SECTION XI: Quality Management

OVERVIEW

The Quality Management (QM) Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of care and services, and the structures and processes by which they are delivered to Plan members, and to continuously pursue opportunities for improvement and problem resolution.

SCOPE

The scope of the QM Program is comprehensive and includes activities that have a direct and indirect influence on the quality and outcome of clinical care and services delivered to all Care1st Plan members. The scope of the QM Program encompasses both quality of care and quality of service. Responsibility for monitoring the scope of care rests with the QM Department.

This QM Program covers all programs and products. All QM standards and procedures are applicable to all ONECare members.

Quality Management/Quality Improvement activities may include but are not limited to:

- Access to and availability of care
- Provider satisfaction
- Credentialing/Re-credentialing
- Clinical practice guidelines
- Under/over utilization
- Adverse outcomes/sentinel events
- Medical record keeping practices
- Facility/Office site review results
- Member satisfaction, complaints and grievances
- Timeliness of handling claims
- High risk and high volume services
- HEDIS results
- Performance Improvement Measures
- Quality Improvement Projects
- Patient Safety Measures

ONECare adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured. Practice guidelines are available on our website (www.care1st.com/az) under the Providers drop down menu. For requests for training, obtaining additional

information or if you do not have internet access and would like a coy mailed to your office, please contact Provider Network Operations.

Compliance with standards is measured using a variety of techniques, including but not limited to:

- Quality of service concerns
- HEDIS
- Quality of care concerns
- Performance Indicators
- Medical record audits
- Facility/Office site review results
- Outcome measures
- Focused review studies
- Member satisfaction surveys
- Peer Review
- Access to care audits
- Disease management outcomes
-

CONFIDENTIALITY AND CONFLICT OF INTEREST

All information related to the QM process is considered confidential. All QM data and information, inclusive of but not limited to, minutes, reports, letters, correspondence, and reviews, are housed in a designated and secured area within the QM Department. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

All persons attending the Clinical and Service Quality Improvement Committee and Medical Management (CASQIC) or any related committee meetings will sign a Confidentiality Statement. All Care1st/ONECare personnel are required to sign a Confidentiality Agreement upon employment.

No persons shall be involved in the review process of QM issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated.

Furthermore, information provided to physicians within the network may be proprietary and/or confidential. When this occurs it is expected that physicians will hold this information in confidence and treat the handling of such information with care.

SECTION XI: Quality Management

RELEASE OF MEMBER INFORMATION

To ensure the confidential release of member information, the following apply:

- Providers should submit all necessary documentation when submitting a request for a referral.
- Providers may release a member's medical information to other health care providers, ONECare or CMS as long as it is necessary for treatment of the member's condition, or administration of the program.
- Member's records are to be transferred to a new PCP within ten business days when one is selected.
- Release of medical information to out of network providers generally requires authorization from the member or guardian.
- Medical records must be released in accordance with Federal or State laws, court orders, or subpoenas.

CREDENTIALING

The Credentialing/Peer Review Committee (CPRC) is delegated the responsibility of monitoring credentialing and re-credentialing activities for providers and practitioners. The Credentialing Committee meets at least ten times annually, but may meet more frequently as needed.

Scope of responsibilities include but are not limited to:

- Review, recommend, approve or deny initial credentialing and re-credentialing of contracted network.
- Ensure appropriate reporting to regulatory/national data banks.
- Ensure the provision of a fair hearing process.
- Oversight of delegated credentialing.
- Peer review for adverse outcomes.
- When a practitioner's contracting/re-credentialing status is denied or restricted based upon a quality concern, the practitioner is provided appeal rights and procedures upon notice of the denial or restriction.

SECTION XI: Quality Management

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, to review or monitor a pattern of care provided by a specific provider or to review aspects of care, behavior or practice, as may be deemed inappropriate. The CMO is responsible for authorizing the referral of cases for peer review based on an outcome severity level.

All peer review consultants (including members of the Credentialing/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in active practice. At least one consultant will be a provider with the same or similar specialty training as the provider whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty.

If the Peer Review Committee makes a recommendation to the Chief Medical Officer (CMO) to deny, limit, suspend or terminate privileges based on a medical disciplinary cause or reason, the affected provider shall be entitled to a formal hearing pursuant to the Fair Hearing Procedure.

FAIR HEARING

A provider is entitled to an appeal and/or hearing if the Peer Review Committee makes a recommendation to:

- Suspend
- Terminate or
- Non-renew a physician's contract.

The provider will be notified of the committee's recommendation and has 30 days following the date of notice, to request a hearing. The request must be submitted in writing to the CMO.

The CMO will schedule a hearing as soon as practicable. The CMO will appoint at least 3 providers and an alternate who have the requisite expertise to ensure a fair hearing. At least 1 provider will be of the same specialty as the practitioner requesting the hearing. No provider will be in direct economic competition with the affected provider and will not stand to gain direct financial benefit from the outcome.

Both parties are entitled to legal representation. Expert testimony and presentation of supporting documents are allowed.

The committee will complete its investigation within 30 days unless both parties agree to a longer period of time to obtain information.

The committee will issue a final decision which may consist of one of the following:

- Continue the immediate action effect
- Impose other sanctions structured to prevent harm to member or to correct identified issues
- Remove the immediate action.

A provider may appeal an action only after the committee renders a final decision. Any action taken as a result of the recommendation of the committee becomes a part of the provider's Credentialing file. ONECare reports to the appropriate authorities such as licensing or disciplinary bodies, CMS or to other appropriate authorities, any provider who are terminated for quality of care issues.

MEDICAL RECORD GUIDELINES

PCPs must maintain a legible medical record for each enrolled member who has been seen for medical appointments or procedures, and/or for whom a provider receives medical/behavioral health records from other providers who have seen the enrolled member. The record must be kept up-to-date, be well organized and comprehensive with sufficient detail to promote effective patient care and quality review. The PCP must maintain a comprehensive record whether a hard copy chart or electronic medical record (EMR) is used, that incorporates at least the following components:

1. Member identification information on each page of the medical record. (i.e., name or ONECare identification number)

2. Identifying demographics including the member's name, address, telephone number, ONECare identification number, gender, age, date of birth, marital status, next of kin, and if applicable, guardian or authorized representative

3. Initial history for the member that includes family medical history, social history and preventive laboratory screenings. The initial history for members under age 21 should also include prenatal care and birth history

4. Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received

5. Immunization records (recommended for adult members if available)

6. Dental history if available, and current dental needs and/or services

7. Current problem list

8. Current medications

9. Documentation, initialed by the member's PCP to signify review of:

    a. Diagnostic information including:

        i. Lab tests and screenings
        ii. Radiology reports
        iii. Physical examination notes, and/or other pertinent data

    b. Reports from referrals, consultations and specialists

    c. Emergency/urgent care reports

    d. Hospital discharge summaries, and

    e. Behavioral health referrals and services provided, if applicable

10. Documentation as to whether or not an adult member has completed advance directives

11. Documentation related to requests for release of information and subsequent release

12. Documentation that reflects diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers as appropriate to promote continuity of care and quality management of the member's health care

13. Obstetric providers must also complete a risk assessment tool for obstetric patients (i.e. Mutual Insurance Company of Arizona Obstetric Risk Assessment Tool [MICA] or American College of Obstetrics and Gynecology [ACOG]). Lab screenings for members requiring obstetric care must also conform to ACOG guidelines.

14. Documentation that each member of reproductive age is notified verbally or in writing of the availability of family planning.

SECTION XI: Quality Management

MEDICAL RECORD RETENTION

All providers must maintain medical records in accordance with all federal and state regulations.