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for placement and service planning.	90%	The Contractor must develop a corrective action plan to ensure service planning is complete.
CM 7 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for the Client Assessment Tracking System (CATS).	91%	The Contractor must develop a corrective action plan to ensure the CATS screens are accurately completed on a timely basis.
CM 8 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for Service Plan monitoring.	100%	None
CM 9 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for Service Plan monitoring and reassessment.	100%	None
CM 10 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for Service Plan monitoring and reassessment.	100%	None
CM 11 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for providing and	95%	None

Case Management (CM)	**CM Standard Area Score = 97% (1753 of 1800)**	
monitoring behavioral health (BH) services.		
CM 12 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for providing and monitoring behavioral health (BH) services.	100%	None
CM 13 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for providing and monitoring skilled nursing services.	100%	None
CM 14 (DES/DDD Only) The Contractor implements policies and procedures for monitoring the cost effectiveness of its members.	N/A	None
CM 15 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for reporting abuse and neglect.	100%	None
CM 16 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for conducting case management staff orientation/training.	100%	None
CM 17 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for internal monitoring of the case management program on a quarterly basis.	100%	None
CM 18 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for monitoring case management caseloads for compliance with AHCCCS Standards.	85%	The Contractor must develop a corrective action plan to ensure the CMs' caseloads do not exceed the Standard Weighted Value of 96.
CM 19 (ALTCS/EPD and DES/DDD Only) The Contractor implements policies and procedures for a comprehensive inter-rater reliability process to ensure consistency in member assessments and service authorizations.	100%	None
CM 20 (DES/DDD Only) The Contractor implements policies and procedures for monitoring Targeted Case Management services for program compliance.	N/A	None

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 Plan must demonstrate that it regularly checks the exclusion database for excluded individuals and vendors.

Claims and Information Systems (CIS)	CIS Standard Area Score = 88% (1051 of 1200)	
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.	26%	The Contractor must ensure that all remits include a detailed description of denials and adjustments, the accurate amount billed, the application of coordination of benefits and copays, provider rights and instructions and timeframes for claims disputes and the resubmission of corrected claims.

Claims and Information Systems (CIS)	CIS Standard Area Score = 88% (1051 of 1200)	
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.	27%	The Contractor must ensure it pays interest on hospital claims at the rate of one percent per month for each month or portion of a month following the 60th day of receipt of the clean claim until the date of payment. The Contractor must ensure it pays non-hospital claims at the rate of 10% per annum (calculated daily) on claims paid more than 45 days after the date of receipt of the clean claim submission. The Contractor must ensure it pays interest clean claims for ALTCS services not paid within 30 calendar days after the claim is received at the rate of one percent per month from the date the claim is submitted. The Contractor must ensure it pays interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission.
CIS 6 The Contractor accurately applies quick-pay discounts.	100%	None
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.	100%	None
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 The Contractor accepts and integrates evidence of eligibility and enrollment data provided by AHCCCS into its Claims and Information Systems timely and accurately (last daily and Monthly Roster).	100%	None
CIS 10 The Contractor accepts and integrates evidence of provider registration data provided by AHCCCS into its Claims and Information Systems.	100%	None

Claims and Information Systems (CIS)	CIS Standard Area Score = 88% (1051 of 1200)	
CIS 11 Contractor has a process to identify resubmitted claims and a process to adjust claims for data corrections or revised payment.	100%	None
CIS 12 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.	98%	None

Delivery Systems (DS)	DS Standard Area Score = 92% (830 of 900)	
Standard	**Score**	**Required Corrective Actions**
DS 1 The Contractor has a process to evaluate its Provider Services staffing levels based on the needs of the provider community.	100%	None
DS 2 The Contractor monitors the number of members assigned to each PCP and the PCP's total capacity in order to assess the providers' ability to meet AHCCCS appointment standards.	100%	None
DS 3 Provider Services Representatives are adequately trained.	100%	None
DS 4 The Contractor provides the following information via written or electronic communication to contracted providers: Exclusion from the Network, Policy/Procedure Change, Subcontract Updates, Termination of Contract, and Disease/Chronic Care Management Information.	65%	The Contractor must amends all subcontracts on their regular renewal schedule or within 6 calendar months of AHCCCS making changes to the Minimum Subcontract provisions. The Contractor must notify contracted providers when a material change in the network occurs 30 days in advance of the material change.
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	100%	None

Delivery Systems (DS)	DS Standard Area Score = 92% (830 of 900)	
The Contractor has a mechanism for tracking and trending provider inquiries that includes timely acknowledgement and resolution and taking systemic action as appropriate.		
DS 8 The Contractor refers members to out of network providers if it is unable to provide requested services in its network.	100%	None
DS 9 The Contractor develops, distributes and maintains a provider manual, and makes its providers and subcontractors aware of its availability.	65%	The Contractor must ensure that all requirements in ACOM 416 are not just documented in policy, but are also present in the provider manual itself.
DS 10 (CRS Only) For the CRS Only and CRS Partially Integrated Behavioral Health members, the CRS Contractor has a policy that states that medically necessary non-emergency transportation will be coordinated with the member's Acute Care Contractor.	N/A	None

General Administration (GA)	GA Standard Area Score = 100% (300 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.	100%	None

Grievance Systems (GS)	GS Standard Area Score = 100% (1700 of 1700)	
Standard	**Score**	**Required Corrective Actions**
GS 1 The Contractor issues and carries out appeal decisions within required	100%	None

Grievance Systems (GS)	**GS Standard Area Score = 100% (1700 of 1700)**	
timeframes.		
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
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.	100%	None
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.	100%	None
GS 8 The Contractor issues Notices of Appeal Resolution that include all information required by AHCCCS.	100%	None
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.	100%	None
GS 10 The Contractor's member appeal policies allow for, and require notification of the member of, all rights granted under rule.	100%	None

Grievance Systems (GS)	GS Standard Area Score = 100% (1700 of 1700)	
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.	100%	None
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.	100%	None
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.	100%	None

Adult, EPSDT and Maternal Child Health (MCH)	MCH Standard Area Score = 100% (1400 of 1400)	
Standard	**Score**	**Required Corrective Actions**
MCH 1 The Contractor has established and operates a maternity care program, with goals directed at achieving optimal birth outcomes that meet AHCCCS minimum requirements.	100%	None
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)	100%	None

Adult, EPSDT and Maternal Child Health (MCH)	MCH Standard Area Score = 100% (1400 of 1400)	
Maternity Care Appointment Standards.		
MCH 3 The Contractor ensures postpartum care is provided for a period of up to 60 days after delivery.	100%	None
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.	100%	None
MCH 6 The Contractor monitors member compliance with obtaining EPSDT services.	100%	None
MCH 7 The Contractor monitors provider compliance with providing EPSDT services.	100%	None
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.	100%	None
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 The Contractor coordinates with appropriate agencies and programs (VFC, WIC, and Head Start), as well as provides education, assists in referrals and connects eligible EPSDT members with appropriate agencies, according to federal and state requirements.	100%	None
MCH 11 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	100%	None

Adult, EPSDT and Maternal Child Health (MCH)	MCH Standard Area Score = 100% (1400 of 1400)	
up to verify that members receive timely and appropriate treatment.		
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 (Acute, CMDP, CRS and DES/DDD only) The Contractor transitions members who are identified as having a Children's Rehabilitative Services (CRS) eligible condition, lose eligibility for CRS, or choose to not stay with the CRS Contractor after turning 21 years of age.	N/A	None
MCH 15 The Contractor ensures that women's preventive care services are provided according to the AHCCCS Medical Policy Manual (AMPM).	100%	None

Medical Management (MM)	MM Standard Area Score = 97% (1936 of 2000)	
Standard	**Score**	**Required Corrective Actions**
MM 1 The Contractor shall execute processes to assess, plan, implement and evaluate utilization data management activities.	100%	None
MM 2 The Contractor has an effective concurrent review process which includes a component for reviewing the medical necessity of inpatient stays.	88%	The Contractor must identify the barriers that prevent concurrent review from being conducted within one business day of notification and implement actions to ensure compliance.
MM 3 The Contractor conducts proactive discharge planning for members admitted into acute care facilities.	96%	The Contractor must implement actions to ensure compliance with proactive discharge planning including post discharge contact with the member as well as a physician follow up appointment when the member is discharged to home.
MM 4 The Contractor shall process Prior Authorization requests in accordance with State and Federal requirements.	100%	None
MM 5 The Contractor shall process Prior Authorization requests in accordance with State and Federal requirements.	100%	None

Medical Management (MM)	MM Standard Area Score = 97% (1936 of 2000)	
MM 6 The Contractor shall process Prior Authorization requests in accordance with State and Federal requirements.	100%	None
MM 7 The Contractor has a comprehensive inter-rater reliability (IRR) program to ensure consistent application of criteria for clinical decision making.	100%	None
MM 8 The Contractor conducts retrospective reviews based on reasonable medical evidence or a consensus of relevant health care professionals.	100%	None
MM 9 The Contractor adopts, disseminates and monitors compliance with evidenced based clinical practice guidelines.	100%	None
MM 10 The Contractor evaluates new technologies and new uses for existing technologies.	100%	None
MM 11 The Contractor establishes processes for ensuring coordination and provision of appropriate services for members transitioning from the justice system; those members who receive Seriously Mentally Ill (SMI) decertification; or those members in court ordered treatment.	100%	None
MM 12 The Contractor identifies and coordinates care for members with special health care needs.	100%	None
MM 13 The Contractor identifies and coordinates the care for members who are potential candidates for stem cell or solid organ transplants.	100%	None
MM 14 The Contractor promotes health maintenance and coordination of care through disease or chronic care management programs that are developed based upon analysis of high risk, high cost and high volume utilization data.	100%	None
MM 15 The Contractor has a system and process that outlines a Drug	100%	None

Medical Management (MM)	**MM Standard Area Score = 97% (1936 of 2000)**	
Utilization Review (DUR) Program.		
MM 16 The Contractor facilitates coordination of all services being provided to a member when the member is transitioning between Contractors.	89%	The Contractor must ensure ETI forms are complete and comprehensive in order to provide a seamless and gap free transition for their members.
MM 17 (Acute and CMDP Only) The Contractor provides guidance for primary care providers who wish to treat members diagnosed with anxiety, depression and Attention Deficit Hyperactivity Disorder (ADHD) related to medication management.	N/A	None
MM 18 (Pima and Maricopa County Acute Plans Only) The Contractor assists homeless clinics with the prior authorization process.	N/A	None
MM 19 (Acute, CRS and DES/DDD Only) The Contractor provides medical home services to members.	N/A	None
MM 20 The Contractor does not deny emergency services.	85%	The Contractor must update policy to include that payment is not denied when a representative of the Contractor instructs the enrollee to seek emergency services.
MM 21 (Acute and CMDP Only) The Contractor monitors nursing facility stays of members to assure that the length of stays, including those covered by a third party insurer, do not exceed the 90 day per contract year limitation.	N/A	None
MM 22 The Contractor issues a Notice of Action (NOA) letter to the member when a requested service has been denied, limited, suspended, terminated, or reduced.	98%	None
MM 23 (Acute, CMDP and DES/DDD Only) The Contractor collaborates to identify members with high needs/high costs to improve coordination of care and individual outcomes.	N/A	None
MM 24 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 25 The Contractor identifies, monitors, and implements interventions to prevent the misuse of controlled and non-controlled medications.	80%	The Contractor must develop processes and include in policy how specific instructions are given to members, the assigned exclusive pharmacy and/or exclusive provider, and their Pharmacy Benefit Manager (PBM) on

Medical Management (MM)	**MM Standard Area Score = 97% (1936 of 2000)**	
		how to address emergencies, out-of-stock medication at the exclusive pharmacy and what to do when the exclusive pharmacy is closed.

Member Information (MI)	**MI Standard Area Score = 100% (900 of 900)**	
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.	100%	None
MI 5 The Contractor notifies affected members timely when a PCP or frequently utilized provider leaves the network.	100%	None
MI 6 The Contractor notifies affected members of material changes to network and operations at least 30 days before the effective date of the change.	100%	None
MI 7 The Contractor distributes at a minimum two member newsletters per contract year which contain the required member information.	100%	None
MI 8 The Contractor's Member Services, Transportation, and Prior Authorization staff has access to, and utilizes, appropriate mapping services when scheduling appointments and/or referring members to services or service providers.	100%	None

Member Information (MI)	MI Standard Area Score = 100% (900 of 900)	
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

Quality Management (QM)	QM Standard Area Score = 98% (2744 of 2800)	
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.	96%	None
QM 2 The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for system improvement.	100%	None
QM 3 The Contractor has a structure and process in place to identify and investigate adverse outcomes, including mortalities, for member/system improvement.	100%	None
QM 4 (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.	100%	None
QM 5 (ALTCS/EPD and DES/DDD Only) The Contractor ensures that Home Community Based Services (HCBS) and residential settings are monitored by qualified staff.	100%	None
QM 6 The governing body and the Contractor are accountable for all Quality Management/Quality Improvement (QM/QI) program functions.	100%	None
QM 7 The Contractor has the appropriate staff employed to carry out Quality Management (QM) and Performance Improvement (QI) Program	100%	None

Quality Management (QM)	QM Standard Area Score = 98% (2744 of 2800)	
administrative requirements.		
QM 8 The Contractor has a structured Quality Management Program that includes administrative requirements related to policy development.	100%	None
QM 9 The Contractor has implemented a structured peer review process that includes administrative requirements related to the peer review process.	100%	None
QM 10 The Contractor ensures credentialing, re-credentialing, and provisional credentialing of the providers in their contracted provider network.	100%	None
QM 11 The Contractor has a process to grant provisional credentialing which meets the AHCCCS required timelines.	100%	None
QM 12 The Contractor ensures the credentialing and recredentialing of providers in the contracted provider network.	98%	None
QM 13 The Contractor has a process for verifying credentials of all organizational providers.	100%	None
QM 14 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 15 The Contractor conducts a new member health risk assessment survey and identifies specific health care needs.	100%	None
QM 16 The Contractor has implemented a process to complete on-site quality management monitoring and investigations.	100%	None
QM 17 The health information system data elements include at least the following information to guide the selection of and meet the data collection requirements for quality improvement expectations.	100%	None

Quality Management (QM)	**QM Standard Area Score = 98% (2744 of 2800)**	
QM 18 The Contractor maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement its QM/QI Program.	100%	None
QM 19 (Acute, CRS, ALTCS/EPD and DES/DDD Only) The Contractor has written policies and procedures and monitors to ensure that providers discuss advance directives with all adult members receiving medical care.	50%	The Plan needs to provide proof that Advance Directive activities have been implemented for members. The Plan needs to demonstrate medical records and DNRs are kept in easily accessible areas, while protecting them in some confidential manner.
QM 20 (Acute and CMDP Only) The Contractor provides ongoing medically necessary nursing services for members who, due to their mental health status, are incapable or unwilling to manage their medical condition when the member has a skilled medical need.	N/A	None
QM 21 (Acute and CMDP Only) Primary Care Providers (PCP) are informed that they may medically manage behavioral health members for the treatment of anxiety, depression and Attention Deficit/Hyperactive Disorders (ADHD) and are informed about the coverage of medications to treat depression, anxiety and ADHD by the Contractor. The Contractor ensures that its quality management program incorporates the monitoring of the PCPs' medical management of behavioral health disorders (anxiety, depression and ADHD).	N/A	None
QM 22 The Contractor ensures that training and education is available to Primary Care Providers (PCP) regarding behavioral health referrals and consultation procedures members identified as having behavioral health needs.	100%	None
QM 23 (Acute and CMDP Only) The Contractor ensures the initiation and coordination of a referral when a behavioral health need has been identified and follows up to determine if the member received behavioral health services.	N/A	None
QM 24 The Contractor collaborates with the Arizona State Hospital prior to member discharge.	100%	None

Quality Management (QM)	QM Standard Area Score = 98% (2744 of 2800)	
QM 25 (Acute, CRS, ALTCS/EPD and DES/DDD) The Contractor ensures that members receive medically necessary behavioral health services.	100%	None
QM 26 (ALTCS/EPD and DES/DDD Only) The Contractor shall ensure that members transferring to the ALTCS program who have previous enrollment with a Regional Behavioral Health Authority and/or a Behavioral Health Provider are appropriately transitioned.	100%	None
QM 27 (Acute, CRS, ALTCS/EPD and DES/DDD Only) The Contractor has a process to monitor services provided by out of state placement settings.	100%	None
QM 28 The Contractor conducts Performance Improvement Projects (PIPs) to assess the quality and appropriateness of its service provision and to improve performance.	100%	None
QM 29 The Contractor has implemented a process to measure and report to the State its performance, using standard measures required by the State.	100%	None
QM 30 (CRS, ALTCS/EPD, and DES/DDD Only) The Contractor has mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	100%	None
QM 31 (Acute, CRS, ALTCS/EPD and DES/DDD Only) The Contractor ensures care is coordinated between the Primary Care Provider (PCP), specialists, behavioral health, service organizations and community supports.	100%	None

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

Reinsurance (RI)	RI Standard Area Score = 100% (400 of 400)	
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 = 100% (700 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.	100%	None
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

Third Party Liability (TPL)	**TPL Standard Area Score = 100% (700 of 700)**	
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