Purpose: This chapter provides a description of the Quality Management standards used at Health Partners Plans.

Topics:

- Quality Management principles
- Quality Management initiatives
### Table of Contents

**Overview**  
9-4

**Quality Management Principles**  
9-4

**Goals**  
9-4

- Program Compliance with Regulatory and Accrediting Bodies  
9-5

**Community Partnerships**  
9-5

**Program Components**  
9-5

**Quality Initiatives**  
9-6

- Quality Management Site Review Prior to Credentialing/Recredentialing  
9-7
- Member Satisfaction Survey  
9-7
- Provider Satisfaction Survey  
9-7

**Provider Quality of Care Sanctions and Appeals**  
9-7

- Quality of Care Levels  
9-7
- Quality of Care Sanctions  
9-8
- Responsibility and Authority  
9-8
- Sanction Process and Appeal Procedure  
9-9
- Appeal  
9-9
- Pharmacy Drug Utilization Review  
9-10
Overview

The Health Partners Plans Quality Management (QM) program supports the commitment of the organization to provide quality care and service in a cost-effective manner to its members. This is reflected in the National Committee for Quality Assurance (NCQA) awarding an accreditation status of Excellent to Health Partners Plans' Medical Assistance plan in 2006 and 2009 for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

The QM program is an organization-wide, dynamic, systematic program designed to monitor and oversee all aspects and components of care and service. Monitoring activities include credentialing, utilization management, appeals and grievances, complaints, access and availability of practitioners, assessment of member satisfaction, sentinel event monitoring, medical record reviews, pharmacy service drug utilization reviews, peer review and assessment of Health Partners Plans service improvements. Health promotion initiatives include disease management programs, promotion of preventive health screenings, pre- and postnatal case management and EPSDT. Health promotion initiatives include disease management programs, promotion of preventive health screenings, pre- and postnatal case management, EPSDT, Dual Special Needs Plan (D-SNP) Model of Care (MOC), and special needs case management.

Quality Management Principles

The QM program is based on the principles and concepts of continuous quality improvement.

The QM program is reviewed and approved annually by Health Partners Plans' Quality Management Committee and Board of Directors. Implementation of all QM activities is monitored by the Medical Director for Quality Management and Vice President of Quality Management. Updates may be made as necessary throughout the year. A summary of the QM program annual description and work plan is available on request by calling the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-14).

All Health Partners Plans participating providers are expected to support and participate in the QM program as identified in the provider contracts. Participation by the provider occurs by participation in various committees and task forces, review and recommendations for draft guidelines, provision of chart copies as requested, providing access to medical records for various chart review studies or investigation of member complaints and participation in the credentialing and re-credentialing process.

Goals

The primary goals of the QM program are to develop and refine monitoring systems that allow Health Partners Plans to identify opportunities for improvement in the quality of care being delivered and to craft interventions directed at these opportunities with the ultimate goal of improving the health outcomes of our members.
The specific steps in the process include: analyzing data collected by Health Partners Plans for selected quality of care and service indicators to assess plan performance; comparing plan performance to established benchmarks and goals; identifying opportunities for improvement as well as root causes or barriers for areas below goals; designing and implementing interventions that will increase the quality of care and service delivered to members; and re-measuring plan performance to identify the effectiveness of the quality improvement interventions and initiatives.

**Program Compliance with Regulatory and Accrediting Bodies**

Health Partners Plans' comprehensive Quality Management (QM) Program is developed and administered to be in compliance with the standards established by the National Committee for Quality Assurance (NCQA), the Pennsylvania Department of Human Services (DHS), the Pennsylvania Department of Health (DOH), the Pennsylvania Insurance Department (PID) and the Centers for Medicare & Medicaid Services (CMS).

Annually Health Partners Plans completes Healthcare Effectiveness Data and Information Set (HEDIS) data collection and tabulation. HEDIS is administered by the National Committee for Quality Assurance (NCQA) and is a standardized and comprehensive set of measures and reports that show how managed care plans compare regarding the care provided to members. Approximately 80 measures are reported to evaluate the effectiveness of services offered, utilization of services and member satisfaction. Some examples of these measures include use, accessibility, and availability of services and how the plan manages health problems such as heart disease, cancer, diabetes, asthma and smoking. The data is an important part of measuring the quality of care provided for our members. Additionally, HEDIS scores impact Health Partners Plans’ NCQA accreditation status.

**Community Partnerships**

Health Partners Plans has built strong partnerships within the communities we serve. We work with our local school systems to provide health education to our youth. We support the Segal Puppet Theatre, which presents “Tooth Buddy Tales,” a live puppet show about good dental health, to children from Kindergarten through 3rd grade at various schools in the HealthChoices zone. In addition, we partner with Need in Deed, an independent education organization that assists its school teachers in conjunction with their students to identify health topics for research and study. The Health Partners Community Educator enhances the topic with an interactive presentation.

**Program Components**

The QM program utilizes a variety of studies, quality indicators and routine performance monitors that provide an ongoing mechanism for quality improvement. Various performance measures are utilized to evaluate the QM program.

These performance measures include:

- Topic-specific focused reviews based on established standards, parameters, or guidelines
- Comprehensive medical record and office review of all PCP, OB/GYN and high-volume specialist sites at least every 24 months
- Preventive health/health status reviews (immunization, childhood, adolescent, adult, well elderly, obstetric)
- Population-based studies
- HEDIS measures
- PA performance measures
- Internal quality of care measures
- Disease Management Program studies
- Dual Special Needs Program (D-SNP) Studies
- Clinical and/or service audits as mandated by DHS and/or PID
- Member complaints and/or grievances
- Annual member satisfaction survey (CAHPS)
- Access indicators
- Availability indicators
- Annual provider satisfaction surveys
- Sentinel events monitoring
- Drug utilization review
- Inpatient quality of care referrals
- Over and underutilization reports
- Continuity and coordination of care monitoring
- Credentialing and re-credentialing of providers
- Evaluation and oversight of all delegations and subcontractors' quality management programs, including dental and vision services
- Adverse events - Hospital Care-Acquired Conditions (HCAC), Other Provider Preventable Condition (OPPC) and Potential Serious Adverse Effects (PSAE)

A summary of Health Partners Plans' Quality Management annual program description and work plan is available on request by calling Health Partners Plans (see Table 1: Service Department Contact Information on page 1-14).

Health Partners Plans specialists choosing to leave the network or otherwise becoming unavailable to members (for example, by limiting their practice) must notify Health Partners Plans in advance of that change, so we can notify members under their ongoing care.

In keeping with NCQA quality standards, Health Partners Plans requires that specialists provide 60 days advance notification to Health Partners Plans when:

- The entire practice terminates its participation with Health Partners Plans
- Any single specialist terminates participation under his/her Health Partners Plans contract
- Any single practitioner within a group practice, or the entire specialty group, leaves or becomes unavailable to members

**Quality Initiatives**

The Quality Management Committee and the Board of Directors have identified and prioritized activities on which to focus for the future. These initiatives reflect the goals and previous performance levels of Health Partners Plans, as well as the managed care rules and regulations of the Department of Human Services, Pennsylvania Insurance Department, Department of Health and CMS. Please refer to the Healthier You section for a listing of Health Partners Plans clinical quality
programs. The clinical quality programs assist Health Partners Plans to continually improve the health outcomes of our members.

**Quality Management Site Review Prior to Credentialing/Recredentialing**

Health Partners Plans staff performs site assessments of potential obstetric, high volume specialist and primary care providers prior to presenting these providers to the Health Partners Plans Credentialing Committee. This review consists of a two-part assessment by Quality Management Coordinators. The first part is an on-site review to assess physical location, staffing, office hours and access. Also assessed are housekeeping, confidentiality and organization of records, equipment, safety measures, and availability of patient education materials. The second part includes a review of medical records to assess performance regarding overall medical record keeping practices and preventative care audits for pediatric, adolescent, adult, well elderly and obstetric populations, as applicable. Once completed, the results are considered by the Credentialing Committee prior to credentialing/re-credentialing.

Site review results are forwarded to each practitioner/practice. If the results in any of the categories listed fall below established target goals or expectations, the Quality Management (QM) department develops a Corrective Action Plan in cooperation with the provider. The mutually agreed upon corrective action plan includes a specific time frame for implementation. The results of the Corrective Action Plan are monitored by the QM department and a follow-up audit is performed. Oversight of this process is provided by the Quality Management Committee.

**Member Satisfaction Survey**

Health Partners Plans commissions an outside agency to perform the Consumer Assessment of Health Providers and Systems (CAHPS) survey in accordance with HEDIS and NCQA requirements. Members are specifically asked to rate quality of service, quality of care, and satisfaction with their providers of care, the health plan and the Utilization Management program. After results are reviewed by the QM Committee, providers may be asked to review the results and comment, when appropriate, on their plans to address identified problem areas. Providers may also be asked to participate in initiatives aimed at increasing customer service awareness.

**Provider Satisfaction Survey**

Health Partners Plans conducts an annual satisfaction survey of the provider network to assess satisfaction with the plan. The survey tool also allows for comments and recommendations from the provider network. The responses provide a catalyst for an internal review of Health Partners Plans' programs and services, helping to identify areas of strength and opportunities for improvement. The results are reviewed by the QM Committee, a peer review committee that provides input on the findings and Health Partners Plans strategies to improve satisfaction and services.

**Provider Quality of Care Sanctions and Appeals**

The following section provides an overview of possible sanctions and the appeal process associated with Quality Management initiatives and actions.

**Quality of Care Levels**

Quality of Care levels are numerical codes used to categorize the severity of an event that may constitute a potential adverse effect. These codes are assigned during the investigation and review
process by the QM department (levels 0 and 1) or the QM Committee (> level 1). There are four levels currently used in this process.

These are:

- **Level 0 - No Quality of Care Concern(s) Identified**
  There was no adverse member outcome. Clinical issue identified and/or an issue could not be substantiated due to a lack of information.

- **Level 1 - Quality of Care Concern(s) Identified, No Risk of Patient Harm**
  A physical or mental health incident has been identified, but appears to have not caused harm/damage to the member.

- **Level 2 - Quality of Care Concern(s) Identified, Potential for Harm but not Identified**
  An incident has been identified and appears to have contributed to harm/damage in which the member has fully recovered.

- **Level 3 - Quality of Care Concern(s) Identified, Potential for Patient Harm**
  An incident has been identified and appears to have contributed to the permanent harm/damage/death of the member.

**Quality of Care Sanctions**

It is the goal of Health Partners Plans to assure the provision of quality health care services in an efficient and economical setting. A provider may be subject to quality of care review and sanctions by Health Partners Plans when a review of an individual incident or a trend of data reveals that a practitioner or provider is not in conformity with local standards of care or practice, quality management and utilization management criteria; has failed to adhere to policies and procedures established by Health Partners Plans; or has failed to demonstrate improvement following a specific corrective action process.

Quality of care sanctions for Health Partners Plans providers will be determined on a case by case basis. Quality of care sanctions may apply to any service provided where a review indicates there was a deviation from the standard of care regarding diagnosis, treatment, or expected outcome.

The appeal process applies to any provider who has received a quality of care sanction from Health Partners Plans.

**Responsibility and Authority**

A Health Partners Plans Medical Director will review all potential quality of care sanctions. Sanctions for quality of care will be reported to the Quality Management Committee (QMC), a subcommittee of the Board of Directors. A Health Partners Medical Director will review all potential quality of care sanctions. Sanctions for quality of care will be reported to the QMC and to Health Partners Plans' Chief Medical Officer (CMO). All sanctions that may lead to termination of a provider's Agreement with Health Partners Plans are also discussed with the CMO, who reports to the President and Chief Executive Officer (CEO) of Health Partners Plans, prior to any termination action being taken.
Cases where a potential for immediate harm to members is identified will be reviewed with a Health Partners Plans CMO or their designee who can act immediately to terminate health plan participation if patient welfare will be compromised by delay. An investigation of the facts and circumstances will take place prior to the termination action.

Sanction Process and Appeal Procedure
If, following review of the individual circumstance, Health Partners Plans determines that the provider's treatment and care of a member is not in conformity with local standards of care and practice, quality management and utilization management criteria, or the provider has failed to adhere to policies and procedures established by Health Partners Plans, then a Health Partners Plans CMO or designee may issue sanctions.

The sanction process will typically work as follows:

1. The provider will receive a letter identifying the issue(s) and will be provided an opportunity to conform to the appropriate procedures and protocols within a specified time frame.
2. Repeated instances of nonconforming behavior may subject the provider to a second letter and the provider will not be permitted to accept additional members until all issues are resolved to the satisfaction of Health Partners Plans.
3. Failure to conform thereafter will be grounds for immediate termination of the provider's agreement with Health Partners Plans.
4. Notwithstanding the foregoing, if, in the sole discretion of Health Partners Plans, the provider's behavior is egregious, negligent, criminal, or threatens the ability of Health Partners Plans to ensure quality health care to members, the provider agreement may be terminated immediately. In the event of such termination, the provider will not be permitted to accept additional members and the provider's current member panel will be advised that the provider is no longer a physician authorized to provide medical services to Health Partners Plans members. Cases when there is a potential for immediate harm to members will be reviewed with the Health Partners Plans CMO, who can act immediately to terminate health plan participation if patient welfare will be compromised by delay. An investigation of the facts and circumstances will take place prior to the termination action.

Appeal/Sanction Dispute
The provider may dispute the proposed quality of care sanctions by sending a “Dispute Letter” to Health Partners Plans, Attn: Legal Affairs Dept., within 30 calendar days of the notice of action or sanction. This Dispute Letter shall either waive the provider’s right to a sanction hearing or request a sanction hearing. If the provider waives his/her right to a hearing, the Dispute Letter shall detail the reason(s) such action or quality of care sanction should not be implemented.

If no Dispute Letter is received by Health Partners Plans within 30 days of the notice of action or sanction, then the proposed sanction will become final and Health Partners Plans will implement the sanction as soon as practical.
If the provider timely submits a Dispute Letter, Health Partners Plans will appoint either a single hearing officer (not employed by Health Partners Plans) or a three-person Sanction Review Panel to hear the provider's dispute. A sanction hearing date will be scheduled within 60 days of Health Partners Plans receipt of the provider’s Dispute Letter.

At least 20 days in advance of the sanction hearing, Health Partners Plans shall notify the provider of the date, time, and location of the hearing, and the name(s) of the hearing officer or panel members, and the name(s) of any witnesses expected to testify on behalf of the Plan/the QMC. The hearing will be coordinated by Health Partners Plans’ Legal Affairs department.

In the hearing notification letter, Health Partners Plans shall notify the provider of his/her right to be represented at the hearing by an attorney or other representative, the provider's right to call, examine and cross-examine witnesses, his/her right to submit a written statement at the close of the hearing, and his/her right, upon timely notice given to Health Partners Plans, to have a record made of the hearing at the provider’s expense. The hearing notification letter will also notify the provider that if the hearing panel affirms Health Partners Plans’ proposed sanction, the provider is required to pay the reasonable costs of the hearing incurred by Health Partners Plans, including but not limited to any expert witness expenses, costs of transcripts, and attorney’s fees.

At least ten (10) business days in advance of the hearing, the provider must notify Health Partners Plans in writing of the names of the provider's witnesses and all supporting documentation the provider intends to present at the hearing. Also, should the Provider wish to be represented by an attorney or other representative at the hearing, the Provider must also notify Health Partners Plans of the representative’s name at least ten (10) business days in advance of the hearing.

The hearing officer or panel shall make a written report of its decision and the basis thereof, within thirty (30) days of the sanction hearing date. Health Partners Plans shall notify the provider of the hearing officer or panel’s final decision within thirty (30) days after its receipt of the hearing panel’s conclusion.

Regardless of whether a sanction hearing is held, those incidents that result in Health Partners Plans or its designee to limit a physician’s clinical privileges for more than thirty (30) days, or result in a quality of care termination are generally considered to be a reportable sanction. The reporting to the National Practitioners Data Bank and DHS is done by Health Partners Plans.

**Pharmacy Drug Utilization Review**

The Health Partners Plans pharmacy drug utilization program is coordinated with our quality assurance programs to achieve quality care through a disease management approach.

The pharmacy Drug Utilization Review Program (DUR) is designed to identify and correct potentially harmful prescribing patterns, enhance community-prescribing standards, and detect patterns of fraud and abuse. The policy and procedures meet federal statute/regulations citation Section 4401 (g) of OBRA “93” and 42 CFR 456, as well as NCQA guidelines. Health Partners Plans’ continuous quality improvement philosophy allows for annual evaluation and assessment of
the program, resulting in the implementation of improved programs that are responsive to the needs of our members and providers.

The Prospective DUR system provides us with the ability to minimize the number of potentially dangerous conditions that result from improper drug utilization.

The system achieves this objective by:

- Reviewing prescription drug claims for therapeutic appropriateness prior to medication dispensing;
- Using criteria that include the patient’s medical history and clinical parameters; and
- Focusing on those members with conditions that place them at the highest level of risk for a potentially harmful outcome.

The system evaluates each incoming drug claim when the pharmacist enters the information for the prescription with respect to the member’s drug and medical history. The system identifies potential drug therapy problems. Monitoring is accomplished through an online alert message system that transmits a message in conjunction with claim adjudications that may present potential therapeutic problems. When appropriate, the pharmacist receiving this advice then takes additional steps to evaluate the order, such as calling the prescribing physician.

The following drug therapy problems types are evaluated:

- excessive drug dosage (age-specific)
- insufficient drug dosage (age-specific)
- drug pregnancy contraindications
- excessive quantity dispensed
- early refill (over utilization)
- late refill (underutilization)
- drug age contraindications
- drug to drug interactions
- therapeutic duplications
- drug to diagnosis contraindications
- generic product availability

All criteria are rated using the following severity indicators:

- cause serious harm to relatively few people (high risk and low incidence),
- cause relatively minor harm to a large number of people (low risk and high incidence), and
- significantly increase the cost of health care by increasing hospitalizations or other treatment modalities

In the event a medication requires prior authorization, a system alert message will appear, advising the pharmacist to call for prior authorization.
A claim that is submitted either online (or, if previously approved for paper, via paper claim) by a participating pharmacy and subsequently approved for payment that includes DUR messages is subject to post-payment audit and recoupment if written documentation is not maintained that pertains to the message(s) returned with the claim. If a message is returned saying that the approved claim has a dosage that exceeds standards developed by a national database company, and no notation is retrievable that documents a discussion between the pharmacist and the prescriber verifying the high dose, the claim is subject to reversal upon audit. Likewise, a claim paid but returned with duplicate therapy message is subject to reversal unless there is documentation demonstrating that the prescriber spoke with the dispensing pharmacist and approved the concurrent administration of both drugs involved.