STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARIZONA

STANDARDS ESTABLISHED AND METHODS USED
TO ASSURE HIGH QUALITY CARE

The AHCCCS mission is to administer an innovative managed care program effectively and efficiently, and continually improve accessibility and delivery of quality health care to eligible members through integrated health systems. Below are the standards and methods used to assure high quality care:

1. AHCCCS has established a comprehensive system for assuring the delivery of high quality care. The Office of the Medical Director (OMD) in AHCCCS is responsible for facilitating quality health care delivery to members through identification, development and evaluation of quality indicators, formulation and interpretation of medical policy and by establishing health care service parameters.

2. Health Plans (HP) and Program Contractors (PC) are required, through contracts with AHCCCS, to provide quality medical care regardless of eligibility category or payer source. Each HP and PC must establish and implement processes to initiate, plan, assess, and evaluate quality improvement activities. The HP and PC must maintain a written QM/UM plan which provides detailed plans for compliance with requirements set forth in federal and State rules and the AHCCCS Medical Policy Manual, including the Manual requirement to report all standardized clinical outcome indicators. AHCCCS conducts annual on-site reviews to verify contract requirements are met.

    a. The OMD reviews are conducted to assess each HP's and PC's management of medical issues, quality management (QM), utilization management (UM) including both over and under utilization, compliance with AHCCCS medical policy, maternal child health services, family planning, EPSDT, dental services, immunization, case manager services and ALTCS Fee-For-Service (institutional and home and community based services). Quality management analysis (e.g., utilization reports and performance indicators) is a part of this process

    b. AHCCCS provides continuous training, technical assistance and interface to the HPs and PCs to develop and refine their QM plan, including performance indicators.

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c. Problem resolution, including individual quality of care issues for members, access to care, level of coverage, quality of coverage provided and technology assessment takes place on an "as needed" basis.

3. All service providers must be registered with AHCCCS and assigned a provider type prior to furnishing services to members. Providers are required to meet the established provider profile and sign a provider agreement. The provider agreement language and format is consistent with Medicaid regulations and is mandatory for participation as an AHCCCS provider. Any provider who violates the terms of the provider agreement is subject to penalties, sanctions or termination.

a. Any facility where care is provided to AHCCCS members must be appropriately licensed and/or certified as required by Arizona State law. OMD coordinates with regulatory agencies on the status of licensure/ certification of facilities and on the distribution of information to PCs and HPs when necessary.

b. All providers must meet licensure and/or certification requirements appropriate to the provider type and as required by the professional licensing and certification boards or entities, and State statutes and rules. Each provider must submit documentation of required licenses and/or certifications prior to registration as an AHCCCS provider.

4. OMD provides prior authorization, concurrent and retrospective reviews for members receiving services through the ALTCS Fee-For-Service (FFS) program and the Emergency Services Program, and eligible members who are not yet enrolled in a HP or with a PC. OMD is responsible for resolution of FFS quality of care issues and utilization management/monitoring, including reinsurance review and utilization profiling. They also coordinate care for high risk member populations and tracking /trending of numbers and costs.