



Chapter 900	Quality Management and Performance Improvement Program
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**910 QUALITY MANAGEMENT / PERFORMANCE IMPROVEMENT PROGRAM
ADMINISTRATIVE REQUIREMENTS**

EFFECTIVE DATE: May 13, 2016

REFERENCES: ACOM 900:910

- A. The Division's written Quality Management/Performance Improvement (QM/PI) Plan addresses the proposed methodology to meet or exceed the standards and requirements in the Arizona Health Care Cost Containment System (AHCCCS) Contractor Operations Manual chapter 900:910 and the contractual requirements between the Division and AHCCCS.
- B. The QM/PI Plan describes how program activities will improve the quality of care, service delivery, and satisfaction for members.
- C. The QM/PI Plan, and any subsequent modifications are submitted to the AHCCCS/Division of Health Care Management/ Clinical Quality Management (DHCM/CQM) for review and approval prior to implementation.
- D. The QM/PI Plan includes, at a minimum, in paginated detail, the following components:
 - 1. QM/PI Program Administrative Oversight,
 - 2. QM/PI Committee,
 - 3. Peer Review,
 - 4. The QM/PI Staffing,
 - 5. Delegated Entities,
 - 6. Health Information System Policies and Procedures,
 - 7. Annual Work Plan,
 - 8. Annual QM/PI Program Evaluation,
 - 9. QM/PI Documentation,
- E. Quality Management and Performance Improvement (QM/PI) activities include:
 - 1. Policies and Procedures,
 - 2. Studies and Performance Improvement Plans,
 - 3. Reports,
 - 4. Processes/Desktop Procedures,

5. Standards,
6. Worksheets,
7. Meeting Minutes,
8. Corrective Action Plans (CAPs), and
9. Other information and data appropriate to support changes made to the scope of the QM/PI Plan or Program.

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

REVISION DATE: 7/15/2016

EFFECTIVE DATE: May 27, 2016

REFERENCES: AMPM 1600; AHCCCS contract, AMPM 910; (42 C.F.R. 438.208).

QM/PI Program Components

The QM/PI (Quality Management/Performance Improvement) Program Components include:

- A. A detailed, written set of specific measurable objectives that demonstrates how the Division's QM/PI Program meets established goals and complies with all components of this Chapter.
- B. A work plan to support the objectives including:
 - 1. A description of all planned goals and objectives for both clinical care and other covered services,
 - 2. Targeted implementation and completion dates for quality management measurable objectives, activities and performance improvement projects,
 - 3. Methodologies to accomplish measurable goals and objectives,
 - 4. The inclusion of measurable behavioral health goals and objectives,
 - 5. Staff positions responsible and accountable for established goals and objectives, and
 - 6. Detailed policies and procedures implementing all components and requirements of this Policy.
- C. A requirement to conduct a new member health risk assessment or a "best effort" attempt has been made to conduct an initial health risk assessment including follow up on unsuccessful attempts to contact a member within 90 days of the effective date of enrollment. Each attempt is documented. The Division utilizes the results of health assessments to identify individuals at risk for and/or with special health care needs and to coordinate care (42 C.F.R. 438.208).
- D. Requirements to ensure continuity of care and integration of services through Policies and Procedures:
 - 1. The Division ensures that each member has the choice to select or have a Primary Care Provider (PCP) assigned to them who is formally designated as having primary responsibility for coordinating the member's overall health care, including coordination with the behavioral health medical professional.
 - 2. The Division ensures all services provided by the Division or its subcontractors

are coordinated with specific documentation of these processes.

3. Coordination of covered services with community and social services, are generally available through contracted or non-contracted providers.
 4. Policies specifying services coordinated by the Division's Health Care Services Unit and sub-contractors, and
 5. The Division ensures timely and confidential communication of clinical information amongst providers, as required by the Arizona Health Care Cost Containment System (AHCCCS).
- E. Oversight of implementation of measures to ensure members:
1. Are informed of specific health care needs that require follow-up,
 2. Receive, training in self-care and other measures they may take to promote their own health, as appropriate, and
 3. Are informed of their responsibility to comply with ordered treatments or regimens.
- F. Maintenance of records and documentation as required under State and Federal law.

QM/PI Program Monitoring and Evaluation Activities

The Division's QM/PI Program includes a comprehensive evaluation of activities used by the Division, and demonstrates how these activities improve the quality of services and the continuum of care in all services sites. Monitoring and evaluation activities include:

- A. Using data from monitoring showing trends in quality of care issues to select and develop performance improvement projects.
- B. Reporting all incidents of abuse, neglect, exploitation, and unexpected deaths to AHCCCS Clinical Quality Management Unit under established timelines.
- C. Reporting identified quality of care, reportable incidents and/or service trends to the AHCCCS Clinical Quality Management Unit immediately upon identification of the trend, including trend specifications such as providers, facilities, services, and allegation types.
- D. Tracking and reporting Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC) to the AHCCCS Clinical Quality Management Unit on a quarterly basis utilizing the established AHCCCS format.
- E. Incorporating the ADHS licensure and certification reports and other publicly reported data, as applicable.

- G. Reviewing quality of care trend reports, and incorporating the reports into the QM/PI evaluation.
- H. Ensuring the health and safety of members in placement settings or service sites that are found to have survey deficiencies that may impact the health and safety of members. The Division actively participates in both individual and coordinated efforts to improve the quality of care by taking appropriate and collaborative action regarding:
1. Placement settings or service sites that have been identified through the Licensure Survey process or other mechanisms as having an immediate jeopardy situation or have had multiple survey or complaint investigations resulting in a finding of non-compliance with licensure requirements.
 2. Facilities, placement settings, or service sites that have been identified by AHCCCS as an Immediate Care Need.
 3. Meetings scheduled to develop work plans and corrective action plans to ensure placement setting or service sites are in compliance with ADHS Licensure and/or AHCCCS requirements.
 4. Scheduled and unscheduled monitoring of placement setting or service sites that are in an Immediate Jeopardy status or have serious identified deficiencies that may affect health and safety of members (Immediate Care Needs).
 5. Assisting in the identification of technical assistance resources focused on achieving and sustaining licensure compliance.
 6. Monitoring placement setting or service sites upon completion of the activities and interventions to ensure that compliance is sustained.

- a. The following services and service sites will be monitored at a minimum annually by the Division, or its sub-contractor, and will include the following:

SERVICES	SERVICE SITES
<ul style="list-style-type: none"> Behavioral Health Therapeutic Home Care Services 	<ul style="list-style-type: none"> Behavioral Health Outpatient Clinics
<ul style="list-style-type: none"> Behavioral Management 	<ul style="list-style-type: none"> Behavioral Health Therapeutic Home (Adults and Children)
<ul style="list-style-type: none"> Behavioral Health Personal Assistance 	<ul style="list-style-type: none"> Independent Clinic
<ul style="list-style-type: none"> Family Support 	<ul style="list-style-type: none"> Federally Qualified Health Center
<ul style="list-style-type: none"> Peer Support 	<ul style="list-style-type: none"> Community Mental Health Center
<ul style="list-style-type: none"> Case Management Services 	<ul style="list-style-type: none"> Community/Rural Health Clinic (or Center)
<ul style="list-style-type: none"> Emergency/Crisis Behavioral Health Services 	<ul style="list-style-type: none"> Crisis Service Provider
<ul style="list-style-type: none"> Emergency Transportation 	<ul style="list-style-type: none"> Community Service Agency
<ul style="list-style-type: none"> Evaluation and Screening (initial and ongoing assessment) 	<ul style="list-style-type: none"> Hospital (if it includes a distinct behavioral health or detoxification unit)
<ul style="list-style-type: none"> Group Therapy and Counseling 	<ul style="list-style-type: none"> Inpatient Behavioral Health Facility
<ul style="list-style-type: none"> Individual Therapy and Counseling 	<ul style="list-style-type: none"> Behavioral Health Residential Facility
<ul style="list-style-type: none"> Family Therapy and Counseling 	<ul style="list-style-type: none"> Residential Treatment Center
<ul style="list-style-type: none"> Marriage/Family Counseling 	<ul style="list-style-type: none"> Psychiatric Hospital
<ul style="list-style-type: none"> Substance Abuse Treatment 	<ul style="list-style-type: none"> Substance Abuse Transitional Center
<ul style="list-style-type: none"> Inpatient Hospital 	<ul style="list-style-type: none"> Unclassified Facility
<ul style="list-style-type: none"> Inpatient Psychiatric Facilities (resident treatment centers and sub-acute facilities) 	<ul style="list-style-type: none"> Integrated Behavioral Health and Medical Facility
<ul style="list-style-type: none"> Institutions for Mental Diseases 	<ul style="list-style-type: none"> Individual Respite Homes
<ul style="list-style-type: none"> Laboratory and Radiology Services 	
<ul style="list-style-type: none"> Non-emergency Transportation 	
<ul style="list-style-type: none"> Nursing 	
<ul style="list-style-type: none"> Opioid Agonist Treatment 	
<ul style="list-style-type: none"> Partial Care (supervised day program, therapeutic day program and medical day program) 	
<ul style="list-style-type: none"> Psychosocial Rehabilitation (living skills training, health promotion and supported employment) 	
<ul style="list-style-type: none"> Psychotropic Medication 	

- b. The following services and service sites will be monitored at a minimum every three years by the Division, or its sub-contractor, and will include the following:

SERVICES	SERVICE SITES
• Ancillary	• Ambulatory Facilities
• Dental	• Hospitals
• Emergency	• Nursing Facilities
• Early Periodic Screening, Diagnosis and Treatment (EPSDT)	• Individual Respite Homes
• Family Planning	
• Obstetric	
• Pharmacy	
• Prevention and Wellness	
• Primary Care	
• Specialty Care	
• Other (e.g. Durable Medical Equipment (DME)/Medical Supplies, Home Health Services, Therapies, Transportation, etc.)	

- c. The following services and service sites will be monitored at a minimum every three years (unless otherwise noted) by the Division, or its sub-contractor, and will include the following:

SERVICES	SERVICE SITES
Adult Day Health Care*	Assisted Living Centers*
Ancillary	Assisted Living Homes*
Attendant Care*	Ambulatory Facilities
Behavioral Health	Behavioral Health Facilities
Dental	Developmentally Disabled (DD) Group Homes*
Durable Medical Equipment (DME)/ Medical Supplies	Developmental Homes*
Emergency	Hospice*
Emergency Alert	Hospitals
Environmental Modifications	Institution for Mental Diseases*
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	Intermediate Care Facility for Persons with Intellectual Disabilities*
Family Planning	Nursing Facilities*
Habilitation Services (as applicable)	Own Home*
Home Delivered Meals	Residential Treatment Centers*
Home Health Services	Traumatic Brain Injury Facilities*
Homemaker*	Individual Respite Homes*
Hospice	
Medical/Acute Care	
Obstetric	
Personal Care Services* †	
Directed Care Services*††	
Prevention and Wellness	
Respiratory Therapy	
Respite Care	
Specialty Care	
Therapies (Occupational Therapy [OT], Physical Therapy [PT], Speech Therapy [ST])	
Transportation	
<p>*These services must be reviewed annually. †Defined in ARS §36-401(36) ††Defined in ARS §36-401(15)</p>	

- d. The Division monitors Attendant Care, Homemaker services, Respite services, and Habilitation services on an annual basis. When deficiencies or potential deficiencies are identified, they are addressed from a member and system perspective.
- e. The Division submits monitoring results to AHCCCS CQM annually by December 15. Additionally, an agreed upon tool is used and includes at a minimum:
 - i. General Monitoring of these services includes but is not limited to the review and verification of:
 - The written documentation of timeliness,
 - The implementation of contingency plans,
 - Customer/Member satisfaction information,
 - The effectiveness of service provision, and
 - Mandatory documents in the services or service site personnel file:
 - Cardio Pulmonary Resuscitation (CPR),
 - First Aid,
 - Verification of skills or competencies to provide care, and
 - Evidence that the agency contacted at least three references, one of which must be a former employer. Results of the contacts are documented in the employee's personnel record.

Specific monitoring requirements are as follows:

- ii. Completing Direct Care Services (Attendant Care/Homemaker services) monitoring; the verification and documentation of compliance must include:
 - Mandated written agreement between the member and or member representative and the Direct Care Worker (DCW) which delineates the responsibilities of each,
 - Evaluation of the appropriateness of allowing the member's immediate relatives to provide attendant care, and

- DCWs meet competencies to provide care including training, testing, verifying and sharing testing records of DCWs.
 - Continuing education standards.
 - Incorporation of testing results into monitoring tools for organizational providers that are and are not Approved DCW Training and Testing Programs.
 - Timeliness and content of supervisory visitations.
- f. The Division monitors that the Arizona Long Term Care System services a member receives aligns with those documented in the member's service plan and are appropriate, and
- g. Uses the National Core Indicator Survey to assess the experience of members receiving long term care services.

Implementation of Actions to Improve Care

- A. If problems are identified, the Division may develop and monitor a corrective action plan required by AHCCCS and may require the development and monitoring of a corrective action plan by its service providers. The CAP addresses the following:
1. Specified specific problem(s) requiring the corrective action. Examples include:
 - a. Abuse, neglect, and exploitation,
 - b. Healthcare acquired conditions,
 - c. Unexpected death,
 - d. Isolated systemic issues,
 - e. Trends,
 - f. Health and safety issues, Immediate Jeopardy and Immediate Care Need situations,
 - g. Lack of coordination,
 - h. Inappropriate authorizations for specific ongoing care needs, and
 - i. High profile/media events, and

- j. Other examples as identified by the Division.
 2. All determinations regarding quality issues that are referred for peer review will be made only by the Peer Review Committee chaired by the Chief Medical Officer. Per the ruling of the Peer Review Committee to refer a decision for review, the person(s) or body (e.g., board) will be responsible for making the final determinations regarding quality issues.
 3. Type(s) of action(s) to be taken, include:
 - a. Education/training/technical assistance,
 - b. Follow-up monitoring and evaluation of improvement,
 - c. Changes in processes, organizational structures, forms,
 - d. Informal counseling,
 - e. Termination of affiliation, suspension or limitation of the provider (if an adverse action is taken with a provider the Division reports the adverse action to the AHCCCS Clinical Quality Management Unit within one business day),
 - f. Referrals to regulatory agencies, and/or,
 - g. Other actions as determined by the Division.
 4. Method(s) for internal dissemination of findings and resulting corrective action plans to appropriate staff and/or network providers, and documentation of assessment of the effectiveness of actions taken.
 5. Method(s) for dissemination of pertinent information to AHCCCS Administration and/or regulatory boards and agencies (e.g., Arizona Department of Health Services, Arizona Medical Board, Arizona Board of Pharmacy, Arizona State Board of Nursing).
- B. The Division maintains documentation confirming implementation of corrective action.

950 CREDENTIALING AND RECREDENTIALING PROCESSES

EFFECTIVE DATE: May 13, 2016

Credentialing and Recredentialing System

The Division maintains a system for credentialing and recredentialing providers.

- A. The Division conducts and documents credentialing and recredentialing for all providers, including those employed by an organizational provider contracted with the Division for care and services to members. Credentialing and recredentialing is completed for the following provider types:
1. Physicians (Medical Doctor [MD])
 2. Doctor of Osteopathic Medicine [DO]
 3. Doctor of Podiatric Medicine (DPM)
 4. Nurse practitioners
 5. Physician Assistants
 6. Certified Nurse Midwives acting as primary care providers, including prenatal care/delivering providers
 7. Dentists (Doctor of Dental Surgery [DDS] and Doctor of Medical Dentistry [DMD])
 8. Affiliated Practice Dental Hygienists
 9. Psychologists
 10. Optometrist
 11. Certified Registered Nurse Anesthetist
 12. Occupational Therapist
 13. Speech and Language Pathologist
 14. Physical Therapists

15. Independent behavioral health professionals who contract directly with the Division and other non-licensed or certified providers that provide behavioral health services including:
 - a. Licensed Baccalaureate Social Workers (LBSW)
 - b. Licensed Clinical Social Worker (LCSW)
 - c. Licensed Professional Counselor (LPC)
 - d. Licensed Associate Counselor (LAC)
 - e. Licensed Marriage/Family Therapist (LMFT)
 - f. Licensed Associate Marriage/Family Therapist (LAMFT)
 - g. Licensed Substance Abuse Technician (LSAT)
 - h. Licensed Associate Substance Abuse Counselor (LASAC)
 - i. Licensed Independent Substance Abuse Counselor (LISAC)
 - j. Board Certified Behavioral Analysts (BCBAs)
 - k. Any non-contracted provider that is rendering services and sees fifty (50) or more members per contract year, and
 - l. Covering or substitute providers that provide care and services to members while providing coverage or acting as a substitute during an absence of the contracted provider.
- B. The Division ensures:
 1. The credentialing and recredentialing processes do not discriminate against a health care professional who serves high-risk populations or who specializes in the treatment of costly conditions.
 2. Compliance with federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid or that employ individuals or entities that are excluded from participation.
 3. The Division delegates a portion of the required responsibilities of credentialing/recredentialing to subcontractors.
 - a. The Division retains the right to approve, suspend, or terminate any provider credentialed by a subcontractor.
 - b. The Division is responsible for making an independent decision regarding any provider approved through a delegated credentialing process into its network.

4. The Division's Chief Medical Officer, or in the absence of the Chief Medical Officer, another designated physician:
 - a. Acts as the Chair of the Credentialing Committee
 - b. Implements the decisions made by the Credentialing Committee, and
 - c. Oversees the credentialing process.
5. The Division ensures the use of participating Arizona Medicaid network providers in making credentialing decisions through participation in the Credentialing Committee.
6. The Division or its subcontractor maintains an individual electronic or hard copy credentialing/recredentialing file for each credentialed provider in accordance with AHCCCS policy.
7. Credentialed providers are included in the claims payment system with an effective date no later than the date the provider was approved by the Credentialing Committee.
8. For Locum Tenens, the Division's or its subcontractor verifies the status of the physician with the Arizona Medical Board and national databases.

Initial Credentialing

The Division uses the Arizona Health Plan Association's Credential Verification Organization (CVO) as part of the credentialing process. The initial credentialing of physicians, other licensed health care providers, behavioral health providers, and Board Certified Behavioral Analysts follow AHCCCS policy.

The Division or its subcontractor ensures network providers can ensure physical access, accommodations, and accessible equipment for members with physical and mental disabilities. Accommodations are reasonable and providers ensure culturally competent communications with members. The Division or its subcontractor ensures that providers can communicate with limited-English-proficient members in their preferred language.

Temporary/Provisional Credentialing

The Division or its subcontractor maintains procedures to address temporary or provisional credentials, when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-Alike Center, as well as hospital employed physicians (when appropriate), are credentialed using the temporary or provisional credentialing process, even if the provider does not specifically request their application be processed as temporary or provisional.

- A. The Division follows AHCCCS policy when granting temporary or provisional credentialing to:
1. Providers needed in medically underserved areas
 2. Providers joining an existing, contracted oral health provider group, and
 3. Covering or substitute providers providing services to members during a provider's absence from the practice.

The Division or its subcontractor renders a decision regarding temporary or provisional credentialing in 14 calendar days from receipt of a completed application.

If a covering or substitute provider is used and is approved through the temporary/provisional credentialing process, the Division or its subcontractor ensures that its system allows payments to the covering/substitute provider. Covering or substitute providers also meet the requirements set forth in AHCCCS policy.

- B. For consideration of temporary or provisional credentialing, at a minimum, a provider completes a signed application that includes:
1. Reasons for any inability to perform the essential functions of the position, with or without accommodation
 2. Lack of present illegal drug use
 3. History of loss of license and/or felony convictions
 4. History of loss or limitation of privileges or disciplinary action
 5. Current malpractice insurance coverage, and
 6. Attestation by the applicant of the correctness and completeness of the application. A copy of the most current signed attestation will be included in the provider's credentialing file.
- C. The applicant furnishes:
1. Work history for the past five years, or total work history if less than five (5) years, and
 2. Current Drug Enforcement Agency (DEA) or Controlled Drug System (CDS) certificate.
- D. The Division conducts primary verification of the following Licensure or certification; a print out of license from the applicable Boards' official website denoting that the license is active with no restrictions is acceptable.
1. Board certification, if applicable, or the highest level of credential attained, and

2. National Provider Data Bank (NPDB) query, including:
 - a. Minimum five year history of professional liability claims resulting in a judgment or settlement
 - b. Disciplinary status with regulatory board or agency
 - c. State sanctions or limitations of licenses, and
 - d. Medicare/Medicaid sanctions, exclusions, and terminations for cause.

The Division's Chief Medical Officer reviews the information obtained and determines whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and Credential Committee review, as outlined in this policy, is completed.

Recredentialing Individual Providers

- A. The Division, or its subcontractors, utilizes the Arizona Health Plan Association's Credential Verification Organization as part of its credentialing process.
Recredentialing physicians and other licensed or certified health care providers:
 1. Occur at least every three (3) years
 2. Include an update of information obtained during the initial credentialing process
 3. Verify continuing education requirements are met, if applicable
 4. Include a process for monitoring health care providers specific information including:
 - a. Member concerns, which include grievances (complaints)
 - b. Utilization management information (e.g., emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization)
 - c. Performance improvement and monitoring (e.g., performance measure rates)
 - d. Results of medical record review audits, if applicable
 - e. Quality of care issues (including trend data). If an adverse action is taken with a provider, including non-renewal of a contract, the Division reports the adverse action and includes the reason for the adverse action to the AHCCCS Clinical Quality Management Unit within one business day.
 5. Pay for performance and value-driven health care data/outcomes, if applicable
 6. Evidence that the provider's policies and procedures meet AHCCCS requirements

7. Timely approval (or denial) by the Division's Credentialing Committee within 90 days of recredentialing being initiated.

Initial Assessment of Organizational Providers

- A. The Division ensures the organizational provider has established policies and procedures that meet AHCCCS and Division requirements, as a prerequisite to contracting with an organizational provider. The requirements described in this section are met for all organizational providers included in its network including, but not limited to:
 1. Hospitals
 2. Home health agencies
 3. Attendant care agencies
 4. Habilitation Providers
 5. Group homes
 6. Nursing facilities
 7. Dialysis centers
 8. Dental and medical schools
 9. Freestanding surgical centers
 10. Intermediate Care Facilities
 11. State or local public health clinics
 12. Community/Rural Health Clinics (or Centers)
 13. Air Transportation
 14. Non-emergency transportation vendor
 15. Laboratories
 16. Pharmacies
 17. Respite Homes/Providers
 18. Behavioral health facilities, including but not limited to:
 - a. Independent Clinics
 - b. Federally Qualified Health Centers (FQHC)
 - c. FQHC look-alikes
 - d. Community Mental Health Centers

- e. Level 1 Sub-Acute Facility
 - f. Level 1 Sub-Acute Intermediate Care Facility
 - g. Level 1 Residential Treatment Center (secure and non-secure)
 - h. Community Service Agency
 - i. Crisis Services Provider/Agency
 - j. Behavioral Health Residential Facility
 - k. Behavioral Health Outpatient Clinic
 - l. Integrated Clinic
 - m. Rural Substance Abuse Transitional Agency
 - n. Behavioral Health Therapeutic Home
 - o. Respite Homes/Providers
 - p. Specialized Assisted Living Centers, and
 - q. Specialized Assisted Living Homes.
- B. Prior to contracting with an organizational provider, the Division:
- 1. Confirms the provider has met all the state and federal licensing and regulatory requirements (a copy of the license or letter from the regulatory agency will meet this requirement)
 - 2. Confirms the provider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS) (a copy of the accreditation report or letter from the accrediting body will meet this requirement), when applicable
 - 3. Conducts an onsite quality assessment. The Division utilizes assessment criteria, for each type of unaccredited organizational provider with which it contracts, that includes, at minimum, confirmation that the organizational provider has:
 - a. A process for ensuring that the organizational provider credentials its providers for all employed and contracted providers listed in this policy
 - b. Liability insurance, and
 - c. Business license.
 - d. In addition, for Community Service Agencies:
 - i. A signed relationship agreement with the RBHA whose members they are serving

- ii. An approved application with the RBHA
 - iii. A signed contract with a RBHA contracted network provider
 - iv. A description of the services provided that matches the services approved on the Title XIX Certificate
 - v. Fire inspection reports
 - vi. Occupancy permits
 - vii. Tuberculosis testing
 - viii. CPR certification
 - ix. First Aid certification, and
 - x. Respite providers provide and maintain consistently a signed agreement with an Outpatient Treatment Center.
2. Reviews and approves the organizational provider and the providers credentialed by the organizational provider through the Division's or its subcontractor's Credentialing Committee.
 3. Reviews a maintenance schedule for vehicles used to transport AHCCCS members and the availability of age appropriate car seats when transporting children, for transportation vendors.
 4. Reviews the information below, for behavioral health providers that utilize behavioral health technicians and behavioral health paraprofessional staff:
 - a. Personnel files to document:
 - i. Specific skills and services by classification of staff
 - ii. Qualifications of staff including education and training
 - iii. Supervision of staff and required documentation of direct supervision/clinical oversight.
 - b. Completed written application, including:
 - i. Reasons for any inability to perform the essential functions of the position, with or without accommodation
 - ii. Lack of present illegal drug use
 - iii. History of any disciplinary actions taken by the Board of Behavioral Health Examiners or any convictions
 - iv. History of loss or limitation of scope of services or disciplinary action, if applicable

- v. Work history for the past five years or total work history if less than five years, and
 - vi. Attestation by the applicant of the correctness and completeness of the application. (A copy of the signed attestation is included in the provider's credentialing file).
- c. Documentation that behavioral health technicians and paraprofessionals have:
- i. Arizona Finger Print Clearance Card, if working with children
 - ii. Cardio-pulmonary resuscitation training
 - iii. First aid training
 - iv. Crisis prevention and intervention training
 - v. Required training for orientation to the facility as stated in the facility's policies and procedures
 - vi. Initial Training, with at least 80 hours completed within the first six months of employment, that includes the following topics:
 - Ethics and professional conduct
 - Documentation and patient confidentiality
 - Maintaining client and personal safety
 - Clinical competence including medications, and
 - Mandatory reporting and cultural competency
 - vii. Initial training does not prohibit a behavioral health paraprofessional or technician from providing services during training
 - viii. Personnel member's skills, training and proficiency are verified before providing any services and re-verified at least every 12 months
 - ix. Evidence of lack of current infectious tuberculosis
 - x. Documentation of work experience and/or training relevant to the population with which the individual staff is working,
 - xi. In-service/continuing education requirements for personnel of a minimum of one hour per month documented in personnel file,
 - xii. A minimum of a high school diploma or high school equivalency diploma or higher, and

- xiii. Evidence of being at least twenty-one (21) years of age.
- d. Each facility has documentation of direct supervision for behavioral health paraprofessionals and clinical oversight for behavioral health technician, consisting of eighty (80) hours initially. One hour of continuing supervision and/or oversight is completed for every forty (40) hours of full time work after the initial orientation. Documentation of all or part of the initial clinical oversight for behavioral health technicians and supervision for behavioral health paraprofessionals are transferrable at the discretion of the hiring organization.

Reassessment of Organizational Providers

- A. The Division reassesses organizational providers at least every three years. The reassessment includes the following:
 - 1. Confirmation the organizational providers remain in good standing with state and federal bodies, and, if applicable, are reviewed and approved by an accrediting body. To meet this component the Division validates the organizational provider meets the conditions listed below:
 - a. Is licensed to operate in the State, and is in compliance with any other state or federal requirements as applicable
 - b. Is reviewed and approved by an appropriate accrediting body. If an organizational provider is not accredited or surveyed and licensed by the State, an on-site review is conducted.
 - 2. Review of:
 - a. The most current review conducted by the Arizona Department of Health Services (ADHS) and/or summary of findings (date of ADHS review is be documented) and, if applicable, review of the online "Hospital Compare" or "Nursing Home Compare"
 - b. Record of on-site inspection of non-licensed organizational providers to ensure compliance with service specifications
 - c. Supervision of staff and required documentation of direct supervision/clinical oversight as required, including, if applicable, review of a valid sample of clinical charts
 - d. Most recent audit results of the organizational provider
 - e. Confirmation that the service delivery address is correct
 - f. Verification that staff meet the credentialing requirements.
 - 3. Evaluation of organizational provider-specific information, including:
 - a. Member concerns which include grievances (complaints)

- b. Utilization management information
 - c. Performance improvement and monitoring
 - d. Quality of care issues
 - e. Onsite assessment.
4. The Division's Credentialing Committee reviews and approves all credentialing decisions.
 5. The Division reviews and monitors other types of organizational providers in accordance with their contract.

Notification Requirements - Suspensions and Terminations

The Division reports within one business day to the AHCCCS Clinical Quality Management Unit deficiencies that result in a provider's suspension or termination from the Division's network. If the deficiency is determined to have criminal implications, including allegations of abuse or neglect, the Division promptly notifies a law enforcement agency, and Adult Protective Services or the Department of Child Safety.

The Division reports to the AHCCCS Clinical Quality Management Unit all credentialing, provisional credentialing, recredentialing, and organizational credentialing denials.

- A. The Division indicates in its notification to AHCCCS the reason for the denial decision and when restrictions are placed on the provider's contract, such as denials or restrictions which are the result of licensure issues, quality of care concerns, excluded providers, alleged fraud, and waste or abuse. The Division:
 1. Maintains documentation of implementation of the procedures
 2. Has an appeal process for instances in which the Division places restrictions on the provider's contract based on issues of quality of care and/or service
 3. Informs the provider of the Quality Management (QM) dispute process through the QM Department, and
 4. Notifies the AHCCCS Clinical Quality Management (CQM) within one business day for all reported events.

Notification Requirements - Final Adverse Actions

- A. Within one business day, the Division reports to the AHCCCS Clinical Quality Management Unit in writing, any final adverse action for any reason, taken against a health care provider, supplier/vendor, or practitioner.
- B. A final adverse action includes:
 1. Civil judgments in federal or State court related to the delivery of a health care item or service,
 2. Federal or State criminal convictions related to the delivery of a health care item or service, and
 3. Actions by federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including:
 - a. Formal or official actions, such as restriction, revocation or suspension of license (and the length of any such suspension), reprimand, censure or probation,
 - b. Any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or
 - c. Any other negative action or finding by such federal or state agency that is publicly available information,
 - d. Exclusion from participation in federal or state health care programs as specified in current statute, and
 - e. Any other adjudicated actions or decisions as necessary.
 4. Any adverse credentialing, provisional credentialing, recredentialing, or organizational credentialing decision or any adverse action from a quality or peer review process, that results in denial of a provider to participate in the Division's network, provider termination, provider suspension or an action that limits or restricts a provider.
- C. A final adverse action does not include an action with respect to a malpractice notice or settlements in which no findings or liability has been made.
- D. The Division submits to the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB):
 1. Within 30calendar days from the date the final adverse action was taken or the date when the Division became aware of the final adverse action, or
 2. By the close of the Division's next monthly reporting cycle, whichever is later.

- E. The Division immediately notifies the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding any allegation of fraud, waste or abuse of the AHCCCS Program, including allegations of fraud, waste or abuse that were resolved internally but involved AHCCCS funds. The Division also reports to AHCCCS, as specified in Attachment F3, Contractor Chart of Deliverables, any credentialing denials issued by the Credential Verification Organization including, but not limited to, those that are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. AHCCCS-OIG conducts a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. The Division reports, within one (1) business day, the following:
1. The name and Tax Identification Number (TIN) (as defined in section 7701(A)(41) of the Internal Revenue Code of 1986[1121])
 2. The name (if known) of any health care entity with which the health care provider, supplier, or practitioner is affiliated or associated
 3. The nature of the final adverse action and whether such action is on appeal
 4. A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information determined by regulation, for appropriate interpretation of information reported under this section
 5. The date the final adverse action was taken, its effective date and duration of the action
 6. Corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, and
 7. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider is disclosed to AHCCCS/OIG immediately:
 - a. The System of Award Management (SAM) www.sam.gov formerly known as the Excluded Parties List System (EPLS)
 - b. The Social Security Administration's Death Master File
 - c. The National Plan and Provider Enumeration System (NPPES)
 - d. The List of Excluded Individuals (LEIE)
 - e. Any other databases directed by AHCCCS or CMS



Credentialing Timeliness

The Division processes credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing, the Division divides the number of complete applications processed (approved/denied) during the time period per category by the number of complete applications that were received during the time period per category.

The timeliness standards for approvals/denials, expressed as a percentage of total received, is shown below.

	30 days	60 days	90 days
Initial Credentialing	50%	75%	100%
Recredentialing	50%	75%	100%
Organizational Credentialing	50%	75%	100%

960 TRACKING AND TRENDING OF MEMBER AND PROVIDER ISSUES

EFFECTIVE DATE: May 20, 2016

Documentation Related to Quality of Care Concerns

As a part of the Division's process for reviewing and evaluating member and provider issues, there are written procedures regarding the receipt, initial and ongoing processing of these matters that include the following:

- A. Documenting each issue raised, when and from whom it was received, and the projected time frame for resolution.
- B. Determining promptly whether the issue is to be resolved through the Division's established:
 1. Quality management process,
 2. Grievance and appeals process,
 3. Process for making initial determinations on coverage and payment issues, or
 4. Process for resolving disputed initial determinations.
- C. Acknowledging receipt of the issue and explaining to the member or provider the process that will be followed to resolve his or her issue through written correspondence.
- D. Assisting the member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.
- E. Ensuring confidentiality of all member information.
- F. Informing the member or provider of all applicable mechanisms for resolving the issue external to the Division's processes.
- G. Documenting all processes (including detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each complaint, grievance or appeal, including but not limited to:
 1. Corrective action plan(s) or action(s) taken to resolve the concern,
 2. Documentation that education/training was completed. This may include, but is not limited to, in-service attendance sheets and training objectives,
 3. New policies and/or procedures,
 4. Follow-up with the member that includes, but is not limited to:
 - a. Assistance as needed to ensure that the immediate health care needs

are met,

- b. 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, and
- c. Referral to the Division's compliance department and/or AHCCCS Office of the Inspector General.

Process of Evaluation and Resolution of Quality of Care and Service Concerns

The quality of care concern include documentation of identification, research, evaluation, intervention, resolution and trending of member and provider issues. Resolution includes both member and system interventions when appropriate. The quality of care/service concern process is a stand-alone process completed through the quality management unit with assistance from other units when necessary. The process is not combined with other Division meetings or processes. Other units outside of the Quality Management unit do not have the authority to solely conduct quality of care investigations but may provide subject matter expertise throughout the investigative process.

- A. The Division maintains procedures that address analysis the quality of care issues through:
 1. Identification of the quality of care issues,
 2. Initial assessment of the severity of the quality of care issue,
 3. Prioritization of action(s) needed to resolve immediate care needs when appropriate,
 4. Review of trend reports obtained from the Division's quality of care concern data to determine possible trends related to the provider(s), including organizational providers involved in the allegation(s) severity and substantiation,
 5. Research, including, but not limited to:
 - a. A review of the log of the events,
 - b. Documentation of conversations,
 - c. Medical records review, and
 - d. Mortality review.
 6. Quantitative analysis which may include root cause analyses when needed, and

7. Interviews of members, direct care staff, and witnesses to a reportable event; when applicable and appropriate.
- B. Onsite visits are conducted by the Division's Quality Management staff when:
1. There are identified health and safety concerns,
 2. Immediate jeopardy,
 3. Other situations as determined by Division administration, or
 4. At the request of AHCCCS.
- Subject matter experts outside the Quality Management unit may participate in the onsite visit but may not take the place of Quality Management staff during reviews.
- C. The Division participates in efforts to prevent, detect and remediate all critical issues including those that are self-identified, or when notified by AHCCCS of issues.
- D. The Division does not delegate quality of care investigation processes or onsite quality of care issues.
- E. The Division maintains a process to assure that action is taken when needed by:
1. Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring,
 2. Determining, implementing, and documenting appropriate interventions,
 3. Monitoring and documenting the success of the interventions,
 4. Incorporating interventions into the organizations Quality Management (QM) program if successful, or
 5. Implementing new interventions/approaches when necessary.
- F. The Division maintains a process to ensure resolution of the issue. Member and system resolutions may occur independently from one another.
- G. The Division maintains a process to determine the level of severity of the quality of care issue.
- H. The Division maintains a process to confirm referral and/or reporting of issues to the appropriate regulatory agency including:
1. The Department of Child Safety,
 2. Adult Protective Services,

3. Arizona Department of Health Services (AZDHS),
4. The Attorney General's Office,
5. Law Enforcement,
6. AHCCCS, and/or
7. Other entities as necessary.

Initial reporting may be made verbally, but must be followed by a written report within one business day.

- I. The Division maintains a process to refer the issues to the Division's Peer Review Committee when appropriate. Referral to the Peer Review Committee is not a substitute for implementing interventions aimed at individual and systemic quality improvement.
- J. If an adverse action is taken with a provider for any reason including those related to quality of care concern, the Division must report the adverse action to the AHCCCS Clinical Quality Management Unit within 24 hours of the determination to take an adverse action as well as to the National Practitioner Data Bank when needed.
- K. The Division maintains a process to determine the level of substantiation of the quality of care or service issue.
- L. The Division maintains a process to provide written notification to the appropriate regulatory/licensing Board or Agency and AHCCCS when a health care professional/s organizational provider or other provider's affiliation with its network is suspended or terminated for any reason, including those related to quality of care issues.
- M. The Division maintains a process to document the criteria and process for closure of the review or investigation including:
 1. A description of the problems, including new allegations identified during the investigation/review process, and the substantiation and severity level for each allegation as well as the case overall.
 2. Written response or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or Medical Examiner.
- N. The Division notifies AHCCCS CQM and takes appropriate action with the provider including suspension or corrective action plans and referrals to appropriate regulatory Boards including the Pharmacy Board when an investigation identifies an adverse outcome, including mortalities, due to prescribing issues or failure of the provider to check the CSPMP, to coordinate care with other prescribers, refer for substance use treatment or pain management. The case finding are presented to the Division's Peer Review Committee for discussion and review.

Requests for Copies of Death Certificates

As part of the quality of care investigative process, the Division will request copies of member death certificates from the ADHS Office of Vital Statistics. The following process is followed:

- A. The Division sends a letter, on Division letterhead, providing one or two names of employees who are authorized to make the request for a copy of the death certificate.
- B. Only those individual(s) listed on the letter are eligible to apply/request a copy of the death certificate.
- C. The letter must include original ink signatures and is mailed to:
 1. Arizona Department of Health Records
Office of Vital Records
Office Chief
P.O Box 3887
Phoenix, Arizona 85030
- D. The Division notifies the AZDHS Office of Vital Statistics in writing of any termination of employment of those listed on the original letter. Included in the notification should be the name of the replacement managerial or supervisory staff person. These changes should be mailed to:
 1. Operations Section Manager
Arizona Department of Health Services
Office of Vital Records
P.O Box 3887
Phoenix, Arizona 85030
- E. The following information will be included on requests for death certificates:
 1. The decedents' s (member's) name,
 2. Date of death,
 3. Purpose of request (i.e. quality of care investigation process), and
 4. Signature of the authorized employee

Documentation showing that the decedent was a member of the Division (copy of an eligibility screen with the Division's name, members name and date of eligibility is acceptable)
- F. All requests for death certificates are sent to:
 1. Arizona Department of Health Records

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

Tracking and Trending of Quality of Care Issues

- A. The Division maintains a system to document, track, trend and evaluate complaints and allegations received from members and providers or as requested by AHCCCS, inclusive of quality care, quality of service and immediate care need issues.
- B. The information from the quality of care concern data is analyzed and evaluated to determine any trends related to the quality of care or service in the Division's service delivery system or provider network. The Division incorporates trending of quality of care issues in determining systemic interventions for quality improvement.
- C. The Division documents quality tracking and trending information as well as documentation that the information was submitted, reviewed and considered for action by the Division's Quality Committee and Chief Medical Officer, as Chairman of the Quality Management Committee.
- D. Quality tracking and trending information from all closed quality of care issues within the reporting quarter is submitted to AHCCCS/Division of Health Care Management/Clinical Quality Management (AHCCCS/DHCM/CQM) utilizing the Quarterly Quality Management Report template provided by AHCCCS. The report is due 60 days after the end of each quarter and includes the following reporting elements:
 - 1. Types and number/percentages of substantiated quality of care issues,
 - 2. Intervention implemented to resolve and prevent similar incidents, and
 - 3. Resolution status of "substantiated", "unsubstantiated" and "unable to substantiate" quality of care issues.
- E. If significant negative trends are noted, the Division considers developing performance improvement activities focused on the topic area to improve the issue resolution process itself, and to make improvements that address other system issues raised during the resolution process.
- F. The Division subcontracts to AHCCCS CQM all pertinent information regarding an incident of abuse, neglect exploitation, unexpected death (including all unexpected transplant deaths), and other critical incidents as determined by the Division or AHCCCS as soon as the Division is aware of the incident, and no later than 24 hours after receiving a credible report. Pertinent information must not be limited to autopsy results, and must include a broad review of all issues and possible areas of concern. Delays in receipt of autopsy results shall not result in delays of the Division's investigation of a quality of care concern. Delayed autopsy results shall be used by the Division to confirm the resolution of the quality of care concern.

- G. The Division ensures member health record are available and accessible to authorized staff and to appropriate State and Federal authorities, or their delegates, involved in accessing quality of care/service or investigating member or provider quality of care concerns, complaints, allegation of abuse, neglect exploitation, serious incidents, grievances, Provider Preventable Conditions and Healthcare Acquired Conditions (HCAC). Member record availability and accessibility complies with Federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPPA) and C.F.R. 431.300 et seq.
- H. Information related to coverage and payment issues is maintained for at least five years following resolution of the issue, and is made available to the member, provider and/or AHCCCS authorized staff upon request.

Provider-Preventable Conditions

- A. Payments are prohibited for services related to Provider-Preventable Conditions. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC).
1. If an HCAC or OPPC is identified, the Division conducts a quality of care investigation, and
 2. Reports the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

The term HCAC and OPPC are defined as follows:

Health Care Acquired Condition (HCAC) – means a Hospital Acquired Condition (HAC) under the Medicare program which occurs in any inpatient hospital setting and is not present on admission. (Refer to the current CMS list of Hospital-Acquired Conditions).

Other Provider Preventable Conditions (OPPC) – means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

- A. Surgery on the wrong member,
- B. Wrong surgery on a member, and
- C. Wrong site surgery.

970 PERFORMANCE MEASURES

EFFECTIVE DATE: May 13, 2016

REFERENCE: ACOM [Appendix A](#)

Performance Measures are reported to Arizona Health Care Cost Containment System (AHCCCS) Clinical Quality Management on a quarterly basis. The Division evaluates performance based on sub-categories of populations when reasonable to do such.

Quality Management Performance Measure Requirements

The Division complies with AHCCCS quality management requirements to improve performance in all AHCCCS established performance measures. The Division applies the correct performance measure methodologies including the Center for Medicare and Medicaid Services (CMS) methodology for its internal monitoring of performance measure results.

A. The Division:

1. Achieves at least the Minimum Performance Standards (MPS) established by AHCCCS for each measure, based on the rate calculated by AHCCCS or,
2. Develops an evidence-based Corrective Action Plan (CAP) for each measure not meeting the MPS to bring performance up to at least the minimum level established by AHCCCS.
3. Receives AHCCCS approval prior to implementation. Each CAP will minimally include the components set forth by AHCCCS.
4. Monitors and reports to AHCCCS the status of and any discrepancies identified in encounters submitted to and received by AHCCCS including paid, denied, and pended encounters for purposes of Performance Measure monitoring. The Division monitors encounter submissions by its subcontractors.
5. Shows demonstrable improvement from year to year, which is sustained over time, in order to meet goals for performance established by AHCCCS.
6. Complies with national performance measures and levels that may be identified and developed by the CMS in consultation with AHCCCS.
 - a. The Division Quality Management/Performance Improvement Program internally measures and reports to AHCCCS its performance on contractually mandated performance measures, using standardized methodology established or adopted by AHCCCS.
 - b. The Division utilizes the results of the AHCCCS contractual performance measure in evaluating its quality assessment and performance improvement program.

- c. The Division shows demonstrable and sustained improvement toward meeting AHCCCS Performance Standards.
7. The Division collects data used to measure performance as required by AHCCCS. The Division submits specific documentation as requested by AHCCCS to verify that indicator criteria were met.

980 PERFORMANCE IMPROVEMENT PROJECTS

EFFECTIVE DATE: May 13, 2016

Overview

The Division participates in Performance Improvement Projects (PIPs) selected by AHCCCS in accordance with standardized methodology. The Division also selects and designs additional PIPs specific to needs identified through internal monitoring of trends and data. Topics take into account comprehensive aspects of enrollee needs, care, and services for a broad spectrum of members or a focused subset of the population. The Division considers all populations and services covered when selecting PIPs.

The Division participates in performance measures and performance improvement projects that are mandated by Centers for Medicare and Medicaid Services (CMS) in consultation with AHCCCS, other states, and other stakeholders.

Performance Improvement Projects (PIPs) Design

- A. PIPs are designed, through ongoing measurement and intervention, to achieve:
1. Demonstrable improvement, sustained over time, in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction
 2. Correction of significant systemic problems
 3. Clinical focus topics may include the following:
 - a. Primary, secondary, and/or tertiary prevention of acute conditions.
 - b. Primary, secondary, and/or tertiary prevention of chronic conditions.
 - c. Care of acute conditions.
 - d. Care of chronic conditions.
 - e. High-risk services, and
 - f. Continuity and coordination of care.
 4. Non-clinical focus topics may include the following:
 - a. Availability, accessibility, and adequacy of the Division's service delivery system.

- b. Cultural competency of services.
 - c. Interpersonal aspects of care (i.e., quality of provider/member encounters), and
 - d. Appeals, grievances, and other complaints.
- B. PIP methodologies are developed according to current statute, AHCCCS requirements, and community practice inclusive of quality assessment and performance improvement programs for Medicaid managed care organizations.

Data Collection Methodology

Assessment of the Division's performance on the selected measures is based on systematic, ongoing collection and analysis of the most accurate, valid and reliable data, as collected and analyzed by AHCCCS. The Division collects all or some of the data used to measure performance when needed. The Division ensures inter-rater reliability if more than one person is collecting and entering data. The Division maintains specific documentation to verify that indicator criteria were met.

Measurement of Demonstrable Improvement

The Division initiates interventions that result in significant demonstrable improvement, sustained over time, in its performance for the performance indicators being measured. Improvement is evidenced in repeated measurements of the indicators specified for each PIP undertaken.

- A. The Division strives to meet or exceed established benchmark levels of performance.
- B. The Division defines demonstrated improvement when:
 - 1. It meets or exceeds the AHCCCS overall average for the baseline measurement if its baseline rate was below the average and the increase is statistically significant.
 - 2. It shows a statistically significant increase if its baseline rate was at or above the AHCCCS overall average for the baseline measurement, or
 - 3. It is the highest performing (benchmark) plan in any re-measurement and maintains or improves its rate in a successive measurement.
- C. The Division defines sustained improvement when:
 - 1. The Division maintains or increases the improvements in performance for at least one year after the improvement in performance is initially achieved.

2. The Division demonstrates how the improvement can be reasonably attributed to the interventions undertaken.

Performance Improvement Projects (PIPs) Timeframes

- A. The Division initiates mandated PIPs on a date established by AHCCCS. Baseline data is collected and analyzed at the beginning of the PIP for the AHCCCS determined timeframes.
- B. During the initial year of a mandated PIP, the Division implements interventions to improve performance, based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance, as well as any unique factors such as its membership, provider network, or geographic area(s) served.
- C. The Division utilizes any baseline data provided by AHCCCS in determining optimal interventions.
- D. The Division utilizes a Plan-Do-Study-Act (PDSA) cycle to test changes (interventions) quickly and refine them as necessary. The rapid cycle improvement process is implemented in as short a time frame as practical based on the PIP topic.
- E. The Division's participation in the mandated PIP will continue until demonstration of significant improvement is sustained for at least one year.
- F. Annually, the Division reports to AHCCCS its interventions, analysis of interventions and internal measurements, changes or refinements to interventions and actual or projected results from repeat measurements.