



Arizona Priority CareTM

One Goal. One Priority. Your Healthcare.

2025 Quality Program Description

AZPC Quality Improvement Committee Approved – February 13, 2025

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Table of Contents

ARIZONA PRIORITY CARE NETWORK STRUCTURE	4
MISSION STATEMENT	4
PURPOSE/PROGRAM DESCRIPTION	4
SCOPE OF PROGRAM	4
GOALS AND OBJECTIVES	5
GOALS:	5
OBJECTIVES:	6
QI PROGRAM STRUCTURE	7
GOVERNING BODY:.....	7
SENIOR MEDICAL DIRECTOR:	8
DESIGNATED PHYSICIAN:	8
DESIGNATED BEHAVIORAL HEALTH PRACTITIONER.....	9
VICE PRESIDENT (VP), CLINICAL SERVICES.....	10
DIRECTOR, CLINICAL SERVICES OPERATIONS	11
QUALITY STAFF (CLINICAL & NON-CLINICAL)	11
RESOURCES AND ANALYTICAL SUPPORT	11
EFFECTIVENESS OF THE QI PROGRAM	12
ANNUAL WORK PLAN.....	12
SEMI-ANNUAL REPORTS	12
ANNUAL PLAN EVALUATION	12
QUALITY IMPROVEMENT COMMITTEE ('QIC')	14
COLLABORATIVE QI ACTIVITIES	18
CREDENTIALING COMMITTEE	18
PEER REVIEW	19
QI PROCESS	21
HEALTH SERVICE CONTRACTING.....	21
AVAILABILITY OF PRACTITIONERS:	22
ACCESS TO SERVICE.....	23
MEMBER EXPERIENCE	23
CONTINUITY AND COORDINATION OF MEDICAL CARE:.....	26
CONTINUITY AND COORDINATION BETWEEN MEDICAL CARE AND BEHAVIORAL HEALTHCARE	28
PATIENT SAFETY PROGRAM	29
POTENTIAL QUALITY ISSUES ('PQI'):	30
PEER REVIEW	30
SENTINEL EVENTS / CRITICAL INCIDENTS.....	31
SERIOUS REPORTABLE ADVERSE EVENTS	31
CLINICAL MEASUREMENT ACTIVITIES AND QUALITY PERFORMANCE REPORTING	31
HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS).....	31
CENTER FOR MEDICARE & MEDICAID SERVICES STAR RATINGS PROGRAM	32
OTHER QI ACTIVITY	33
DISSEMINATION OF INFORMATION	34
DELEGATION OF QUALITY MANAGEMENT/IMPROVEMENT	34
QI INFRASTRUCTURE FOR UTILIZATION MANAGEMENT (UM) FUNCTIONS	34

GOALS	35
QI INDICATORS	35
APPROVAL	36

ARIZONA PRIORITY CARE NETWORK STRUCTURE

Arizona Priority Care ('AZPC') will have the Quality Improvement ('QI') infrastructure necessary to improve the quality and safety of clinical care and services we provide to our members.

Arizona Priority Care utilizes the IPA structure to deliver healthcare to our members. The IPA model is an organized system of independent physicians or an association of such physicians. Physicians in this model generally are paid on a modified fee-for-service or capitated basis.

MISSION STATEMENT

Our QI Department's mission is to provide an effective, system-wide, measurable plan for monitoring, evaluating, and improving the quality of care and services and continuity of care provided to our members and practitioners.

PURPOSE/PROGRAM DESCRIPTION

The QI Program is designed to objectively monitor and evaluate the quality, appropriateness, and outcome of care and services delivered to members. Further, the QI Program will identify opportunities for improvement in care delivery and services to both our members and practitioners, ensuring they meet professionally recognized standards of practice. This is accomplished by the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative services.

SCOPE OF PROGRAM

The scope of the QI Program is to monitor care, identify opportunities for improving care and services for both members and practitioners and ensure services meet professionally recognized standards of practice.

This QI Program covers clinical and non-clinical care and services for Medicare Advantage ('MA') populations. It includes an infrastructure for providing quality monitoring and evaluation of utilization management (UM) services to ensure appropriate delivery and coordination of care across the care continuum.

GOALS AND OBJECTIVES

GOALS:

1. Ensuring ongoing communication and collaboration between the AZPC QI Department and the other areas of the organization, including, but not limited to: Utilization Management (UM), Member Service (MS), Care Management, Behavioral Health (BH) providers and Credentialing (CR).
2. Ensuring members receive the highest quality of care and services.
3. Ensuring the quality of UM services is continually monitored and evaluated through analytical methods to ensure performance metrics are met.
4. Ensuring members have full access and availability to qualified and credentialed primary care physicians and specialists.
5. Ensuring that practitioner credentialing is performed accurately and timely according to the standards set forth in the AZPC Credentialing Plan.
6. Ensuring that credentialing performance is analyzed using the SMART goal indicators outlined in the AZPC Credentialing Plan.
7. Ensuring poor provider performance is reported to and reviewed by a peer review body.
8. Ensuring that health plan member concerns are addressed and responded to according to the standards set forth in the AZPC Grievance and Appeal Program.
9. Adhering to the highest standards of healthcare practice through evidence-based Clinical Practice Guidelines ('CPG') as the basis for clinical decision-making.
10. Monitoring and evaluating the care provided by each contracting provider group to ensure the care provided meets professionally recognized standards of practice.
11. Monitoring, improving and measuring member and practitioner satisfaction with all aspects of the local delivery system and network.
12. Fostering a supportive environment to help practitioners and providers improve the quality and safety of their practices.
13. Assessing and meeting the standards for the cultural and linguistic needs of members.
14. Meeting the changing standards of practice of the healthcare industry by adhering to all State and Federal laws and regulations.
15. Monitoring our compliance to regulatory agency and health plan standards through annual oversight audits and survey activities.
16. Adopting, implementing and supporting ongoing adherence with accreditation

- agency standards.
17. Promoting the benefits of a coordinated care delivery system.
 18. Promoting preventive health services and care management of members with chronic conditions.
 19. Emphasizing a caring professional relationship between the patient, practitioner and health plan.
 20. Ensuring there is a separation between medical and financial decision-making.
 21. Ensuring there is no economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted.
 22. Ensuring providers or institutions are not pressured to render care beyond the scope of their training or experience.
 23. Seeking out and identifying opportunities to improve the quality of care and services provided to members and providers.

OBJECTIVES:

1. Maintaining a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity, and performance of each healthcare provider every three years upon credentialing/re-credentialing.
2. Ensuring members are afforded accessible healthcare by continually assessing member access to care and availability of network of practitioners and specialists.
 - a. AZPC is required to meet network adequacy standards established by Federal and State agencies as well as accreditation organizations such as the National Committee on Quality Assurance ('NCQA').
 - b. Network adequacy standards are intended to ensure that provider networks offer consumers access to sufficient numbers and types of providers.
3. Ensure compliance with the requirements of regulatory and accrediting agencies, including, but not limited to, CMS and NCQA, as demonstrated by any and all auditing activity.
4. Appropriately overseeing QI activities, employed practitioners, and contracted physicians.
5. Ensuring that at all times the QI structure, staff and processes are in compliance with all regulatory and oversight requirements by passing all audits and submitting required reports in a timely manner.
6. Actively working to maintain standards for quality of care and accessibility of care

and service by ensuring that office telephone answer times and total office wait times are within required standards and validated annually through sampling of selected encounters.

7. Ensure physician compliance with AZPC requirements by requiring regular and scheduled provider education in order to improve provider availability and telephone access based on the result of annual sampling.
8. Ensuring and conducting focused review studies, with an emphasis on preventative and high-risk services and programs and on services provide by our high-volume practitioners with implementation of processes to measure improvements as evidenced by ratings >75th percentile in Overall Ratings of Doctor & Healthcare.
9. Ensure that mechanisms are in place to support and facilitate continuity of care within the AZPC network, review the effectiveness of such mechanisms on a regular basis, and address issues as they arise.
10. Assess our performance against Federal and State standards for PCP, SCP, High Volume, High Impact Specialists to ensure member access to highly coordinated and managed care.
11. Assure the highest levels of quality care for Medicare beneficiaries by maintaining STARS ratings of 4.0 or better in all measured areas.
12. Identifying potential risk management issues and responding to all potential quality issues raised to the QI/QM Department.
13. Evaluating the consistency with which physician and non-physician reviewers apply the utilization management criteria in decision making through annual inter-rater reliability auditing per policy.
14. Ensuring timely notification to providers and member for utilization management determinations.

QI PROGRAM STRUCTURE

GOVERNING BODY:

AZPC's governing body is the Executive Committee, which grants AZPC's QI Committee ('QIC') authority. The QIC appoints the Senior-level Medical Director and the VP of Clinical Services to act as facilitators for all QI activities and is responsible for overseeing the QI Program.

The Executive Committee directs the establishment of the QI Committee and oversees compliance with all applicable laws, statutes, and regulations in addition to identification and follow-up on quality related issues and appropriate actions. The Executive Committee receives

quarterly reports on all QI activities.

The Executive Committee will ensure sufficient administrative and clinical staff support with sufficient knowledge and resources for the QI Program to achieve its objectives. These resources will include staff, data sources, analytical resources such as statistical expertise and programs. AZPC ensures it is competent to meet regulatory and accreditation standards during our initial oversight survey and annual oversight audits thereafter.

SENIOR MEDICAL DIRECTOR:

The Senior Medical Director, or designee, is a physician who holds a current medical license to practice medicine with the Arizona Medical Board. The Senior Medical Director is the Executive Committee's designee responsible for the implementation of QI Program activities. The Senior Medical Director works in conjunction with the Vice President of Clinical Services, Medical Director('s'), and Clinical Services Directors to develop, implement, and evaluate the QI Program. The Senior Medical Director is the Chairperson of the QI Committee.

Responsibilities include but not limited to:

1. Oversees and directs the medical/clinical operations for AZPC.
2. Oversees and directs the AZPC Clinical Services Department.
3. Oversees the Quality Management, Utilization Management, and Credentialing Programs.
4. Works with leadership to meet the requirements of all health plan deliverables.
5. Provides insight and guidance regarding clinical processes and policies.
6. Assuring compliance with the requirements of regulatory and accrediting agencies, including but not limited to CMS, ADHS, NCQA and the contracted Health Plans.

DESIGNATED PHYSICIAN:

AZPC shall employ, contract or designate a Medical Director with an unrestricted medical license. Note that effective April 10, 2019, the State of Arizona recognizes equivalent occupational or professional licenses for all other States within the United States, pursuant to requirements listed in Arizona HB 2569 – A.R.S. 32-4302 out-of-State applicants; residents; military spouses; licensure; certification; exceptions.

The Medical Director is fully credentialed and serves as the designated physician involved in all aspects of QI Program development and evaluation, provides clinical oversight of all QI

activities, supports the various committees, staff, and resources, and makes recommendations based on clinical care and administrative data. The Senior-Level Medical Director shall be available for assistance with member QI procedures and processes, complaints, development of guidelines, recommendations on service and safety, provide QI statistical data, follow-up on identified issues, and attend the QIC quarterly, at a minimum.

The designated physician will work with the Senior Director of Clinical Services, VP of Clinical Services, Director of Credentialing & Prior Auth, and Director of Quality, to develop, implement and evaluate all aspects of the QI Program. The designated physician helps to plan, develop, organize, monitor, communicate, and recommend modifications to the QI Program and all QI policies and procedures. Responsibilities include but are not limited to:

1. Ensuring that medical decisions are reviewed by qualified personnel, unhindered by fiscal or administrative management.
2. Ensuring that healthcare meets the community standards for acceptable medical care.
3. Ensuring that protocols are followed.
4. Actively participating in the functioning and resolution of the grievance procedures.
5. Providing support and clinical guidance to the program and to all physicians in the network.
6. Assuring compliance with the requirements of regulatory agencies and accrediting, including but not limited to CMS, NCQA and the contracted health plans.
7. Ensuring that the QI and UM Departments interface appropriately to maximize opportunities for QI activities.
8. Directing the implementation of the QI process.
9. Overseeing the formulation, modification, and implementation of comprehensive policies and procedures that support the QI operations.
10. Analyzing QI data.
11. Reviewing pertinent grievances and quality of care concerns, assigning severity levels, and directing corrective actions to be taken, including peer review, if required.
12. Overseeing Credentialing activities.
13. Assisting with the development, conduct, review, and analysis of HEDIS studies

DESIGNATED BEHAVIORAL HEALTH PRACTITIONER

AZPC will designate a behavioral healthcare practitioner to implement and evaluate the behavioral health aspects of the UM and QI Programs. This individual may be a physician or

have a clinical PhD or PsyD, and may be a medical director, clinical director, or participating practitioner from the organization. AZPC may utilize HPN's designated behavioral health care practitioner or may contract with a vendor or provider meeting similar requirements. The behavioral health practitioner shall be involved in all behavioral aspects of the QI program, and assist with member behavioral health complaints, development of behavioral health guidelines, development of programs, recommendations on service and safety, provider behavioral health QI statistical data and follow-up on identified issues. The behavioral health practitioner must attend the QI Committee Meeting quarterly, at a minimum.

The behavioral health practitioner works in conjunction with the VP, Clinical Services to develop, implement, and evaluate the BH aspects of the QI Program.

Responsibilities include but are not limited to:

1. Oversees the behavioral health aspects of clinical operations, including UM, CM, and QI functions and related programs for AZPC, if requested.
2. Provides leadership and support to AZPC, designated senior-level physician and staff regarding AZPC's programs and implementation of the behavioral healthcare aspects of delegated UM, CM, and QI functions.
3. Performs functions and responsibilities of the Designated Behavioral Healthcare Provider as outlined in the UM and QI program descriptions.
4. Ensures that the process by which AZPC review and approve, modify, or deny behavioral healthcare request prior to, retrospectively, or concurrent with the provision of health care services to members, based in whole or in part on medical necessity or on benefit coverage, complies with regulatory, accreditation, and policy requirements, including but limited to state and federal mental health parity laws.
5. Ensures compliance with applicable federal and state requirements (e.g., CMS, ADHS) as well as accreditation standards (e.g., NCQA) for behavioral health care. Involved in setting goals and benchmarks, reviewing performance reports, and in evaluating, identifying, and implementing opportunities for improvement in AZPC's behavioral healthcare aspects of clinical programs.

VICE PRESIDENT (VP), CLINICAL SERVICES

The Vice President, Clinical Services oversees the operations of the Clinical Services Department and is responsible for the execution and coordination of all QI activities. The VP, Clinical Services reports to the Chief Operation Officer and Senior Medical Director. He or she helps to plan, develop, organize, monitor, communicate, and recommend modifications to the QI Program and all QI policies and procedures. It is the VP's responsibility to interface with other departments on QI issues. The VP reports any areas of concern to the Senior Medical

Director and/or the QI Committee.

DIRECTOR, CLINICAL SERVICES OPERATIONS

The Director of Quality Improvement oversees the administrative day-to-day operations of the execution of QI activities and reports directly to the Vice President, Clinical Services. It is the Director's responsibility to interface with all clinical services staff and/or contracted providers on a day-to-day basis on QI processes and issues.

QUALITY STAFF (CLINICAL & NON-CLINICAL)

The quality staff is responsible for clinical and non-clinical activities that support the administrative day-to-day operations of executing Quality Improvement activities, Health Education, cultural and Linguistic, Disease Management, and Medicare QI Activities. They report directly to the Director, Clinical Services Operations.

RESOURCES AND ANALYTICAL SUPPORT

The Clinical Services Department has multidisciplinary staff to address all aspects of the department functions. AZPC has staff and resources to conduct statistical and data analysis sufficient to establish quality controls and improvement projects. Staff can develop access databases relevant to specific functions and pull appropriate information relevant to specific studies.

AZPC will obtain feedback from our members by conducting annual member experience surveys and systematically analyzing the feedback collected. The surveys may include information about the overall program, program staff, the usefulness of the information disseminated by the primary provider group, and the members' ability to adhere to recommendations.

AZPC will evaluate the results of the surveys received. We will develop improvement plans to address areas identified. All results are presented to the QI Committee for review and recommendations.

AZPC coordinates services for our members with complex conditions and help them access needed resources, information and interventions that our organization implements for a member or provider to improve health care delivery and management and promote quality, cost-effective outcomes.

EFFECTIVENESS OF THE QI PROGRAM

ANNUAL WORK PLAN

QI Work Plans are developed annually outlining QI activities for the year and include UM activities covered by the QI program. The work plans will include all activities and tasks for clinical care and monitoring access and availability of covered services. The work plans are reviewed by a Senior-level Medical Director and submitted to the QIC and Executive Committee for review and comment.

The work plan must include the following information:

1. A description of all planned activities and tasks. Activities should address quality and safety of clinical care, quality of service and the member experience.
2. Beginning and ending dates for all objectives.
3. Methodologies to accomplish measurable goals and objectives.
4. Measurable behavioral health goals and objectives.
5. Measurable utilization management goals and objectives.
6. Staff positions/departments responsible and accountable for meeting established goals and objectives.

The QI Work Plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement. The QI Work Plan will also address how the organization monitors previously identified issues.

An annual evaluation of the QI program will be included as a specific activity on the QI Work Plan, with the stated time frame and listing of staff responsible for the evaluation, listed by title.

SEMI-ANNUAL REPORTS

Semi-annual reports are an evaluation of the progress of the QI activities, as outlined in the work plan, and are submitted to the QIC and Executive Committee for review and comment. Activity reports are submitted quarterly, or as deemed necessary.

ANNUAL PLAN EVALUATION

As defined by the QI Work Plan, QI activities will be evaluated annually to measure performance for the year and assist in revising the QI Program and preparing the following year's work plan. The evaluations are reviewed by the senior-level Medical Director and

submitted to the QIC and Executive Committee for review and approval.

AZPC will maintain and report separately by line of business and health plan, as applicable, for the following measures:

1. Appeals
2. Complaints/Grievances
3. Patient Safety
4. Access and Availability

The annual QI evaluation report must contain a summary of all QI activities performed throughout the year, to include:

1. Completed and ongoing QI activities.
2. Measurable goals and/or objectives related to each activity.
3. Department or staff positions involved in the QI activity.
4. Description of communication and feedback related to QI data and activities.
5. An evaluation of baseline data and outcomes utilizing qualitative and quantitative data which must include a statement describing if the goals were met completely, partially, or not at all. This trending will compare results against performance goals and objectives of the QI Program.
6. Actions to be taken for the improvement of corrective action plans ('CAPs').
7. Analysis and evaluation of the effectiveness of the QI program and progress in meeting safe clinical goals. This analysis and evaluation will summarize:
 - a. Adequacy of QI program resources
 - b. QI Committee Structure
 - c. Practitioner participation and leadership involvement in the QI program
 - d. Restructuring or change needs in the QI program for the subsequent year
8. Rationale for changes in the scope of the QI program and plan or documentation indicating if no changes were made.
9. Necessary follow-up with targeted timelines for revisions made to the QI plan.
10. Documentation of QIC review, evaluation, and approval of any changes to the QI plan.
11. An evaluation of the previous year's activities must be submitted as part of the QI Plan after review by the QIC.

QUALITY IMPROVEMENT COMMITTEE ('QIC')

Description

The AZPC QI Committee is established by the authority of the AZPC Executive Committee as a standing committee and are responsible for development, oversight, guidance, and coordination of all quality improvement activities. The QIC has been delegated the responsibility of providing an effective QI Program for members and providers. The QIC monitors provisions of care, identifies problems, recommends corrective actions, and guides the education of practitioners to improve healthcare outcomes and quality of service.

Responsibilities

The QIC's responsibilities include but are not limited to:

1. Directing all QI activity.
2. Recommending policy decisions.
3. Reviewing, analyzing, and evaluating QI activity.
4. Ensuring practitioner participation in the QI Program through planning, design, implementation, and review.
5. Reviewing and evaluating reports of QI activities and regarding practitioner performance.
6. Monitoring, evaluating and directing the overall compliance with the QI Program and identifying needed actions.
7. Annually review and approve the QI Program, Work Plan, and Annual Evaluation.
8. Overseeing and keeping staff and providers informed regarding: QI Projects and Performance Improvement Projects; QI requirements, activities, updates or revisions; Performance measures and results, utilization data, and profiling results.
9. Review and approve QI policies and procedures, guidelines, and protocols.
10. Developing relevant subcommittees for designated activities and overseeing the standing subcommittees' roles, structures, functions, and frequency of meetings as described in this Program. Ad-hoc subcommittees may be developed for short-term projects.
11. Conducting peer review, assigning severity levels, and making recommendations for corrective actions, as needed.
12. Review and evaluate reports regarding any/all critical incidents, reportable events, and sentinel events.

13. Reviewing and evaluating reports submitted by each health plan.
14. Evaluating and giving recommendations concerning audit results, member experience surveys, practitioner experience surveys, access audits, and any QI studies.
15. Evaluating and giving recommendations from monitoring and tracking reports.
16. Ensuring follow-up, as appropriate.
17. Providing a confidential mechanism of documentation, communication, and reporting of QI issues and activities to the Executive Committee, QIC, and other appropriate involved parties.
18. Assessing the effectiveness of the QI Program and making modifications and enhancements as necessary on an ongoing and annual basis.
19. Ensuring that AZPC and its contracted providers are meeting the members' cultural and linguistic needs at all points of contact.
20. Ensuring members have access to all available services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, gender identity, marital status, sexual orientation, health status, or disability.
21. Ensuring mechanisms are in place to identify and evaluate patient safety issues within the network and systems are established to facilitate effective resolutions.

Reporting:

The QI Committee shall submit a summary report of quality activities and actions for review and approval to the QIC on a quarterly basis. This is completed by the approval of the QI quarterly report that is sufficiently detailed to include findings and actions taken as a result of the QI Program and to identify those internal or contracting providers components which the QI program has identified as presenting significant or chronic quality of care issues.

Composition:

Chair Person

A Senior-level Medical Director shall chair the Committee and his/her primary responsibilities may include but are not limited to:

1. Directing the QIC meetings.
2. Reporting QIC activities to the Executive Committee.
3. Acting on the committee's behalf for issues arising between meetings.
4. Ensuring all appropriate QI activities and reports are presented to the committee.
5. Ensuring there is a separation between medical and financial decision-making.

The Senior-level Medical Director, as the chairperson of the QIC, may designate a designee

only when unable to attend the meeting.

Membership:

Membership is assigned and will include representatives from the following disciplines:

1. Medical Director(s)
2. Clinical Services VP/Directors
3. Quality Management/Improvement Director
4. Utilization Management Director
5. Credentialing Director
6. Care Management Director
7. Health Education Directors/Managers
8. Provider Relations/Contracting VP/Directors
9. Member Services Director
10. Behavioral Health Practitioners
11. Representation of network physicians serving our members to monitor the scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. This may include primary care practitioners, an appropriate range of specialty care practitioners, or other appropriate licensed professionals
12. Appropriate clinical representatives
13. Other members are appointed at the discretion of the Chairperson

Committee members who are employees of AZPC are permanent members unless reassigned or employment ends. Independent physicians are assigned on a bi-annual basis or as vacancies arise and are staggered to protect the continuity of the committee functions by the Committee Chair. Representatives of regulatory agencies and health plans may attend upon written request and chair approval.

Quorum and Voting:

Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. All actions are approved by a majority vote and/or motion for approval by two voting physician members without challenge.

A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not

cast a vote on any related issue.

Non-physician members of the QIC may not vote but shall attend the meetings and provide support to the deliberations. In the event that the QIC is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

Meetings:

The QIC meets no less than quarterly but can meet more frequently if circumstances require or to accomplish the committee's objectives. The Committee Chair may act on the committee's behalf on issues that arise between meetings.

Confidentiality:

All committee members and participants, including network practitioners, consultants, and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. The QIC must ensure that each of its members or attending guests is aware of the requirements related to confidentiality and conflicts of interest by having signed statements on file and/or QIC sign-in sheets with requirements noted on them. An affirmation statement of confidentiality and conflict of interest presented at the start of any QIC meeting shall have the effect of each member/attendee attesting to this requirement.

Breach of confidentiality may result in disciplinary action, including termination. Activities and minutes of the QIC are for the sole and confidential use of AZPC and are protected by State and Federal laws and the Healthcare Portability and Accountability Act ('HIPAA').

Recording of Meeting and Dissemination of Action:

All QIC meetings are recorded by taking minutes, which are signed and dated and reflect all committee decisions. Meeting minutes and all documentation used by the QIC are the sole property of AZPC and are strictly confidential. When quality issues are identified, the QIC meeting minutes must document discussions of the following:

1. Identified issues.
2. Responsible party for interventions or activities.
3. Proposed actions.
4. Evaluation of the actions taken.
5. Timelines, including start and end dates.

6. Additional recommendations or acceptance of the results, as applicable.

For each QIC meeting conducted:

1. A written agenda will be used for each meeting.
2. Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up, and evaluation of activities.
3. The minutes are recorded in a nationally recommended format. All unresolved issues/action items are tracked in the minutes until resolved.
4. The minutes and all case-related correspondence must be maintained in the Clinical Services Department.
5. The minutes must be available for review as required to appropriate representatives from contracted health plans and regulatory and accrediting agencies. Representatives must adhere to applicable confidentiality and conflict of interest statements.

The dissemination of QIC information and findings to physicians may take various forms. Practitioners and providers must be informed of information related to their performance. These methods may include, but are not limited to:

1. Informal one-on-one meetings;
2. Formal medical educational meetings;
3. Newsletters;
4. Provider Relations and physician reports;
5. Quarterly and/or semi-annual reports to the Executive Committee.
6. AZPC's Website

COLLABORATIVE QI ACTIVITIES

CREDENTIALING COMMITTEE

The Credentialing Committee consists of physicians, practitioners, and other staff qualified to evaluate practitioner performance and the selection of Primary Care Providers and Specialists that are contracted with AZPC and are in good standing with regulatory agencies and the community they serve.

The Credentialing Committee:

1. Has final authority to approve or disapprove applications by providers for AZPC

participation or delegate such authority to the Senior-level Medical Director for approving clean applications, provided that such designation is documented and provides reasonable guidelines.

2. Discuss whether organizational providers meet reasonable community standards of care.
3. Access appropriate clinical peer input when discussing standards of care for a particular organizational provider.
4. Review files for organizational providers that do not meet the AZPC's established criteria.
5. Review files for State survey and licensing deficiencies of organizational providers.
6. Review files when there are reported potential quality of care issues, reportable events, sentinel events, critical incidents, complaints, and/or the facility has been sanctioned by a regulatory agency.
7. Maintains minutes of all committee meetings and documents all actions.
8. Provide guidance to AZPC staff on the overall direction of the Credentialing Plan.
9. Evaluate and report to AZPC management on the effectiveness of the plan.
10. Review and approve credentialing policies and procedures at least annually.
11. Meets as often as necessary to fulfill its responsibilities, but no less than quarterly.
12. Are peer review documentation protected by State and Federal Law. Peer review documents must not leave the room and must be collected by staff at the meeting closure. Any Committee members copies, hand-written notes, post-it notes, or other material that will not be retained in the case file must be destroyed at the end of the session.
13. Must provide peer review documentation to State and Federal agencies upon request. Providers and practitioners must be informed regarding the peer review process and peer review grievance procedures.
14. Has the authority to delegate authority to the senior clinical staff person, such as another medical director or other equally qualified provider for approving clean applications for continuing participation.
15. Reviews aggregate data and trends regarding the accuracy and timeliness of credentialing files as well as data regarding practitioner complaints.

PEER REVIEW

Peer Review occurs through AZPC's Credentialing Committee. The committee's purpose is to

improve the quality of the medical and behavioral healthcare provided to our members by practitioners and providers. AZPC cannot delegate the function of peer review to another entity.

The Peer Review Committee's scope includes the review of cases where there is evidence of deficient quality or the omission of the care or service provided by a participating or non-participating healthcare professional or provider.

Peer Review occurs during the Credentialing Committee meetings held at least quarterly. Reviews may include potential quality care issues, resulting in a serious member negative outcome.

At a minimum, the Peer Review shall include:

1. The Medical Director and/or appointed physician designee;
2. Providers of the same or similar specialty as the provider involved in the case in question. If the specialty is not represented on the Peer Review Committee, the Committee may utilize peers of the same or similar specialty through external consultation.
3. A Behavioral Health provider when a behavioral health specialty is being reviewed.

Peer Review Functions

1. Peer Review members sign a confidential and conflict of interest statement at least annually.
2. Peer Review members must not participate in peer review activities if they have a direct or indirect interest in the peer review outcome.
3. Peer Reviewers must evaluate the case referred to peer review based on all information made available.
4. Peer Reviewers are responsible for making recommendations to the appropriate regulatory agency or board and State agency for further investigation or action when it is determined that care was not provided according to community standards. Initial notice may be verbal but must be followed by a written report within 10 days.
5. All information used in the peer review process is kept confidential and is not discussed outside of the peer review process. The reports, meetings, minutes, documents, recommendations, and participants must be kept confidential except for implementing recommendations made by the Peer Review Committee.
6. Peer Review meetings are protected by State and Federal law. Documents from the proceedings must not leave the confines of the meeting and shall be retained by staff

at the meeting closure. Any committee member copies, hand-written notes, post-it notes, or other material that will not be retained in the case file must be destroyed at the end of the session.

7. Peer review documentation must be provided to State and Federal agencies upon request. Providers and practitioners must be informed regarding the peer review process and peer review grievance procedures.

QI PROCESS

HEALTH SERVICE CONTRACTING

AZPC contracts with individual practitioners and providers, including those making UM decisions, specify that contractors cooperate with its QI Program to improve the quality of care and services and the members' experience. This shall include the collection and evaluation of data and participation in the QI Program.

A practitioner is a licensed or certified professional who provides behavioral healthcare or medical care services.

An organizational provider is an institution or organization that provides services for members, such as a hospital, residential treatment center, home health agency, or rehabilitation facility.

For the purpose of this section, practitioners and organizational providers will be known as "providers".

Our contracts will foster open communication and cooperation with all QI activities. Our contracts with providers will specifically require that:

1. Providers cooperate with QI activities.
2. Providers maintain the confidentiality of member information and records and shall keep member information confidential and secure.
3. Providers allow the plan to use their performance data. This shall include allowing the collection of performance measurement data, evaluating the data, and assisting the organization in improving clinical and service measures.
4. Providers will provide access to medical records as permitted by State and Federal law.
5. Providers shall not discriminate against any member in the provision of contracted services whether on the basis of the member's coverage under a benefit program, age,

sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, health status, source of payment, utilization of medical or mental health services, equipment, pharmaceuticals or supplies, or other unlawful basis including, without limitation, the filing by such beneficiary of any complaint, grievance, or legal action against the provider or payer.

Contracts with practitioners and providers include an affirmative Statement indicating that providers may freely communicate with patients about the treatment options available, including medication treatment options, regardless of benefit coverage limitations.

AVAILABILITY OF PRACTITIONERS:

In creating and developing the delivery system of practitioners, Arizona Priority Care takes into consideration the preferences and the special and cultural needs of our members. AZPC will ensure the practitioner network has sufficient numbers and types of practitioners to meet the needs and preferences of membership by effectively:

1. Annually assessing the cultural, ethnic, racial, and linguistic needs of members
2. Annually assessing the number and geographic distribution of each type of practitioner providing primary care, specialty care, hospital-based care, and ancillary care to members.
3. Adjusting the availability of practitioners within the network based on the community served, the local delivery system, and clinical safety.
4. Linking members with practitioners who can meet members cultural, racial, ethnic and linguistic needs and preferences.

Arizona Priority Care establishes the availability of primary care, specialty care, hospital-based and ancillary practitioners by:

1. Ensuring standards are in place to define practitioners who serve as primary care practitioners ('pediatrics, family practice, general practice, internal medicine').
2. Ensuring standards are in place to define high-volume and high-impact specialty care practitioners ('obstetrics/gynecology, cardiologists, dermatologists, ophthalmologists, orthopedic surgeons, gastroenterologists').
3. Ensuring a database is in place which analyzes practitioner availability and ability to meet the special cultural needs of members.
4. Ensuring a database is in place which analyzes the geographic distribution of members to primary care, specialty care, behavioral healthcare, hospital based, and ancillary practitioners.

5. Facilitating transportation for members as needed, as delegated.
6. Providing processes for member requests for special cultural and linguistic needs.
7. Annual reviews and measurement of the effectiveness of these standards through specialized studies.

ACCESS TO SERVICE

Arizona Priority Care has established standards and mechanisms to assure the accessibility of primary care, specialty care and member services. Standards include, but are not limited to:

1. Preventive care appointments
2. Regular and routine care appointments
3. Urgent care appointments
4. Emergency care
5. After-hours access and care
6. Telephone service

AZPC's employed and contracted practitioners and providers shall comply with all State and Federal accessibility guidelines. Annual access-to-care audits will be conducted using the standards to implement and measure improvements made in performance.

MEMBER EXPERIENCE

Grievance Process

The AZPC clinical grievance process assesses the member experience with the services provided by AZPC and our practitioners and supports the health plans in resolving client complaints and issues, including timely response to client concerns. Each quarter we evaluate our member complaints and appeals by collecting data for each of the following five (5) categories:

1. Quality of Care
2. Access
3. Attitude and Customer Service
4. Billing and Financial Issues
5. Quality of Practitioner Office Site

The data collected is further aggregated and evaluated by the total population served.

Sufficient data is collected to identify areas of dissatisfaction on which we can act. The rates are computed over time by reason and related to the total member population. Annually we conduct a quantitative and causal analysis of our aggregate results and trends over time and compare our results against a standard goal. We identify opportunities for improvement based on our analysis, and their significance to our members.

Member Experience Surveys – Consumer Assessment Health Plan Service (CAHPS)

Surveys are conducted to monitor members' experience with healthcare services, accessibility of care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunities to improve member experience and the processes that impact satisfaction. Surveys are conducted at least annually. We receive survey results from our contracted Health Plans or vendors. The results of the surveys are evaluated and improvement plans are developed to address problem areas identified. All available results are presented to the QIC for review and recommendations semi-annually.

Member Experience Surveys – CCM and SNP Programs

AZPC will obtain feedback from members by conducting focus member experience surveys and systematically analyzing the feedback we collect at least annually. The surveys may include information about the overall program, program staff, the usefulness of the information disseminated by the primary provider group, and the members' ability to adhere to recommendations. The feedback obtained will be specific to the CCM and SNP Programs, when delegated.

AZPC will evaluate the results of the surveys received. Improvement plans will be developed to address areas identified. All results are presented to the QIC for recommendations and interventions.

COMPLEX CARE MANAGEMENT ('CCM' OR 'HIGH RISK'):

AZPC coordinates services for members with complex conditions and helps them access needed resources. The program includes all information and interventions that the organization implements for a member or provider to improve healthcare delivery and management and promote quality, cost-effective outcomes.

CCM is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. members eligible for CCM may include those with physical or developmental disabilities, multiple chronic conditions or severe injuries.

Since CCM is considered an opt-out program, all eligible members have the right to participate

or decline participation.

The goal of CCM is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a patient centered care management plan with performance goals, monitoring and follow up.

Distinguishing factors of CCM:

1. Degree and complexity of illness or condition is typically severe.
2. Level of management necessary is typically intensive.
3. Amount of resources required for member to regain optimal health or improved functionality is typically extensive.

When delegated, AZPC will annually assess the entire population. Based on the findings, the CCM process and resources will be reviewed and updated in order to meet members needs effectively.

SPECIAL NEEDS PROGRAM ('SNP')

The Special Needs Program ('SNP') is a Medicare program that focuses on three populations: those with chronic conditions, those that are deemed institutional, and those that have Medicare and Medicaid dual benefits. The care management departments have written processes for the identification of enrollees with multiple or sufficiently severe chronic conditions and meet the criteria for participation in the program, when delegated by the health plan.

When delegated, all Special Needs Program members have an annual risk assessment completed where an individualized care plan for that member is generated and completed. The criteria are developed, reviewed and approved through the QIC. The program details which chronic conditions are monitored, types of services offered and the types of measures that are used to assess performance.

Clinical Practice Guidelines:

AZPC is accountable for adopting and disseminating clinical practice guidelines relevant to members for the provision of preventive, acute or chronic medical and behavioral health services.

AZPC uses evidenced-based guidelines to help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances and behavioral health services. AZPC will distribute guidelines to their practitioners by posting them on our website or through

the provider web portals. Notification of online availability will be faxed to our network providers within 30 days of QIC approval. In addition, if changes or revisions are made, a notice will be sent to the practitioners by fax blast within 30 days of QIC approval.

AZPC adopts nationally recognized Clinical Practice Guidelines ('CPGs') that include professional medical associations, voluntary health organizations, and NIH Centers and Institutes. If the guidelines are not from a recognized source, they are created with the involvement of a board-certified practitioner. Selected CPGs are presented to the QIC for discussion and recommendations. Evidence based CPGs for at least two medical conditions shall be adopted, e.g., diabetes, heart failure, COPD, Coronary Heart Disease.

We ensure all clinical practice guidelines are reviewed and approved through the QIC at least every two years and as needed if changes are made.

Preventive Health Guidelines

AZPC will adopt and disseminate Preventive Health Guidelines ('PHGs') for our population.

AZPC approves, adopts, and disseminates these Preventive Health Guidelines in an effort to improve healthcare quality and reduce unnecessary variation in care. AZPC will distribute guidelines to our contracted providers by posting them on the website. Notification of online availability will be faxed to our network providers within 30 days of QIC approval. In addition, if changes or revisions to the guidelines occur, a notice will be sent to the practitioners by fax blast within 30 days of QIC approval.

AZPC adopts nationally recognized Preventive Health Guidelines ('PHGs') from the U.S. Preventive Services Task Force for adults. AZPC may include other guidelines from professional medical associations, voluntary health organizations, and NIH Centers and Institutes. If the guidelines are not from a recognized source, they are created with the involvement of a board-certified practitioner.

Selected PHGs are taken to the QIC for discussion and recommendations. PHGs are reviewed and approved by the QIC at least every two years and as needed if changes are made.

CONTINUITY AND COORDINATION OF MEDICAL CARE:

AZPC ensures the continuity and coordination of care that our members receive. The members may select a Primary Care Provider ('PCP'), or the health plan may assign a PCP to the members with the primary responsibility for coordinating the members overall healthcare. AZPC will ensure that there is continuity and coordination of medical services and will facilitate, across transitions and settings of care, that (1) patients receive care and services

they need, and (2) practitioners or providers will get the information they need to provide care the patients need.

AZPC will use valid data collection methodology to identify the following:

1. Care transitions between health care practitioners and across settings, based on changing needs, during episodes of acute or chronic illness. AZPC will collect the data needed to assess the coordination of care during these transitions.
2. Movement of members between practitioners. This includes the inception/cessation of patient care by a practitioner and coordination of care across practitioners who concurrently or intermittently provide care to members.
3. Member movement across settings, which includes moving from hospital or from hospital to a rehabilitation facility.
4. After conducting quantitative and causal analysis of data to identify improvement opportunities, AZPC will identify and select opportunities for improvement. These initiatives will be a direct result of data collected and analysis performed 1-3, above.
5. AZPC will then act annually to improve the coordination of medical care by acting on the opportunities noted above and also by annually measuring the effectiveness of improvement actions taken for the first three opportunities. The effectiveness of these actions will be measured twice, and the results of each of those remeasurements will be analyzed. AZPC will define the variables in order to measure the performance of identified issues and collect data on at least one of the following:
 - a. Activities;
 - b. Events;
 - c. Occurrences; and
 - d. Outcomes
6. Measures are based on practice guidelines and accepted standards of care and will include objective clinical criteria from authoritative resources (i.e., Clinical literature, consensus panels or HEDIS measures).
7. Quantitative analysis will define the (1) numerator, (2) denominator, (3) sampling methodology, (4) sample size calculations, and (5) measurement periods and seasonality effects, and AZPC will perform a causal analysis if stated goals are not met.

AZPC must:

1. Identify members with special health care needs, including those that would benefit from Disease Management.
2. Ensure an appropriate health care professional assesses the ongoing needs of each

member with special health care needs or conditions.

3. Identify medical procedures and/or behavioral health services to address and/or monitor the need or condition.
4. Ensure adequate care coordination among providers, including other practitioners, and a behavioral health provider, as necessary, and
5. Ensure a mechanism to allow direct access to a specialist as appropriate for the member's condition and identified special health care needs (e.g., a standing referral or an approved number of visits).

Notification of Termination:

AZPC will notify members affected by the termination of a practitioner or practice group, as stated in the policy. Notification must be in writing and may be distributed via the Internet. Written notification about the availability of information on the website and paper must be mailed to members, and a printed copy of the information must be made available upon request.

All communication must include the following information when delegated:

1. The practitioner's name and the effective termination date
2. Procedures for selecting another practitioner

AZPC is not responsible for notifying members of practitioner relocations or office closures as long as the practitioner remains available to members as part of the organization's network.

If a practitioner notifies AZPC of termination less than 30 calendar days prior to the effective date, AZPC should notify the affected members as soon as possible but no later than 30 calendar days after receipt of the notification.

Continued Access to Practitioners:

In the event that a practitioner's contract is discontinued, the policy of AZPC outlines specific circumstances under which affected members may maintain access to their practitioner, as well as the duration of continued care. Furthermore, AZPC will assist members in transitioning to alternative care, if necessary, when their benefits conclude or during the transition from pediatric to adult care.

CONTINUITY AND COORDINATION BETWEEN MEDICAL CARE AND BEHAVIORAL HEALTHCARE

AZPC will collaborate with our contracted behavioral healthcare practitioners to monitor and

improve coordination between medical care and behavioral healthcare.

AZPC monitors the quality and coordination of behavioral health services. We must ensure timely updates from primary care providers to behavioral health providers regarding a member's change in health status. The update must include but is not limited to, diagnosis of chronic conditions, support for the petitioning process for long-term care, and all medication prescribed.

PATIENT SAFETY PROGRAM

AZPC's Clinical Services Department has developed a patient safety program which identifies, supports and facilitates patient safety throughout our network operations. This program evaluates multiple aspects of the patient care process, such as hospital safety, health education, practitioner office safety and drug utilization safety.

Poly-Pharmacology

Programs are in place through our EMR systems to identify members who are on medications that are contraindicated (such as drug interactions) or when warnings have been issued. All members that are prescribed eight (8) or more medications are reviewed for patient safety, drug-to-drug interactions, and drug-disease interactions by their primary care provider.

Medication Reconciliation

1. Upon discharge from a facility, a complete list of a patient's current medications, allergies, and medication sensitivities will be obtained and documented from all relevant sites of care and settings within our Network of practitioners and providers. This list is updated at all visits whenever medications are administered or prescribed or the response to the care provided to the patient could be affected by medications.
2. All new medications prescribed or administered will be reconciled against this list during the patient's care. Inpatients transferred between services or levels of care will have all medications reconciled. If a new medication is prescribed (or changes are made to current regimen), the patient's electronic medication list is then updated, and a copy of the updated list is provided to the patient.

Patient Adverse Outcomes

AZPC will track and trend the number of grievances, Appeals, Sentinel Events, and CMS Reportable Events received by category, sub-category, provider type and level of severity. We take these events seriously and a full investigation shall occur to ensure that safe care is

provided to our members across our network.

Documenting and investigating serious reportable events, such as Critical incidents, Sentinel Events, and CMS Reportable Events, is essential. Analyzing information from these events can enhance coordination of program services, improve processes, and prevent the recurrence of events in the future.

POTENTIAL QUALITY ISSUES ('PQI'):

A major component of the QI Program is the identification and review of potential quality issues and the implementation of appropriate corrective action to address confirmed quality of care issues. This process identifies and corrects potential quality issues for all provider entities, including physicians, hospitals, and laboratories as applicable.

A PQI is a deviation or suspected deviation from expected practitioner performance, clinical care, or outcome of care that cannot be determined to be justified without additional review. Such issues must be referred to the Clinical Services Department for review and investigation.

PEER REVIEW

Peer review is conducted in any situation where peers are needed to assess the appropriateness or necessity of a particular course of treatment, review or monitor a pattern of care provided by a specific practitioner, or review aspects of care, behavior, or practice that may be deemed inappropriate.

1. The Senior Medical Director/Medical Director is responsible for authorizing the referral of cases for peer review.
2. All peer review consultants (including members of the Credentialing/Peer Review or ad-hoc Peer Review Committee) are duly licensed professionals in active practice.
3. At least one consultant will be a practitioner with the same or similar specialty training as the practitioner who is being reviewed, except in cases where there is no applicable board certification for the specialty.
4. The Senior Medical Director can send cases out for specialty review and consultation, which can be used for the peer review process.
5. The Senior Medical Director will confirm that the peer review consultants have the necessary experience and qualifications for the review.
6. The QI Management prepares all materials for review by the Peer Review Committee and conducts all follow-ups, as required by the Committee.

SENTINEL EVENTS / CRITICAL INCIDENTS

A sentinel event or critical incident is “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, ‘or risk thereof’ includes any process variation for which a recurrence carries a significant chance of a serious adverse outcome.”

A major component of the QI Program is the use of sentinel events to monitor important aspects of care, accessibility and service in medical and behavioral healthcare. These events are called "sentinel" because they signal the need for immediate investigation and response. As such, all sentinel events must be monitored, tracked, and investigated.

SERIOUS REPORTABLE ADVERSE EVENTS

A Serious Reportable Adverse Event (‘SRAE’) is an incident involving death or serious harm to a patient resulting from a lapse or error in a healthcare facility. It is broken down into three major categories by the Centers for Medicare & Medicaid Services:

1. Never Events;
2. Hospital Acquired Condition (‘HAC’); and
3. Provider Preventable Condition

AZPC will ensure our compliance with all Federal and State guidelines. All serious reportable adverse events will be monitored, tracked, and investigated.

CLINICAL MEASUREMENT ACTIVITIES AND QUALITY PERFORMANCE REPORTING

AZPC adheres to all regulatory standards for quality performance reporting. AZPC will cooperate and assist regulators and their contracted QI Organizations (‘QIO’). AZPC uses data collection and analysis to track clinical issues that are relevant to the population. AZPC will adopt and establish quantitative measures to assess performance and to identify and prioritize as appropriate.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

AZPC actively takes part in the annual Health Plan Effectiveness Data and Information Set (HEDIS) and Structure and Process measures. HEDIS Studies and Structure and Process

measures are conducted for all lines of business with 30 or more members and are in accordance with CMS and NCQA standards.

AZPC facilitates collection of HEDIS measure data through multiple sources:

1. Claims and encounter data.
2. Proactive medical record review.
3. Complex Care Management and Special Needs Programs ('when delegated').
4. Proactive measure review.
5. Specialized software program that runs each measure proactively every month during the measurement year.
6. Member listings of services that have not been captured are provided to primary care practitioners at a minimum of every three months.
7. Annual education and training of practitioners and their office staff
8. HEDIS coordinators work alongside and provide provider relations representatives detailed reports to contact primary care practitioners and discuss the importance of the reports and services not yet captured at a minimum of every three months.

HEDIS measure outcome data is compared to national benchmarks (or if a benchmark is not available, a goal is established), and final rates are reported through the QIC. A formal corrective action plan will be developed for all measures that do not meet minimum performance levels (25th percentile of the national rate or not meeting goal) or have a significant drop-in rate.

CENTER FOR MEDICARE & MEDICAID SERVICES STAR RATINGS PROGRAM

The Center for Medicare & Medicaid Services Star Ratings Program has the responsibility of reaching out to practitioners and their office staff and providing them with intensive education and incentives.

In addition, practitioners can obtain the program tools/information via AZPC's provider web portal. The CMS Star Program was implemented to make changes at the "point of care" and ensure members received required annual services and that the appropriate use of diagnosis codes is captured.

A key component of the CMS Star Ratings Program is to develop strong and collaborative relationships with practitioners and office staff through outreach efforts. In addition, through this educational mechanism, staff will comply as it relates with CMS Star Technical

Specifications, Healthcare Effectiveness Data and Information Set (HEDIS) Measures and the completion of encounter forms, collection of HCC Diagnosis Codes, Initial Health Risk Assessment related to Medicare members (if available), improve patient care, and overall improvement of medical record documentation practices.

As part of the Quality Outreach Program, Provider Relations/Network staff will routinely visit the office site, offering intensive education on the following:

1. Healthcare Effectiveness Data and Information Set ('HEDIS') and CMS Stars.
2. Improving documentation practices.
3. Providing tools that focus the practitioner's office on specific members requiring services and the use of CMS Star and HEDIS-specific encounter billing and documentation.
4. Identify opportunities to limit barriers between the physician and the health plan.
5. Collaborate on the collection of important diagnosis and procedure codes and service information to limit the intrusion into the physician's office.
6. Inform the physician that Provider Relations/Network staff have the resources to get questions answered and issues resolved quickly.
7. Work toward improvement in members' access to care.
8. Educate the provider's office on the submission of Medicare diagnosis and procedure codes through the encounter/claims systems while utilizing an incentive program.
9. Identify Medicare members who have not been seen or have gaps in care to help them schedule their needed services with contracted providers and facilities.
10. In-service practitioners and staff on how they can increase revenue through the improvement of documentation and data submission.
11. In-service on how to complete an Annual Wellness Assessment of the Medicare members, including scheduling the member to be seen by the physician for incentive opportunities.

OTHER QI ACTIVITY

AZPC conducts other quality improvement studies and programs to assess quality of service to our members. Audits are also conducted to ensure AZPC is compliant with regulatory and accrediting agency requirements. When conducting any activity that reveals any opportunity for improvement, AZPC will have a corrective action plan developed. The corrective action plans can be developed from issues arising from, but not limited to:

1. Member/Practitioner Experience Surveys.
2. Access to care audits
3. Availability audits/surveys.
4. Potential or actual quality of care issues ('PQI').
5. Grievances received from health plans.

Follow-up surveys and/or focus audits may be conducted based on our findings, and actions taken.

DISSEMINATION OF INFORMATION

The QI Program description is made available to all network practitioners and members. Members and practitioners are notified of the availability of the QI Program through the website, Provider Manual, and newsletters. The results and intervention analysis are available by request for all practitioners and members. The notification of online availability is sent by fax blast to all network providers within 30 days of QI Committee approval.

DELEGATION OF QUALITY MANAGEMENT/IMPROVEMENT

AZPC does not delegate QI activities. For any delegated activity from the health plan, there shall be a signed and dated agreement:

1. Stating that it is mutually agreed upon.
2. Describe the delegated activities and the responsibilities of the health plan and AZPC.
3. Requiring at least semi-annual reporting by AZPC.
4. Describing the process by which the health plan will evaluate AZPC's performance.
5. Describing the remedies available to the health plan if AZPC does not fulfill their obligations up to and including revocation of the delegation agreement.

AZPC must provide to the Health Plan when requested:

1. Member Experience data, when requested; and
2. Clinical Performance data.

QI INFRASTRUCTURE FOR UTILIZATION MANAGEMENT (UM) FUNCTIONS

As a component of the QI program, AZPC has an infrastructure for ongoing monitoring of UM activities to ensure established metrics are met and to identify any improvement opportunities.

AZPC's QIC or UMC will continually evaluate the QI Program through ongoing reporting as well as the appropriate work plans which will document goals, objectives, areas of focus, planned monitoring, and action steps to be taken to ensure the appropriateness of the UM activities.

GOALS

Monitoring and measuring UM activities to ensure the implementation of such activities support positive outcomes and identify opportunities to improve quality of care.

1. Implementing interrater reliability process to ensure reviewers are applying the UM Decision making criteria consistently.
2. Monitoring UM decision making turnaround times through sampled audits.
3. Tracking and trending telephone statistics, including abandonment rates and average speed to answer, to ensure appropriate access to care.
4. Monitoring the process for resolving client complaints and issues, including procedures for responding to concerns timely per policy.**
5. Monitoring appeals handling turnaround times through sampled audits.**

QI INDICATORS

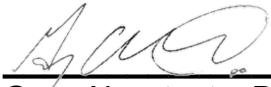
The following quality indicators are used to monitor and measure UM performance. Each indicator has a metric with an established benchmark to evaluate performance at least semi-annually. A quantitative analysis of the data, activities and performance are tracked and trended within the appropriate QI or UM work plans assessment of performance, opportunities for improvement and barrier are identified and corrective actions are taken for indicators that do not meet goal. Findings are presented to the appropriate QI or UM Committee.

1. Interrater reliability of UM decision making
2. Turnaround time of UM decision making
3. Telephone statistics, such as call abandonment rates and average speed of answer
4. Client complaint-handling turnaround times **
5. Appeal- handling turnaround times **

**Note: AZPC is not delegated by any full-service Health Plan to process or resolve member grievances/complaints or appeals. However, any complaints/appeals received will be forwarded to the Health Plan for processing, per agreements and non-delegated status.

APPROVAL

This AZPC Quality Program Description was approved at the Quality Management Meeting on February 13, 2025. The affixed signatures below endorse approval. Approval is valid for, at a maximum, of one year.



Greg Alaestante, DO
Medical Director
AZ Priority Care



Mujtaba Shafiq, MD
VP of Clinical Services
AZ Priority Care

2/13/2025

Date

2/13/2025

Date

[END OF DOCUMENT]