Auditing and Monitoring Policy

Department:	**Compliance, Corporate**	**Policy No:**	**149**
Prepared By/Date:	Emily Coriale / June 1, 2018	Date Originated:	**6/1/2018**
Approved By/Date:	Compliance Committee – June 26, 2018	Last Revision Date:	**N/A**
Areas of Impact:	**All P3 Employees and Departments**	**Supersedes P&P No.**	**N/A**

1. PURPOSE:

To describe the process P3 Health Group Holdings, LLC ("**P3**")[1] will use to conduct audits and monitoring of internal departments and First Tier, Downstream and Related Entities ("**FDR**") to assure compliance with required elements of the Medicare program(s) as well as Client Plan Sponsor agreements.

2. SCOPE:

a. This policy applies to all of P3's employees, management, contractors, student interns, and volunteers.

b. This policy describes P3's objectives and policies regarding how it audits and monitors operational units and FDRs.

3. DEFINITIONS:

Unless defined in the body of this policy (which would be indicated by a term in parenthetical, underlined and with quotations around the defined term), the following terms, have the following meanings for this policy:

Abuse: Includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit: A formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.

[1] When the term "**P3**" is used herein, it also includes the following entities, in addition to P3 Health Group Holdings, LLC ("**Holdings**") – P3 Health Partners, LLC; P3 Health Group Management LLC; P3 Consulting, LLC; P3 Health Partners-Nevada, LLC; Kahan Wakefield Abdou, PLLC; Bacchus Wakefield Kahan, PC; as well as any direct or indirect subsidiaries of Holdings, whether now existing or hereafter formed.

Client Plan Sponsor: Any entity that holds a contract directly with CMS who is involved with the Medicare Advantage ("**MA**") benefit ("**MAO**") or Part D benefit, and who contracts with P3 to provide certain services (e.g., Blue Cross Blue Shield of Arizona).

CMS: The Center for Medicare and Medicaid Services.

Compliance Officer: P3's compliance officer and his or her designee(s).

Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between a MAO or applicant or a Part D plan sponsor or applicant and an FDR. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

FDR: First Tier, Downstream or Related Entity.

First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with a MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.

Fraud: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

FWA: Fraud, waste and abuse.

Monitoring Activities: Regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Related Entity: Any entity that is related to an MAO or Part D sponsor by common ownership or control and:

1. Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation;
2. Furnishes services to Medicare enrollees under an oral or written agreement; or
3. Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period.

Waste: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

4. POLICY:

P3 conducts monitoring and auditing of its operations to confirm compliance with Medicare and Client Plan Sponsor requirements. P3 ensures a baseline assessment of potential compliance risks are identified (*see* Risk Assessment and Annual Work Plan Development Policy), and utilizes it to conduct effective auditing and monitoring of internal departments and FDRs. The risk assessment and auditing and monitoring work plans are developed annually. The auditing and monitoring work plan identifies the specific areas to be monitored or audited, and is updated as needed to capture newly identified risks. All internal departments and FDRs conducting Medicare business are subject to audit and/or routine monitoring. P3 requires corrective action plans ("**CAPs**") from internal operational departments and FDRs for audits and

monitoring resulting in findings. Audit and monitoring results and any resulting CAPs are reported to the Compliance Committee for review. P3's CEO and governing body are also informed of audit and monitoring results. If applicable, P3 notifies its Client Plan Sponsors, or law enforcement of findings.

5. PROCEDURE:

A. Monitoring Activities

The Compliance Officer determines monitoring activities based on the results of the annual risk assessment (*see* Risk Assessment and Annual Work Plan Development Policy).

1. Monitoring activities and monitoring frequency will be identified in the Audit and Monitoring Work Plan (*see* Attachment 1).
2. The Compliance Officer routinely monitors P3's FDRs and internal operational areas that are participating in Medicare program activities.
3. The results of monitoring activities and any corresponding corrective actions are forwarded to the Compliance Committee for review at the next regularly scheduled meeting (*see* Compliance Committee Charter). P3's CEO and the governing board will also be informed of audit results.

B. Audits

1. The Compliance Committee determines the audits of P3's FDRs and internal operational areas based on the results of the annual risk assessment (*see* Risk Assessment and Annual Work Plan Development Policy).
2. Audit activities and their start/end dates will be identified in the Audit and Monitoring Work Plan (*see* Attachment 1).
3. The Compliance Committee audits P3's FDRs and internal operational areas who are participating in Medicare program activities.
    a. Auditors are knowledgeable about CMS operational requirements for the areas under review.
    b. Auditors are independent and do not engage in self-policing. Audits of Compliance Program activities will be conducted by a separate Internal Audit unit or external party.
    c. P3 uses CMS audit protocols, including required audit universe layouts and audit methods, and/or industry standard audit protocols for its audits.
    d. P3 utilizes appropriate methods for auditing (i.e., sample size, data mining, etc.).

C. Auditing/Monitoring Techniques

1. P3 uses different monitoring and auditing methods and techniques including, but not limited to:
    a. On-site Audit – Involves a scheduled or unscheduled review of predetermined functions within P3's operational areas or its FDRs. Management is notified of the specific items to be reviewed.
    b. Off-site/Desk Audit – Involves the review of a specific P3 operational area or FDR with no site visit and no mandate to notify the respective department in advance. Such audits utilize reports as well as internal and external data to monitor performance and occur on a regular basis.
    c. Data Analysis – Involves the use of data analytical techniques to identify patterns of potential over- or abusive utilization, claims 'up-coding,' etc.
    d. Attestation Validation – The Compliance Officer may utilize attestations to monitor compliance (e.g., review of P3's Code of Conduct and/or compliance policies and procedures, completion of compliance and subject matter training). The Compliance

Officer will periodically validate the signature and/or information attested to by P3's internal departments or FDRs.

e. Independent Review – Involves the use of an outside, independent reviewer with knowledge, skills, and abilities to conduct the review.

2. Scheduled On-site Procedure
   a. One month prior to the scheduled audit, or as required by FDR contractual requirements, the assigned compliance auditor notifies the P3 operational department or FDR of the visit via email. The notification will include the scope, review period, a description of any documentation or universes required, including the format, due date, and method of delivery.
   b. Upon receipt of the requested universe(s), the assigned compliance auditor selects the samples according to the appropriate CMS audit protocol criteria, as applicable, or based on other appropriate sampling methodologies (e.g., selection of random or targeted samples, determining appropriate sample size).
      i. If the minimum number of cases is not available in the universe, the reviewer may expand the audit period, select all the cases in the universe for review, and/or request additional information relating to the universe size to determine appropriateness.
   c. The compliance auditor notifies the Compliance Officer or FDR of samples selected and documentation required for the audit, utilizing the timeframes established by CMS, when applicable.
   d. Sample cases are reviewed electronically whenever possible. The reviewer may, at his/her discretion, request additional materials during the site visit.
   e. The compliance auditor reviews cases in accordance with the applicable regulatory requirements described in the Code of Federal Regulations, Medicare Managed Care Manual, Prescription Drug Benefit Manual, and/or applicable guidance.

3. Unscheduled On-Site Procedure
   a. The Compliance Officer will communicate the purpose and scope of the planned audit to the Compliance Committee and receive prior approval before proceeding. An example of a reason for an unplanned on-site review may or be an investigation of an FWA related compliance issue.
   b. The Compliance auditor will inform the staff or FDR of the purpose of the review and the circumstances that prompted the review upon arriving onsite.
   c. The Compliance auditor conducts the review in accordance with the applicable regulatory requirements described in the Code of Federal Regulations, Medicare Managed Care Manual, Prescription Drug Benefit Manual, and/or other applicable guidance.

4. Attestation Validation Procedure
   a. Upon identifying a sample of required attestations to be validated, the compliance auditor will notify the applicable P3 department or FDR of the attestation title/subject, purpose, and time period.
   b. The compliance auditor will request evidence in support of the attestation (e.g., signed attestation, proof of training, sign in sheets, etc.).
   c. Submitted attestations must be confirmed as accurate and complete.

D. Notification of Findings and Corrective Action

1. The Compliance Committee documents results of its auditing and monitoring activities.
    a. Documentation may be via written report, which details the number of cases reviewed, any recommendations or issues of non-compliance, and if applicable, the level of corrective action required. The Compliance Officer must review and approve reports prior to distribution.
2. The Compliance Officer discusses findings with the Compliance Committee or FDR, as needed.
3. In the event that the Compliance Committee determines that its FDR(s) or operational area has failed to comply with any statutory, regulatory, contractual, P3 policy or other program requirements, the Compliance Committee may require its operational area or FDR to develop and submit a CAP for review and approval.
    a. Corrective action plan requests may be immediate or standard:
        i. Immediate Corrective Action Plan ("**ICAP**") - Requires the department or FDR to correct or begin to correct the detected condition and provide a CAP within 3 calendar days of the request. This occurs when the deficiency poses an immediate threat to member health and safety.
        ii. Corrective Action Plan ("**CAP**") – Requires the P3 department or FDR to correct the detected condition and provide a CAP within 14 calendar days of the request. This occurs when the deficiency does not immediately affect member health and safety.
    b. Both a CAP and ICAP will require the following:
        i. An impact analysis to determine the extent of members impacted.
        ii. Root cause analysis to include review of policies and procedures, staffing, training and systems that failed.
        iii. Documentation of changes to be implemented including timeframes for completion implemented corrective actions.
        iv. Description of the process implemented to monitor adherence to CAP including the implementation of surveillance processes such as compliance dashboards to monitor internal controls to prevent occurrence of the issues in the future.
        v. Attestation by the P3 operational department or FDR that it has corrected the issues and a plan to ensure the deficiency does not recur.
4. The audit results and any corresponding corrective actions are forwarded to the Compliance Committee for review at the next regularly scheduled meeting. The P3 CEO and governing body are also informed of results.

E. Corrective Action Follow-Up

1. The Compliance Committee evaluates its operational areas or FDR's progress on corrective actions and requests updates based on established due dates.
2. The operational area or FDR forwards any newly created or revised documentation related to the corrective actions to the Compliance Officer for review and approval prior to implementation.
3. The Compliance Committee re-audits deficient areas (validation audit) using the methodologies described above to confirm the conditions requiring corrective actions have been resolved. The timing and scope of the audits will depend on the severity of the condition(s) but generally should occur three (3) months after the corrective actions have been implemented.
4. The Compliance Committee documents its findings and shares them with the operational areas or the FDR. Areas of continued non-compliance may require further corrective action.

5. The re-audit findings and any corrective actions are forwarded to the P3 CEO for review and a corrective action closure recommendation. The P3 governing board is also informed of results.
6. The Compliance Committee may continue to monitor and audit deficient areas and their performance of critical functions.

F. Compliance Program Effectiveness Audit

1. P3 performs an annual compliance program effectiveness audit.
   a. Employees who review the effectiveness of the compliance program are independent of, and do not report in any way to the Compliance Committee.
   b. P3 may outsource the audit to external auditors.
2. The results are documented and shared with the Compliance Committee.
   a. Documentation may be via written report, which details the number of samples reviewed, any recommendations or issues of non-compliance, and if applicable, the level of corrective action required.
3. In the event that the Compliance Committee has failed to comply with any statutory, regulatory, contractual, P3 policy or other program requirements, auditor(s) may require the Compliance Committee to develop and submit a CAP for review and approval. Corrective action requests will be in accordance with the procedures described within this policy.
4. The audit results and any corresponding corrective actions are forwarded to the P3 CEO for review at the next regularly scheduled governing board meeting.
5. Audit follow up will be in accordance with the procedures described within this policy.

6. DOCUMENTATION / REFERENCES:

SUPPORTING DOCUMENTS
Attachment #1: Auditing and Monitoring Work Plan
Attachment #2: Corrective Action Plan Form

CROSS-REFRENCED P&PS
Risk Assessment and Annual Work Plan Development Policy

MANUAL
Medicare Managed Care Manual (MMCM) Chapter 21, Section 50.6
Prescription Drug Benefit Manual (PDBM) Chapter 9, Section 50.6

RELEVANT REGULATORY CITATIONS
42 C.F.R. § 422.503(b)(4)(vi)(E), 42 C.F.R. § 422.503(b)(4)(vi)(F)
42 C.F.R. § 423.504(b)(4)(vi)(E); 42 C.F.R. § 423.504(b)(4)(vi)(F)

7. HISTORY:

DATE	REVISED BY	REASON FOR REVISION/CONTENT CHANGED

Auditing and Monitoring Policy

CHRONIC CARE MANAGEMENT

FILE INFORMATION	Threshold	Q1	Q2	Q3	Q4
Total BCBS Membership					
Percentage of Membership					
Opt In Rate					
Opt Out Rate					
Members Outreached					
Members Contacted					
Care Plans Up-to-Date					
Members Discharged					
HEDIS Metrics for Actively Enrolled					
Care Transition					
CM Call w/i 2 Business Days					
PCP visit w/I 10 Business Days					
Med Reconciliation w/I 30 Days of Discharge					
Readmission Rate					
TOTAL/AVERGAE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	

Q1 Results:	**REGULATION: NCQA PHM-5 COMPLEX CARE MANAGEMENT; HEALTH PLAN-BCBS**
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**
Q3 Results:	**FREQUENCY: MONTHLY**
Q4 Results:	

CARE MANAGEMENT

FILE INFORMATION	Threshold	Q1	Q2	Q3	Q4

Total BCBS Membership					
Percentage of Membership					
Opt In Rate					
Opt Out Rate					
Members Outreached					
Members Contacted					
Care Plans Up-to-Date					
Members Discharged					
HEDIS Metrics for Actively Enrolled					
Care Transition					
CM Call w/i 2 Business Days					
PCP visit w/i 10 Business Days					
Med Reconciliation w/i 30 Days of Discharge					
Readmission Rate					
TOTAL/AVERGAE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	

Q1 Results:	**REGULATION: NCQA PHM-1 STRATEGY; HEALTH PLAN-BCBS**
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**
Q3 Results:	**FREQUENCY: MONTHLY**
Q4 Results:	

UTILIZATION MANAGEMENT METRICS REPORT

FILE INFORMATION	Threshold	Q1	Q2	Q3	Q4
Total BCBS Membership					
Hospital A/K					
Hospital Bed Days/K					
Hospital ALOS					
Hospital Readmits/K					
Hospital Obs/K					
Hospital ER/K					

SNF A/K					
SNF Bed Days/K					
SNF ALOS					
SNF Readmits/K					
Acute Inpt Rehab A/K					
Acute Inpt Rehab Bed Days/K					
Acute Inpt Rehab ALOS					
Acute Inpt Rehab Readmits/K					
LTACH A/K					
LTACH Bed Days/K					
LTACH ALOS					
LTACH Readmits/K					
Inpt Behavioral Health A/K					
Inpt Behavioral Health Bed Days/K					
Inpt Behavioral Health ALOS					
Inpt Behavioral Health Readmits/K					
Inpt Behavioral Health Obs/K					
Outpt ASC Procedures/K					
Outpt MRI Scans/K					
Outpt PET Scans/K					
Outpt CT Scans/K					
Outpt CTA Scans/K					
TOTAL/AVERGAE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	

Q1 Results:	**REGULATION: HEALTH PLAN-BCBS**
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**
Q3 Results:	**FREQUENCY: MONTHLY**
Q4 Results:	

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CARE MANAGEMENT PROGRAM-MEMBER SATISFACTION SURVEY

	Threshold	Q1	Q2	Q3	Q4
Total BCBS Membership					

Total Surveys Administered	100%				
Surveys Administered Upon Completion of Program					
Total Survey Responses					
Did you get the care you needed?					
When you need care, do you get care quickly?					
Do you understand your Care Plan?					
Does your Care Team (Provider, Care Manager, ect.) listen to you?					
Do your goals relate to your needs?					
Do you understand your Care Plan?					
Did you receive disease specific information?					
Did you find the information helpful?					
Did you receive preventative care teaching/reminders?					
Were you looking for additional information that was not answered?					
Do you feel better connected to your Provider?					
Do you feel connected to your practice/clinic?					
Do you feel more in control of your health?					
What is your overall satisfaction with your Care Manager?					
What is your overall satisfaction?					
TOTAL/AVERGAE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	

Q1 Results:	**REGULATION: NCQA PHM-5 COMPLEX CARE MANAGEMENT; HEALTH PLAN-BCBS**
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**
Q3 Results:	**FREQUENCY: MONTHLY**
Q4 Results:	**CAP AT 95%**

CARE MANAGEMENT CASE AUDIT

	Threshold	Q1	Q2	Q3	Q4
File Information (Pt. Name, Member ID, Contact Info)	100%				
Plan Type					
Diagnosis					
Risk Stratification Level					
Welcome Letter Sent and Saved					
HRA Completed w/i 30 days					
Disease Specific Assessment if Diagnoses or Positive in Assessment w/i 30 days					
PHQ 2 Complete w/i 30 days					
PHQ 9 if PHQ 2 Positive w/i 30 days					
Problems and Barriers Identified and Related to Time Specific Goals					
Priorities assigned to Individual Care Plan (ICP) based on Assessment(s)					
ICP Created and Sent to IDT					
Advanced Directive Plan					
Follow Up Schedule Created					
Follow Up Administered					
Progress and Status Updated on ICP					
Disease Specific Labs Monitored					
Updated ICP Sent to IDT					
TOTAL/AVERGAE	**100%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	

Q1 Results:	**REGULATION: NCQA CM-1 CM PROGRAM; HEALTH PLAN-BCBS**
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**
Q3 Results:	**FREQUENCY: QUARTERLY**
Q4 Results:	**THRESHOLD: 100%; CAP AT 95%**

HEALTH CARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

FILE INFORMATION	Threshold	Q1	Q2	Q3	Q4
Breast Cancer Screening					
Cardiovascular Conditions-LDL Testing					
Cardiovascular Conditions-LDL <100					
Colorectal Cancer Screening					
COPD-Spirometry Testing					
Daibetes-HbA1c Testing					
Daibetes-HbA1C In Control (</= 9.0%)					
Diabetes-HbA1c 8.0%					
Diabetes-LDL Testing					
Diabetes-LD<100					
Diabetes-Nephropathy Screening					
Diabetes-Eye Exam					
Glaucoma Screening (Age 65+)					
Osteoporosis Screening-Post-Fracture					
Rheumatoid Arthritis Management					
TOTAL/AVERGAE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	

Q1 Results:	**REGULATION: HEALTH PLAN-BCBS**
Q2 Results:	**DATA SOURCE: BCBS CENTURI**
Q3 Results:	**FREQUENCY: MONTHLY**
Q4 Results:	

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DISEASE EDUCATION

	Threshold	Q1	Q2	Q3	Q4
Total Membership					
INSERT CLASS TYPE/TITLE					
Attendance by Members					
Location					
Referral Source					
Individual Education Provided to Pts on Active CM					
TOTAL/AVERGAE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	
Q1 Results:	**REGULATION: NCQA PHM-4 WELLNESS AND PREVENTION; HEALTH PLAN-BCBS**				
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**				
Q3 Results:	**FREQUENCY: QUARTERLY**				
Q4 Results:					

CARE MANAGEMENT (DM) PROGRAM-MEMBER SATISFACTION SURVEY

	Threshold	Q1	Q2	Q3	Q4
Total BCBS Membership					

Total Surveys Administered					
Surveys Administered Upon Completion of Program	100%				
Total Survey Responses					
Did you get the care you needed?					
When you need care, do you get care quickly?					
Do you understand your Care Plan?					
Does your Care Team (Provider, Care Manager, ect.) listen to you?					
Do your goals relate to your needs?					
Do you understand your Care Plan?					
Did you receive disease specific information?					
Did you find the information helpful?					
Did you receive preventative care teaching/reminders?					
Were you looking for additional information that was not answered?					
Do you feel better connected to your Provider?					
Do you feel better connected to your practice?					
Do you feel more in controll of your health?					
What is your overall satisfaction with your Care Manager?					
What is your overall satisfaction?					
TOTAL/AVERGAE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	

Q1 Results:	**REGULATION: NCQA PHM-5 COMPLEX CARE MANAGEMENT; HEALTH PLAN-BCBS**
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**
Q3 Results:	**FREQUENCY: QUARTERLY**
Q4 Results:	

UTILIZATION M

MEDICAL NECESSITY TIMELINESS

	Threshold	Q1	Q2	Q3	Q4
Number of Authorization Requests Received	100%				
Urgent (Expedited) Concurrent Timely (Decisions made w/i 24 Hours)					
Urgent (Expedited) Concurrent Untimely					
Urgent Preservice Timely (Decisions made w/i 72 Hours)					
Urgent Preservice Untimely					
Non-Urgent (Standard) Preservice Timely (Decisions made w/i 14 Days)					
Non-Urgent (Standard) Preservice Untimely					
Postservice Timely (w/i 30 Days)					
Postservice Untimely					
TOTAL DECISIONS MADE WITHIN 3 DAYS	**100%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	
Q1 Results:	**REGULATION:NCQA UM-5 TIMELINESS OF UM DECISIONS; HEALTH PLAN-BCBS**				
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**				
Q3 Results:	**FREQUENCY: MONTHLY**				
Q4 Results:	**100%; CAP AT 95%**				

DENIAL FILE AUDIT

FILE INFORMATION	Threshold	Q1	Q2	Q3	Q4
MD/Appropriate Practitioner Reviewed the Case	100%				
Criteria Hierarchy followed (e.g. Plan eligibility/coverage, CMS, NCD, LCD, etc.)					
EXTENSION					
Was there an extension	100%				
Number of days allowed for member to respond					
Date of Extension Request					
Date of Member Response					
Member Voluntarily Agreed to Extension					
Number of Days Allowed for Extension					
Actual Extension Days Requested					
Actual Extension Response Days					
NOTIFICAITON OF DECISION					
Decision Date Recorded	100%				
Decision Time Met?					
Verbal Notification to Provider Recorded					
Verbal Notification to Member Recorded					
Written Notification to Provider Recorded					
Written Notification to Member Recorded					
Decision Notification Provider-Met					
Decision Notificaiton Member-Met					
WRITTEN NOTIFICATION					
Denial File Contains Clinical Informaiton	100%				
MD/Appropriate Practitioner Provided Opportunity to Discuss Decision with MD/Appropriate Reviewer?					
Specific Reasons for the Denial clearly documented in easy to understand language					
Reference to the Criterion of which the Denial is based (acronym and written out)					
Member can obtain a copy of the criterion					
Description of Appeal Rights					

Explanation of Appeal Process					
Description of Expedited Appeal Process					
Availibility for External Review					
Status Received Documented					
Status Processed Documented					
Denial File created and stored appropriately?					
TOTAL/AVERAGE	100%	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	
Q1 Results:	**REGULATION: NCQA UM-4 APPROPRIATE PROFESSIONALS, UM-5 TIMELINESS OF INFORMATION, UM-7 DENIAL NOTICES, HEALTH PLAN-BCBS**				
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**				
Q3 Results:	**FREQUENCY: QUARTERLY**				
Q4 Results:	**CAP AT 95%**				

TELEPHONE STATISTICS

	Threshold	Q1	Q2	Q3	Q4
Number of Calls Received					
Calls Answered	100%				
Calls Missed	</=5%				
Abandomment Rate	</=5%				
Average Talk Time	</= 5MIN.				
TOTAL/AVERAGE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	
Q1 Results:	**REGULATION: NCQA UM-3 COMMUNICATION SERVICES, UM-7 DENIAL NOTICES**				
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**				
Q3 Results:	**FREQUENCY: QUARTERLY**				
Q4 Results:	**CAP AT 95%**				

ATTEMPTS TO REQUEST ADDITIONAL INFORMATION

	Threshold	Q1	Q2	Q3	Q4

NETWORK PROVIDER					
Total Cases where additional information is needed from provider					
Total Cases outreached for additional information	100%				
Documeted at least 3 attempts to reach provider to request additional information prior to decision					
First Attempt Documented					
Second Attempt Documented					
Third Attempt Documented					
Fourth Attempt By medical Director Documented					
NON-NETWORK PROVIDER					
Total non-network provider cases where additional information is needed					
Total non-work provider cases outreached within 24 hours for additional information	100%				
Documeted at least 3 attempts to reach provider to request additional information prior to decision					
First Attempt Documented					
Second Attempt Documented					
Third Attempt By medical Director Documented					
TOTAL/AVERAGE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	
Q1 Results:	**REGULATION: HEALTH PLAN-BCBS**				
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**				
Q3 Results:	**FREQUENCY: ANNUALLY**				
Q4 Results:					

DETERMINATIONS OVERTURNED ON APPEAL ARE EFFECTUATED

	Threshold	Q1	Q2	Q3	Q4
Total Determinations Overturned on Appeal					
Total Determinations Overturned on Appeal Effectuated w/i 24 hours of date/time decision was received	100%				
UREGENT (EXPEDITED) CONCURRENT					

Total Urgent (Expedited) Concurrent					
Percentage of Authorizations Effectuated w/i 24 hours					
Percentage of Authorizations from an Appeal					
Percentage of Authorizations from an Overturn					
Percentage of Authorizations from a Pre-Service Appeal					
NON-URGENT (STANDARD) PRE-SERVICE					
Total Non-Urgent (Standard) Pre-Service					
Percentage of Authorizations effectuated w/i 24 hours					
Percentage of Authorizations from an Appeal					
Percentage of Authorizations from an Overturn					
Percentage of Authorizations from a Pre-Service Appeal					
TOTAL/AVERAGE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	

Q1 Results:	**REGULATION: HEALTH PLAN-BCBS**
Q2 Results:	**DATA SOURCE: P3 ANALYTICS**
Q3 Results:	**FREQUENCY: ANNUALLY**
Q4 Results:	

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CONTINUITY OF SERVICES (COS)

	Threshold	Q1	Q2	Q3	Q4
Total Membership					
Total Members with needs for COS					
Total Members with needs for COS outreached					

Call w/i 3 business days					
Members outreached and HRA completed					
Members met criteria for CM					
Members actively enrolled in CM					
TOTAL/AVERAGE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	
Q1 Results:	**REGULATION: HEALTH PLAN-BCBS** **DATA SOURCE: P3 ANALYTICS** **FREQUENCY: MONTHLY**				
Q2 Results:					
Q3 Results:					
Q4 Results:					

COST AVOIDANCE REPORT

	Threshold	Q1	Q2	Q3	Q4
Total Membership					
Total Obs					
Average Obs Cost					
Total Inpt					
Avergae Inpt Cost					
Savings = (Average Inpt Cost-Average Obs Cost)					
Q1 Results:	**REGULATION: HEALTH PLAN-BCBS** **DATA SOURCE: P3 ANALYTICS** **FREQUENCY: ANNUALLY**				
Q2 Results:					
Q3 Results:					
Q4 Results:					

UTILIZATION MANAGEMENT PROVIDER SATISFACTION

	Threshold	Q1	Q2	Q3	Q4
My phone calls were answered/returned in a timely manner					
UM team was helpful and courteous					

UM team was knowledgeable					
When requested, the UM team provided Clinical Practice Guidelines in a timely manner					
Prior Authorization turnaround time met expectations					
Overall satisfaction with the UM Prior Authorization Process met expectations					
TOTAL/AVERAGE		**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	

Q1 Results:	**REGULATION: NCQA QI-4, ELEMENT G: ASSESSING EXPERIENCE WITH THE UM PR**
Q2 Results:	**DATA SOURCE: WEB-BASED SURVEY**
Q3 Results:	**FREQUENCY: QUARTERLY**
Q4 Results:	

INSTRUCTIONS

1. Complete the following form.
2. Submit the form to the Compliance Department at Maria Nutile, mnutile@p3hp.org
3. If you have questions, contact Maria Nutile, 702-307-4880.
4. Immediate CAPs must be submitted to Compliance within 3 calendar days of request. All other CAPs must be submitted within 14 calendar days of request.

BUSINESS UNIT – COMPLETE THIS SECTION

Corrective Action Plan Template	
Today's Date	<Date>
Business Unit Title	<Utilization Management, Case Management>
Business Unit Leader	<Name>
CAP Owner	<Name>
ICAP or CAP?	<Immediate Corrective Action Plan or Corrective Action Plan>
Incident Detail	
Description of risk, deficiency or non-compliance	<Description>
How was the issue identified	<Description>

Root Cause	<Description>
Results and Implications	<Description>
Remediation	
Remediation Activity 1	<Detail activities that will occur to resolve the deficiency>
Due Date 1	<Date>
Remediation Activity 2	<Detail activities that will occur to resolve the deficiency>
Due Date 2	<Date>
Remediation Activity 3	<Detail activities that will occur to resolve the deficiency>
Due Date 3	<Date>
Prevention	
Actions to Prevent Future Recurrence	<Detail activities that will occur to prevent reoccurrence>
Goals	
Target Completion Date	<Date>
Compliance Demonstration Goal	<e.g. 95% of health risk assessments will be completed timely. 95% of organization determinations will be processed timely>
Regulatory References/Policies & Procedures	<Citations>

COMPLIANCE DEPARTMENT – COMPLETE THIS SECTION

CAP Tracker	
Date CAP Received	<Date>
Date CAP Due for Completion	<Date>
Impact Analysis Received?	<Yes/No>
Root Cause Analysis Sufficient?	<Yes/No>
CAP Extension Requested?	<Yes/No>
Evidentiary Oversight Acceptable?	<Yes/No>
Comments	
CAP Approval	
Compliance Officer Signature	<Name>
Date	<Date>

CAP Closure	
Compliance Officer Signature	<Name>
Date	<Date>
Business Unit Leader Signature	<Name>
Date	<Date>

CROSS-REFRENCED P&PS
Auditing and Monitoring
Reporting of Potential Compliance Issues
Investigating Reports of Suspected FWA and Non-Compliance

MANUAL
Medicare Managed Care Manual (MMCM), Chapter 21
Prescription Drug Benefit Manual (PDBM), Chapter 9

RELEVANT REGULATORY CITATIONS
42 C.F.R. § 422.503(b)(4)(vi)(G)
42 C.F.R. § 423.504(b)(4)(vi)(G)

INSTRUCTIONS

1. Complete the following form.
2. Submit the form to the Compliance Department at Emily Coriale, ecoriale@p3hp.org.
3. If you have questions contact Emily Coriale at 949 290-6849.
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BUSINESS UNIT – COMPLETE THIS SECTION

Corrective Action Plan Template	
Today's Date	<Date>
Business Unit Title	<Utilization Management, Case Management>
Business Unit Leader	<Name>
CAP Owner	<Name>
ICAP or CAP?	<Immediate Corrective Action Plan or Corrective Action Plan>
Incident Detail	
Description of risk, deficiency or non-compliance	<Description>
How was the issue identified	<Description>

Root Cause	<Description>
Results and Implications	<Description>
Remediation	
Remediation Activity 1	<Detail activities that will occur to resolve the deficiency>
Due Date 1	<Date>
Remediation Activity 2	<Detail activities that will occur to resolve the deficiency>
Due Date 2	<Date>
Remediation Activity 3	<Detail activities that will occur to resolve the deficiency>
Due Date 3	<Date>
Prevention	
Actions to Prevent Future Recurrence	<Detail activities that will occur to prevent reoccurrence>
Goals	
Target Completion Date	<Date>
Compliance Demonstration Goal	<e.g. 95% of health risk assessments will be completed timely. 95% of organization determinations will be processed timely>
Regulatory References/Policies & Procedures	<Citations>

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Comments	
CAP Approval	
Compliance Officer Signature	<Name>
Date	<Date>

CAP Closure	
Compliance Officer Signature	<Name>
Date	<Date>
Business Unit Leader Signature	<Name>
Date	<Date>

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