5 Quality Management

OVERVIEW

Health Choice Generations Quality Management/Performance Improvement (QM/PI) Program, under the leadership of the Chief Medical Officer with the Quality Management Committee, provides the framework for a systematic and organization-wide approach for quality of care measurement and evaluation. Activities are planned in accordance with the goals of Health Choice and all applicable regulatory agencies. The purpose is to continuously improve care and service outcomes to meet the needs/expectations of Health Choice members/beneficiaries and their providers while fulfilling all regulatory and contractual requirements. The QM/PI Program encompasses all Health Choice departments, primary care providers, mid-level practitioners, ancillary services, behavioral health, extended care and acute care facilities.

All referrals of potential quality of care issues are investigated within the Health Choice QM Department under the direction of the Health Choice Quality Management Director in collaboration with the Chief Medical Officer and oversight by the Quality Management Committee. All cases referred to the QM Department are investigated and reviewed for potential quality issues. Cases are assigned a severity level and tracked for trending purposes. Reported potential quality of care concerns or service issues may require additional evaluations/reviews.

The Health Choice Quality Management Department also processes and retains records of complaints from members and providers that may not be directly related to quality of care. These complaints are evaluated and trended as indicated per Health Choice Policy and Procedure.

The Health Choice Quality Management Committee (QMC), chaired by the Health Choice Chief Medical Officer/Medical Director, provides oversight for the QM/PI Program and is responsible for the quality of care and peer review functions. Contracted physicians, representing a variety of medical specialties, serve on the Committee and are appointed by the Chief Medical Officer/Medical Director. If a provider issue is investigated by the QMC, and that particular specialty is not represented within the Committee, the Chief Medical Officer/Medical Director may consult on an ad hoc basis with a peer from that specialty.

The Credentialing/Recredentialing process is an activity of the Health Choice QM/PI Program. The Credentialing Committee is a sub-committee of the QMC. A site evaluation is a required component of the initial credentialing process for PCP's and OBG/YN's. The QMC is responsible for the oversight of the credentialing process.

All contracted Health Choice providers are re-credentialed every three (3) years. Each provider must complete a recredentialing application. At that time, primary source verification of credentials is updated. The National Practitioner Data Bank is queried to obtain current information. The recredentialing process also may include an on-site evaluation, a medical chart audit and an appointment availability survey.

Health Choice encourages communication between the Health Plan and the Primary Care Provider regarding quality of care issues or concerns. Issues may involve specific patient cases or systems problems, which can impact patient care. Concerns may be communicated directly to the QM Department or Chief Medical Officer/Medical Director. All information is confidential and is peer-protected.

The Quality Management Department at Health Choice consists of the following functions:

- Oversight of Medicare quality performance measures and development of quality improvement projects.
- Review, research, resolution, and monitoring of complaints and quality of care issues.
- Oversight of medical record/site evaluation process in coordination with initial credentialing, re-credentialing and in response to identified quality issue.
- Credentialing and Re-credentialing for providers and organizational providers.
- Oversight of Part C and Part D Star Ratings performance measure project.
- Model of Care development and oversight.

The Health Choice Generations strongly encourages a working relationship with providers and welcomes comments, questions, or suggestions.

PEER REVIEW

The formal peer review process at Health Choice is accomplished by evaluating the clinical activities and qualifications of practitioners and providers through the efforts of the QM Department and other review committees of Health Choice. This process is pursuant to the QM/PI (Performance Improvement) Plan and A.R.S. 36-2401 et seq. and 36-2917 ("Arizona Peer Review Laws"). If an adverse action is taken against a provider as a result of the peer review process, the provider has certain rights pursuant to Health Choice Policy "Peer Review Process and Appeals". This policy is available upon request from your Provider Services Representative, and will be sent to any provider when an adverse action is taken. The provider has the right to appeal. If you are interested in participating in the Quality/Peer Review Committee, please call the Sr. Director of Quality Management & Performance Improvement at 480-760-4593

This policy, in summary, contains the following provisions:

☐ The Health Choice Chief Medical Officer/Medical Director and/or QM Director will review all issues referred to the QM department, and will ask the provider for comment and clarification, where indicated. The issue may be referred to the QM Committee for peer review if the care involved is questioned and had potential to harm or did harm the member. If a provider in the same medical specialty is not represented on the Committee, the Health Choice Chief Medical Officer/Medical Director and/or the Committee may secure an ad hoc consultation and participation in the investigation from a provider of the same specialty.

☐ If the Health Choice Quality Management Committee determines, after initial review of all available information regarding a referred Quality of Care concern, that further information is needed, the Committee may invite the provider for a formal interview to obtain the provider's perspective on the case and/or send the provider a letter of inquiry.

☐ The Committee may take one or more of several possible actions:

1. It may impose concurrent or retrospective review of care for specified periods of time, or a Provider Focus Review.
2. It may recommend focused informal education for the provider, communicated by Health Choice staff.
3. It may recommend formal CME requirements.
4. It may recommend limitation of privileges, or termination of privileges.

PERFORMANCE MEASURES

As a health plan serving Medicare members, Health Choice Generations HMO is held accountable by The Centers for Medicare and Medicaid Services (CMS) to meeting performance outcomes, as identified in Part C and Part D Star Ratings. The Star Ratings are made up of several domains, including Staying Healthy: Screenings, Tests and Vaccines; Managing Chronic Conditions; and Member Experience, to name a few. The Star Ratings are also based on several sources of data and information, including but not limited to: HEDIS®, CAHPS®, Health Outcome Survey and Patient Safety, all which will be explained below.

HEDIS®: THE HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET

The **H**ealthcare **E**ffectiveness **D**ata and **I**nformation **S**et is the most widely used set of performance measures in the managed care industry. HEDIS® is designed to ensure that purchasers, regulators and consumers have the information they need to reliably compare the performance of managed care plans. The performance measures in HEDIS® are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. HEDIS® is developed and maintained by the National Committee for Quality Assurance (NCQA) with funding from CMS for the Medicare related measures.

HEDIS Measures included in the Star Ratings:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Care for Older Adults – Medication Review
- Care for Older Adults – Pain Screening
- Care for Older Adults – Functional Status Screening
- BMI Assessment
- Osteoporosis Management in Women Who Have Had a Fracture
- Comprehensive Diabetes Care – Eye Exam
- Comprehensive Diabetes Care – Monitoring for Nephropathy
- Comprehensive Diabetes Care – HbA1c Control
- Controlling High Blood Pressure
- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis
- All-Cause Readmissions

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®)

CMS is committed to measuring and reporting information from the consumer perspective for Medicare Advantage (MA) and Medicare Prescription Drug Plan (PDP) contracts. The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are a set of surveys that provide information to Medicare beneficiaries on the quality of health services provided through MA and Medicare Part D programs. Consumer evaluations of health care and prescription drug services, such as those collected through the Medicare CAHPS® surveys, measure important aspects of a patient's experience that cannot be assessed by other means.

The Medicare CAHPS® surveys produce data on the patient's experience of care on domains that are important to consumers, including: Your Health Plan, Your Healthcare in the Last 6 Months, Your Personal Doctor, Getting Healthcare from Specialists, Coordination of Care, Your Medicare Rights, Your Prescription Drug Plan, and About You.

Star Ratings include CAHPS® questions related to:

- Obtaining an Annual Flu Vaccine
- Overall Rating of Health Care Quality

- Getting Needed Care
  - *In the last 6 months, how often was it easy to get appointments with specialists?*
  - *In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?*

- Getting Appointments and Care Quickly
  - *In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?*
  - *In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?*
  - *In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?*

- Care Coordination
  - *When you visited your personal doctor for a scheduled appointment, how often did she/he have your medical records or other information about your care?*
  - *When your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your doctor's office follow up to give you those results?*
  - *When your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?*
  - *How often did you and your personal doctor talk about all the prescription medicines you were taking?*
  - *Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?*
  - *How often did your personal doctor seem informed and up-to-date about the care you got from specialists?*

HEALTH OUTCOMES SURVEY (HOS)

Each spring a random sample of Medicare beneficiaries is surveyed using the Health Outcomes Survey. Two years later, these same respondents are surveyed again to assess if beneficiaries' health was the same, better or worse than expected between the baseline survey and the subsequent re-measurement.

Stars Ratings include the following topics from the Health Outcomes Survey:

- Percent of all plan members whose physical health was the same or better than expected after two years.
- Percent of all plan members whose mental health was the same or better than expected after two years.
- Percent of senior plan members (≥65 years old) who discussed exercise with their doctor and were advised to start, increase, or maintain their physical activity during the year.
- Percent of plan members (≥65 years old) with a urine leakage problem who discussed the problem with their doctor and got treatment for it within 6 months.
- Percent of plan members (≥65 years old) with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.

PATIENT SAFETY

Performance and quality measures are used by CMS so that Medicare beneficiaries have the information necessary to make informed enrollment decisions by comparing available health and prescription drug plans. As part of this effort, CMS currently calculates and publicizes eight patient safety measures:

High Risk Medication (HRM)**
Diabetes Treatment (DT)**
Drug-Drug Interaction (DDI)
Diabetes Medication Dosage (DMD)
Adherence (ADH) for four therapeutic areas – Diabetes**, Hypertension**, Cholesterol**, HIV/AIDS

** Impact Stars Ratings

MEDICAL RECORD REQUESTS

Each year, Health Choice Generations HMO participates in an audit of the data collected for HEDIS measures that make up part of our Star Rating. We rely on participation from our partners and providers to have a successful audit.

Health Choice Generations HMO contracts with Inovalon to perform HEDIS® medical record data abstraction on its behalf. It is important that you know Inovalon serves Health Choice Generations HMO in a role that is defined and covered by the Health Insurance Portability and Accountability Act (HIPAA). As defined by HIPAA, Inovalon's role is as "Business Associate" of "Covered Entities," and as such, Inovalon is ethically and legally bound to protect, preserve, and maintain the confidentiality of any Protected Health Information (PHI) it gleans from clinical records provided by medical practice locations pursuant to its contractual obligations to Health Choice Generations HMO. In this setting, you may be assured that Inovalon will treat your patients' PHI with the appropriate level of protection and confidentiality.

The HEDIS® medical record data abstraction process will begin in late February or early March. Prior to conducting an onsite review, Inovalon will contact your office to schedule a visit and subsequently distribute information about the scheduled visit to explain its data abstraction process. Inovalon may also request that copies of chart components be sent via mail or fax for off-site review.

Your cooperation in extending Inovalon your professional courtesy is very much appreciated. If you have questions or concerns about any component of this process, please contact us at 480-760-4800. We thank you for partnering with us to improve the health of individuals, families, and communities.

Privacy

Health Choice Generations HMO appreciates the diligence of provider office staff in following protocol and protecting patient health information. Below are references to the disclosure and permitted use of such information for health care operations, including activities related to quality assessment and improvement.

In 45 CFR 164.502 (a)(1)(ii) Uses and Disclosures of Protected Health Information: general rules includes permitted uses and disclosures for the treatment, payment or health care operations, as permitted by and in compliance with §164.506.

In 45 CFR 164.506 (c)(4), the Privacy Rule states:

> *"A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is for a purpose listed in paragraph (1) or (2) of the definition of health care operations."*

In 45 CFR 164.501, Definitions, Health Care Operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions: (1) conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines…"

HIERARCHICAL CONDITION CATEGORY (HEALTH CHOICE C)

Health Choice will be working with our providers to enhance the documentation and coding of our Medicare members. Medicare requires appropriate condition coding (ICD9) to the highest level of specificity Through proper documentation and coding , your patients' medical conditions can be better understood and managed by all providers who serve them. Please look for more information in this in the coming months.