TheHealthPlan

Chapter 11

Quality

Introduction

The Health Plan (THP) is dedicated to ensuring that all federal and state laws, rules, and regulations are compiled in a timely and effective manner, including The Center for Medicare and Medicaid Services (CMS), The Bureau for Medical Services (BMS) and The Department of Insurance (DOI).

THP Quality Improvement Program consists of clinical and service components necessary to improve the quality and safety of member care.

The clinical component objectives include preventive care, acute care, chronic care, population health management, and care for special needs populations. The program description monitors compliance, health outcomes, health initiatives and health education, clinical practice guidelines, member experience, credentialing, delegation, and medical record audits.

The service component objectives monitor availability and accessibility, and member and practitioner experiences through the lens of surveys, complaints, and appeals.

The Quality Improvement Program ensures that members' and practitioners' needs are met, and continuous quality improvement is ongoing at THP.

The Quality Improvement Program is evaluated annually for its effectiveness. Barriers and opportunities for quality improvement are identified and are worked into future focus groups and/or initiatives.

The PDSA (Plan-Do-Study-Adjust) Cycle is utilized throughout the Quality Improvement Program when initiatives are taken into consideration. The PDSA Cycle is essential in understanding the impact of the interventions established for the initiatives.

Goals and Objectives

1. Demonstrate compliance with the following:
    - National Committee for Quality Assurance (NCQA)
    - Centers for Medicare and Medicaid Services (CMS)
    - QIarant - External Quality Review Organization for WV Department of Health Services (DoHS)
    - West Virginia Office of Insurance Commissioner (WV OIC)
    - Ohio Department of Insurance (ODI)

2. Monitor and improve continuity of care between practitioners and across practitioner settings

3. Establish standards and processes for measuring and improving the quality of care and services provided to members through:
    - Peer Review Processes
    - Medical Record Audits
    - Surveys: Consumer Assessment of Healthcare Providers and Systems (CAHPS), Medicare Health Outcomes Survey (HOS), Experience of Care and Health Outcomes for Behavioral Health (ECHO), Provider Satisfaction Surveys
    - Clinical Care
        - Medical/Surgical Potential Deviations in Care
        - Behavioral Health Potential Deviations in Care
        - Medicare Advantage, West Virginia Mountain Health Trust (West Virginia Medicaid, and WV Children's Health Insurance Program) and/or CMS driven clinical reviews which include:
            - Never Events (NE)
            - Hospital-Acquired Conditions (HAC)
            - Health Care-Associated Conditions (HCAC)
            - Provider Preventable Conditions (PPC)and other Provider Preventable Conditions (OPPC)
            - Key Performance Indicators (KPI) to ensure maintaining and exceeding established performance benchmarks
            - Performance Improvement Projects (PIPs)

4. Provide a platform for members and practitioners to express concerns regarding care and service experience:
    - Quality of care
    - Access to care
    - Customer Service
    - Billing/Financial Service by THP
    - Quality of practitioner office site

5. Implement initiatives to improve health care outcomes and clinical safety using evidence-based guidelines and resources

Clinical Care Quality Indicators

The Quality Improvement Department monitors quality of care concerns centered on evidence-based guidelines through a root cause analysis conducted by Quality & Performance Improvement Nurse Coordinators.

THP follows but is not limited to the following evidence-based guidelines:

- Agency for Healthcare Research and Quality (AHRQ) for PSI 90 Member Safety Indicators
- National Healthcare Safety Network (NHSN) for healthcare-associated infections
- National Quality Forum (NQF) for serious reportable events

CMS Star Ratings

The Centers for Medicare & Medicaid Services (CMS) evaluates Medicare Advantage (MA) and Prescription Drug (MA-PD) plans using a star rating system. The CMS Five-Star Quality Rating System provides helpful information to consumers, families, and caregivers for comparing MA-PD plans based on a one-to-five rating:

5. * * * * * = excellent
4. * * * * = very good
3. * * * = good
2. * * = fair
1. * = poor

Many measures included in the CMS rating system are preventive care and routine disease management.

For example:

- Staying healthy — screening, tests, and vaccines:
  - Breast cancer screening
  - Colorectal cancer screening
  - Annual flu vaccine
  - Improving and maintaining physical and mental health
  - Monitoring physical activity

- Managing chronic conditions:
  - SNP Care Management − Care for the older adult: medication review, functional status assessment, and pain screening
  - Managing osteoporosis in women who had a fracture
  - Obtaining diabetes care for eye exams, kidney disease monitoring, and blood sugar and cholesterol control
  - Controlling blood pressure
  - Improving bladder control
  - Reducing the risk of falling
  - Plan all-cause readmissions
  - Medication adherence and management (oral diabetics, hypertension, and cholesterol medications)

Practitioner Expectations

The Quality Improvement Committee (QIC) provides governance, oversight, and expertise in the review of health outcomes and appropriateness of care and utilization with objective evaluations of member care and experiences to promote enhancements and improvement in the quality and safety of clinical care and services provided.

THP's Quality Improvement Committee (QIC) identifies expectations and behaviors for THP participating practitioners.

Practitioners are expected to cooperate with THP's QI activities to improve the quality of care and services and member experience. Cooperation includes timely collection and evaluation of performance measurement data and participation in Quality Improvement programs. THP may use performance data for quality improvement activities.

Additional requirements include cooperation and engagement with potential quality of care root cause analyses, member complaints/grievances, and any review or reporting requirement including state or federal agency with authority i.e., National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data Information Set (HEDIS).

Practitioners are required to provide medical records to THP in a timely manner to meet regulatory requirements. This includes medical records needed to support risk adjustment and quality improvement initiatives.

THP is responsible for implementing procedures for reducing, suspending, or terminating a practitioner's participation for reasons relating to quality of care, competence, or professional conduct. Remedial action plans will be developed within 30 days of identification of the systemic problem. Corrective Action Plans may be instituted for any treatments, procedures, or services which indicate a practitioner is not practicing medicine in a manner that follows reasonable and prevailing standards of care or medical ethics. This may be identified through complaints, QI activities, failure to maintain adequate medical records, failure to provide adequate care or after-hours care.

Corrective actions may vary according to the situation and may include but are not limited to one (1) or more of the following as they relate to treatment, procedure, and service:

- Written warning to the practitioner
- Discussion with the practitioner
- Placing the practitioner under a focused review via medical review or reviews generated by claims data at scheduled intervals; results reported to the Quality Improvement Committee (QIC) who will direct further action of the corrective action plan
- Requiring the practitioner to enter a preceptor relationship with another practitioner, whereby the practitioner acting as the preceptor would monitor and observe the practitioner subject to corrective action, including examining medical records and interaction with members
- Requiring the practitioner to complete continuing medical education regarding treatment, procedure, or service in question
- Limiting the practitioner's privileges i.e., limiting the authority to perform certain procedures
- Recommendation for recredentialing on a shorter cycle
- Recommendation for contract termination

Final determination resulting in corrective action will be communicated to the practitioner in writing, setting forth the type and nature of the corrective action to be taken. Any corrective action will be monitored for compliance at intervals determined by the Quality Improvement Committee. The practitioner will be notified of the results of such monitoring and will be made aware of the termination or continuation of any corrective action as recommended by the QI Committee.

Continuity and Coordination of Care

THP supports the partnership of members and primary care practitioners to ensure continuity and coordination of care. THP's continuity and coordination of care policy specifies the following responsibilities:

- All practitioners involved in a member's care must share clinical information with each other and the member in a timely manner. Most referrals to specialty care should be submitted by the PCP. Treatment plans should specify an adequate number of direct access visits to specialty care to accommodate the treatment plan's implementation. Members are afforded direct access to behavioral health practitioners. All referral notifications will include a reminder to all parties to share clinical information in a timely manner
- Practitioners must document member input in all treatment plans submitted
- THP does not prohibit a health care professional from advising and advocating on behalf of a member
- Practitioners should provide information about the findings, diagnoses, and treatment options regardless of coverage, so the member can decide among all relevant treatment options
- Practitioners should provide members with information about risks, benefits, and consequences of treatment or non-treatment. Members should be provided with a choice to refuse treatment and discuss their preferences about failure of treatment decisions

Practitioner Availability Standards

THP has practitioner network adequacy standards that include adult and pediatric standards for PCPs and specialists, obstetricians/gynecologists, basic hospital services, tertiary hospital services, pediatric and adult dental practitioners behavioral health practitioners and facilities, substance use disorder (SUD) practitioners and facilities, and PRTFs.

Practitioners must ensure hours of operation are convenient, do not discriminate against members and have no less than hours of operation offered to commercial members or comparable to Mountain Health Trust (WV Medicaid and CHIP) members.

Practitioners cannot discriminate against MHT and WV CHIP members in the order that members are seen or appointments are given.

Screening for Behavioral Health Needs

THP encourages PCPs to assess members of all ages for behavioral health needs. If practitioners need assistance with a referral to a behavioral health specialist, contact THP's Behavioral Health Department at 1.877.221.9295 for assistance.

THP suggests the following when encountering a member who may be experiencing problems with substance use disorders:

- Ask about substance use and screen for problem use
- List the member's diagnosis in the medical record
- Refer to a qualified behavioral health clinician, when necessary
- Encourage the member to follow through
- Express interest in their progress

Practitioner Self Care/Treatment and/or Family Care/Treatment

THP follows American Medical Association (AMA) recommendations that practitioners should not treat themselves, their immediate family members, or their household members.

However, it may be acceptable to do so in limited circumstances such as:

- In emergency settings or isolated settings where there is no other qualified practitioner available
- For short term, minor problems
- Except in emergencies, it is not appropriate for practitioners to write prescriptions for controlled substances for themselves or their immediate family members

When treating self or family members, practitioners have a further responsibility to document treatment or care provided and convey relevant information to the member's PCP.

Practitioner Access Standards

Primary Care Practitioners (PCP)	
Routine Care	Within 15 business days
Urgent Care	Within 24 hours
Emergent Care	Immediately or referred to an emergency facility
Behavioral Health	
Routine Care	Within 10 business days
Urgent Care	Within 6 hours
Emergent Care	Immediately or referred to an emergency facility
OBGYN	
Routine Prenatal Care	Within 14 calendar days of the date the member is found to be pregnant
Routine Care for OB members or Non-OB Members	Within 15 business days
Urgent Care	Within 24 hours
Specialty Care	
Routine Care	Within 20 calendar days
Urgent Care	Within 24 hours

Mountain Health Trust only:

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services must be scheduled in accordance with EPSDT guidelines and the EPSDT Periodicity Schedule
- THP encourages members with Mountain Health Trust - Supplemental Security Income (SSI) to schedule an appointment with a PCP or specialist who manages the member's care within forty-five (45) calendar days of initial enrollment. If requested by the member or practitioner, THP schedules or facilitates an appointment with the member's PCP.

After Hours Accessibility

Practices are required to be available to THP members through on a call practitioner, answering service, or voice mail message directing the member to the Emergency Room if the case is emergent.