Health Net Access

Operational Review
Contract Year Ending 2016

August 16, 2017

AHCCCS
Arizona Health Care Cost Containment System

Conducted by the Arizona Health Care Cost Containment System

AHCCCS OPERATIONAL REVIEW
EXECUTIVE SUMMARY
CYE 2016

INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) has served Arizona's most needy since 1982. The Agency's vision is "Shaping 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 Health Net Access (HNA) 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 HNA from June 5 through June 7, 2017.

A copy of the draft version of this report was provided to the Contractor on July 19, 2017. HNA 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 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:

- 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

Corporate Compliance (CC)	CC Standard Area Score = 100% (500 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.	100%	None

Claims and Information Systems (CIS)	CIS Standard Area Score = 90% (1080 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	38%	The Contractor's subcontracted providers' remits must include the reason and detailed descriptions of payments less than billed charges, denials and

Claims and Information Systems (CIS)	CIS Standard Area Score = 90% (1080 of 1200)	
required information.		adjustments, and instructions and timeframes for the submission of corrected claims. The remits must also include the provider's rights for a claims disputes, and instructions and timeframes for the submission of claim disputes.
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.	94%	The Contractor must ensure it pays applicable interest on all claims, including overturned claim disputes.
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.	85%	The Contractor must ensure it processes and pays all overturned claim disputes in a manner consistent with the decision within 15 business days of the decision.
CIS 8 The Contractor ensures that the parties responsible for the processing of claims have been trained on the specific rules and methodology for the processing of claims for the applicable AHCCCS line of business.	100%	None
CIS 9 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.	68%	The Contractor must develop procedures that include matching Contractor files against the newly received AHCCCS files for accuracy and omission and identifies and reconciles newly added and removed records for action.
CIS 11 Contractor has a process to identify resubmitted claims and a process to adjust claims for data corrections or revised payment.	100%	None

Claims and Information Systems (CIS)	CIS Standard Area Score = 90% (1080 of 1200)	
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.	95%	None

Delivery Systems (DS)	DS Standard Area Score = 96% (866 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.	100%	None
DS 5 The Contractor's Provider Selection Policy and Procedure prohibits discrimination against providers who serve high-risk populations or that specialize in conditions that result in costly treatment.	100%	None
DS 6 The Contractor does not prohibit or otherwise restrict a provider from advising or advocating on behalf of a member who is his/her patient.	100%	None
DS 7 The Contractor has a mechanism for tracking and trending provider inquiries that includes timely acknowledgement and resolution and taking systemic action as appropriate.	100%	None

Delivery Systems (DS)	DS Standard Area Score = 96% (866 of 900)	
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.	66%	The Contractor must ensure that its provider manual contains all requirements listed in ACOM 416.
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	

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

Grievance Systems (GS)	GS Standard Area Score = 96% (1624 of 1700)	
Standard	**Score**	**Required Corrective Actions**
GS 1 The Contractor issues and carries out appeal decisions within required timeframes.	100%	None
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

Grievance Systems (GS)	GS Standard Area Score = 96% (1624 of 1700)	
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.	72%	The Contractor must issue provider claim dispute Notices of Decision that comply with the requirements of A.A.C R9-34-405 and Contract/RFP No. YH14-0001 Section F Attachments, A2 Provider Claim Dispute Standards 9.
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.	75%	The Contractor must ensure that claims disputes include the correct and/or complete factual and legal basis for the decision.
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
GS 11 The Contractor maintains claim dispute records.	100%	None
GS 12 The Contractor logs, registries, or other written records include all the	100%	None

Grievance Systems (GS)	GS Standard Area Score = 96% (1624 of 1700)	
contractually required information.		
GS 13 The Contractor confirms all provider claim disputes with a written acknowledgement of receipt.	97%	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.	80%	The Contractor must ensure that all claim disputes are resolved no later than 30 days after receipt of the dispute unless an extension is requested or approved by the provider.
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 = 96% (1433 of 1500)	
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) Maternity Care Appointment Standards.	100%	None
MCH 3 The Contractor ensures postpartum care is provided for a period of up	100%	None

Adult, EPSDT and Maternal Child Health (MCH)	MCH Standard Area Score = 96% (1433 of 1500)	
to 60 days after delivery.		
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 up to verify that members receive timely and appropriate treatment.	100%	None

Adult, EPSDT and Maternal Child Health (MCH)	MCH Standard Area Score = 96% (1433 of 1500)	
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.	100%	None
MCH 15 The Contractor ensures that women's preventive care services are provided according to the AHCCCS Medical Policy Manual (AMPM).	33%	The Contractor must develop and implement written processes to inform all primary care providers (PCPs) and obstetrician/gynecologist (OB/GYN) providers of the availability of women's preventative care services as outlined in AMPM 411. The Contractor must develop and implement written processes to inform all members of the availability of women's preventative health services as outlined in AMPM 411.

Medical Management (MM)	MM Standard Area Score = 97% (2426 of 2500)	
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.	100%	None
MM 3 The Contractor conducts proactive discharge planning for members admitted into acute care facilities.	100%	None
MM 4 The Contractor shall process Prior Authorization requests in accordance with State and Federal requirements.	100%	None

Medical Management (MM)	MM Standard Area Score = 97% (2426 of 2500)	
MM 5 The Contractor shall process Prior Authorization requests in accordance with State and Federal requirements.	100%	None
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.	70%	The Contractor must develop policies and procedures that identifies care coordination activities for members involved in the Justice System, SMI Decertification, and under Court Ordered Treatment.
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	100%	None

Medical Management (MM)	MM Standard Area Score = 97% (2426 of 2500)	
developed based upon analysis of high risk, high cost and high volume utilization data.		
MM 15 The Contractor has a system and process that outlines a Drug Utilization Review (DUR) Program.	100%	None
MM 16 The Contractor facilitates coordination of all services being provided to a member when the member is transitioning between Contractors.	100%	None
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.	100%	None
MM 18 (Pima and Maricopa County Acute Plans Only) The Contractor assists homeless clinics with the prior authorization process.	100%	None
MM 19 (Acute, CRS and DES/DDD Only) The Contractor provides medical home services to members.	60%	The Contractor's policy for monitoring medical home providers must include utilization data such as admissions, readmissions and emergency visits as well as AHCCCS performance measures. The Contractor must monitor the effectiveness of the medical homes. The results of monitoring and interventions taken to improve subpar compliance must be reporting to the MM Committee for recommendations. Implementation, analysis and monitoring of the actions recommended by the MM Committee must be included in subsequent MM committee meetings. Documentation in the MM Committee meeting minutes must clearly identify the medical homes being analyzed.
MM 20 The Contractor does not deny emergency services.	100%	None
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.	100%	None
MM 22 The Contractor issues a Notice of Action (NOA) letter to the member when a requested service has been denied, limited, suspended,	96%	None

Medical Management (MM)	MM Standard Area Score = 97% (2426 of 2500)	
terminated, or reduced.		
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.	100%	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.	100%	None

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	100%	None

Member Information (MI)	MI Standard Area Score = 100% (900 of 900)	
the change.		
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
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 = 99% (2670 of 2700)	
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.	97%	None
QM 2 The Contractor has a structure and process in place for quality-of-care, abuse/complaint tracking and trending for system improvement.	85%	The Contractor must modify its policy: A QM1 Policy AZ.QM.10 Quality of Care Resolution.pdf; to include the requirement to provide proactive care coordination for members who have multiple complaints or concerns regarding services or the AHCCCS program. Associated processes must be further identified in the policy that reflect member engagement and the specific steps to be taken to facilitate the coordination of the member's care (for member who have multiple or concerns regarding services or the AHCCCS program).
QM 3 The Contractor has a structure and process in place to identify and	100%	None

Quality Management (QM)	QM Standard Area Score = 99% (2670 of 2700)	
investigate adverse outcomes, including mortalities, for member/system improvement.		
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.	N/A	
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.	N/A	
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 administrative requirements.	100%	None
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.	98%	None
QM 12 The Contractor ensures the credentialing and recredentialing of providers in the contracted provider network.	99%	None
QM 13 The Contractor has a process for verifying credentials of all organizational providers.	91%	The Contractor must comply with requirement of AMPM Policy 950 in regards to the evaluation of organizational providers in the areas of Utilization Management information, Performance Improvement and

Quality Management (QM)	QM Standard Area Score = 99% (2670 of 2700)	
		monitoring, and Quality of Care concerns and trends in the re-credentialing process.
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
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.	100%	None
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.	100%	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,	100%	None

Quality Management (QM)	QM Standard Area Score = 99% (2670 of 2700)	
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).		
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.	100%	None
QM 24 The Contractor collaborates with the Arizona State Hospital prior to member discharge.	100%	None
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.	N/A	
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

Quality Management (QM)	QM Standard Area Score = 99% (2670 of 2700)	
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.	N/A	
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
RI 2 The Contractor has policies and procedures for auditing of reinsurance cases to determine 1) the appropriate payment due on the case and 2) the service was encountered correctly.	100%	None
RI 3 The Contractor has identified a process for advising AHCCCS of reinsurance overpayments against associated reinsurance encounters within 30 days of identification. This process includes open or closed contract years and open or closed reinsurance cases.	100%	None
RI 4 The Contractor has policies and procedures for monitoring the appropriateness of the reinsurance revenue received against paid claims data.	100%	None

Third Party Liability (TPL)	TPL Standard Area Score = 86 % (600 of 700)	
Standard	**Score**	**Required Corrective Actions**
TPL 1 If the Contractor discovers the probable existence of a liable party that is not known to AHCCCS, the Contractor reports that information to the AHCCCS contracted vendor not later than 10 days from the date of discovery.	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
TPL 5 The Contractor files liens on total plan casualty cases that exceed $250.	0%	The Contractor must file liens on all total plan cases that exceed $250, lien amendments, and lien releases.
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