

QUALITY IMPROVEMENT

Section 9

Quality Improvement Program

The purpose of the Quality Improvement program is to establish a systematic process of Quality Improvement that will ensure a comprehensive, integrated plan-wide system to assess and improve the quality of clinical care and services provided to its members.

The goals of the Quality Improvement Program are:

- To improve the quality of services delivered to its members;
- To ensure the availability of, and access to, qualified and competent providers;
- To provide members with quality health care within a system that promotes efficient use of resources and supports the provider-patient relationship;
- To ensure provider input into the Quality Improvement Program activities; and
- To ensure care will consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, industry and community standards of care and Plan documentation.

The objectives of the Quality Improvement Program are to:

- Monitor and evaluate health care and Plan services;
- Monitor and verify clinical competence;
- Establish and apply clinical indicators and standards;
- Implement action plans in response to identified opportunities for improvement;
- Evaluate the effectiveness of action plans and take additional action when needed;

QUALITY IMPROVEMENT

Section 9

- Evaluate member satisfaction with health care and other Plan services;
- Evaluate provider satisfaction with the Plan's programs and services;
- Manage the utilization of resources;
- Maintain record keeping of all Quality Improvement program activities; and
- Report findings, actions taken and their outcomes to the Board of Directors, Plan administration and staff, providers and members.

The Quality Improvement Program addresses the key areas of access, availability, utilization, quality of care, clinical competence, credentialing, appeals and grievances, member satisfaction, provider satisfaction and administrative services. All product lines, demographic groups, care settings and types of services are included in the program.

The program establishes indicators, standards and benchmarks to use in the evaluation of these areas. Compliance with the established standards is measured and the results of this measurement are profiled. The resulting information is used in the identification of opportunities for improvement in the quality of health care and other services, and the development of program initiatives. Evaluation of the effectiveness of actions taken and program initiatives is performed. The Quality Improvement Program activities are communicated to the Board of Directors, Quality Improvement Committee, Medical Advisory Committee, administration, staff, providers and members.

The Quality Improvement Program incorporates continuous quality improvement processes. This strategy is demonstrated by the structure of the Quality Improvement Program's committees and sub-committees, the QI program description, work plan and annual evaluation. The strategy incorporates the continuous

QUALITY IMPROVEMENT

Section 9

tracking and trending of quality indicators to ensure outcomes are being measured and goals are attained. Copies of the quality descriptions, plans and evaluations can be obtained by contacting your local Quality Improvement team.

External Quality Review

The Plan is required to participate in specific reviews conducted by External Quality Review Organizations and Medicare QIO Programs. These reviews are focused on improving care for beneficiaries enrolled in managed care.

Providers contracted with the Plan are required to participate in all quality improvement functions and tasks required by the QIO. These activities may include but are not limited to:

- Compliance with request for medical records for quality improvement studies and audits;
- Cooperation with quality improvement initiatives related to collaborative projects;
- Cooperation with efforts to improve care for chronic disease and/or preventive care measures; and
- Compliance with requests for information and recommendations for reviewing and resolving beneficiary and/or provider complaints.

Audits are conducted according to local, state and federal guidelines. Providers may be asked to provide copies of office records for these audits. It is very important that the entire record is sent any time a copy of a record is requested.

In addition to monitoring the guidelines in this manual, continuity of all patient care will be monitored (see the **Medical Records** section). The results of all reviews are maintained in a Provider Profile and utilized at the time of re-credentialing.

QUALITY IMPROVEMENT

Section 9

Provider Participation with QI Activities

In accordance with regulatory contracts, accreditation guidelines, the Trust Program and all of its provisions, and Harmony Health Plans, Inc. (the Company's) high standards of business ethics, the Company requires its providers to contractually agree to participate in quality improvement activities.

The following quality improvement activities are required of the provider:

- Medical Record Reviews – Providers are required to copy and provide access to medical records for quality improvement review activities.
- Types of review may include:
 - Medical record content
 - Continuity of care
 - Adult health screening
 - Pediatric health screening
 - Diagnosis specific screening
 - Maternity care
 - HEDIS[®] review
 - Quality of care review to investigate a complaint or grievance
 - Requests for internal QI data from delegated entities
 - State reviews
 - Federal reviews
 - EQRO (External Quality Review Organization)
 - Quality Improvement Organization review
- Disease Management Initiatives to improve health outcomes for members.
- Medicare National QI Projects as established by the Quality Improvement Organizations.
- State QI Projects as established by the External Quality Review Organization for each state or the state Medicaid agency.

QUALITY IMPROVEMENT

Section 9

Corrective Action Plan (CAP) Follow-up:

All reviews in a provider office will conclude with an Exit Review, to include the provider and designated office staff. The provider will be given the results of the review. Any area that is not compliant with regulatory standards will require a plan of correction.

The Corrective Action Plan will be given to the provider at the time of the Exit Review. The CAP must be signed by the provider and faxed or mailed at that time or within 10 days of the review.

In the event a CAP is not received in the stated time frame, a second request will be sent to the provider.

In the event a CAP is not received after the second request, a final request will be sent to the provider informing him/her that new member assignments will be deferred until the signed CAP is received. Re-credentialing will not occur while CAPs are outstanding.

Selected participating contracted providers will be represented on the appropriate quality improvement committees, this may include the: Medical Advisory Committee, Credentialing Committee, Pharmacy and Therapeutics Committee and Utilization Management Committee.

Access to Records

- Access is required to all Plan member medical records in the office or facility for review.

Other Requirements

- Improve the scope and quality of services provided to beneficiaries;
- Promote disease prevention and health promotion programs;

QUALITY IMPROVEMENT

Section 9

- Meet local, state and federal quality parameters;
- Ensure timely response to requests for medical record documentation;
- Enhance work practices to incorporate corrective action plan recommendations; and
- Provide access to, and photocopies of, office records to the Plan, local, state, federal and External Quality Review Organizations for quality initiatives, as requested.

Quality Improvement Activities

The following are Quality Improvement activities performed by the plan on an ongoing basis:

- HEDIS® Reviews
- Performance improvement projects (clinical & administrative)
- Member and provider satisfaction surveys
- Member and provider outreach and educational sessions
- Research of referrals for quality issues
- Disease and case management initiatives
- Local, state and national collaborative QI projects
- Provider specific issues identified through tracking and trending of complaints or referrals
- Medical record content reviews – see the **Medical Records** section for specific documentation standards and requirements.

Results of all reviews will be maintained and utilized during re-credentialing and re-contracting activities.

Quality-of-Care and Quality-of-Service Issues

It is the policy of Harmony Health Plans, Inc. (the “Company”) to maintain an accurate and consistent means of identifying, investigating, tracking, trending and reporting potential and/or actual quality issues, be they quality of care (QOC) or quality of service (QOS) in nature.

QUALITY IMPROVEMENT

Section 9

Issues will be tracked and trended by volume or occurrence.

QOC issues may be identified by members, providers or any department within Harmony, including but not limited to, Customer Service, Appeals and Grievance, Regulatory Affairs, Provider Relations, Risk Management, Health Services (UM/CM/DM/QI) or the medical director(s).

Any record review identifying possible quality of care issues will be referred for peer review. In the event the peer reviewer/panel feels there is a possible quality of care issue, the provider will be asked, in writing, to provide additional information to address the issue. The response is reviewed and a final determination is rendered. If the peer review panel does not receive a written response from a provider, a decision will be rendered and reported to the appropriate agencies without input from the provider.

Refer to the next two pages for charts with information on QOC and QOS issues.

QUALITY IMPROVEMENT

Section 9

QOC ISSUE CATEGORY	TYPES
Procedural Issue	Surgery performed on wrong side of patient's body
	Surgery performed on the wrong patient
	A foreign body left in a patient after surgery
	Anesthesia-related event that lead to death or serious disability
	Inappropriate/incorrect performance of a procedure
	A medical procedure that actually or has the potential to cause a patient's death, paralysis, coma or other major permanent loss of function
Medication Issue	A medication error that actually or has the potential to cause a patient's death, paralysis, coma or other major permanent loss of function. Includes but not limited to: omission error, dosage error, dose preparation error, wrong time, wrong rate of administration, wrong administrative technique and wrong patient
Delay/Omission of Care	Performance of a test
	Medical or surgical consultations
	Treatment or procedure
	Unanticipated readmission within 30 days with the same or a related diagnosis
	Misdiagnosis
	Inadequate assessment
Death or Serious Disability	During or immediately following a surgical procedure
	Associated with elopement
	Associated with suicide/attempted suicide
	Associated with birth (maternal)
	Associated with birth (child) unrelated to a congenital condition in a newborn having a birth weight greater than 2500 grams
Post-op Complications	Wound dehiscence resulting in increased length of stay and/or return to surgery
	Wound Infection resulting in increased LOS
	Hemorrhage
	Perforation, laceration or tear
	Admission after outpatient surgery
Patient Safety	Patient abduction from the facility
	Sexual assault/harassment
	Nosocomial infection
	Fall
	Restraint-related
	Transfusion-related

QUALITY IMPROVEMENT

Section 9

QOS ISSUE CATEGORY	TYPES
Access/Availability Issues	Long wait time in provider office
	Unable to obtain a timely appointment for acute illness, routine care, emergent care or sick care
	Provider office unacceptable distance
	PCP unable to provide medical coverage 24 hours a day, seven days a week
Referral issues	Pre-certification not completed by the provider
	PCP delay in specialist referral
Balanced Billing	PCP billing member balance of covered services
Environmental	Office cleanliness
	Safety: building condition, parking, equipment
Interactions	Communication problem with physician/office staff
	Conduct issue or rude treatment by physician/office staff
	Discriminatory treatment or cultural competency issues

Medical Record Review

Medical record review is conducted to assess the quality of care delivered and documented and compliance with accreditation and regulatory bodies. In addition, assessment is conducted for over- and under-utilization and inclusion of consideration of member input into treatment plan decisions. Medical record reviews may include, but will not be limited to, well visits, members with special health care needs, compliance with clinical practice guidelines, adult preventive care, quality of care issues, compliance with coding practices and medical record documentation.

Policy:

In order to provide consistent quality of care to the members, Harmony Health Plans, Inc. (“the Company”) will adopt medical record review guidelines to promote the appropriate medical record documentation and management of patients. The review will identify areas of medical record documentation and management that may be improved, provide feedback to the providers and identify areas of practice that require peer review. The reviews will seek to identify appropriate utilization of services and inclusion of beneficiary input into the treatment planning process.

QUALITY IMPROVEMENT

Section 9

The findings of the review will provide a performance profile to be utilized during the credentialing process. The medical director, Quality Improvement department and medical staff members will develop criteria for use in the screening of medical records, utilizing the local, state and federal guidelines. The criteria will be reviewed annually to determine if modifications are needed to reflect contractual changes, current knowledge and experience in the management of medical records.

A sample of providers' members will be selected and reviewed in order to determine if there is documentation of the appropriate health screening, medical record content, continuity of care and applicable disease-specific reviews.

Medical record review for content and continuity:

- All medical records shall include the quality, quantity, appropriateness and timeliness of services performed.
- The medical record will have evidence of the following:
 - a. Entries made in the medical record will be:
 - i) Authenticated; name and profession of provider rendering services, (MD, DO, OD), including the signature or initials of the provider;
 - ii) Dated, with the date patient was seen and signed by the appropriate party;
 - iii) Legible;
 - iv) Maintained in an orderly and detailed fashion to facilitate review/follow-up.
 - b. Entries made in the medical record will be timely and contain the following:
 - i) Member identifying information; Personal and biographical data; name, member identification number, date of birth, address, telephone number, sex, legal guardianship (if any);

QUALITY IMPROVEMENT

Section 9

- ii) Allergies, NKA or untoward reaction to medications in a conspicuous place;
- iii) Past medical history; Medical records of previous practitioner to determine periodicity schedule;
- iv) Immunization history;
- v) Medication list, current and past medications;
- vi) Problem list: summary of significant surgical procedures, past and current diagnosis or problems, untoward reactions to drug;
- vii) Information relating to the use of tobacco products and alcohol or substance abuse and follow-up;
- viii) Documentation that the member was provided written information concerning his/her rights regarding Advance Directives and whether or not he/she has executed an Advance Directive. Neither the Plan nor the provider shall, as a condition of treatment, require a member to execute or waive an Advance Directive;
- ix) Primary language spoken by the member and any translation needs;
- x) Communication assistance needs in the delivery of health care services;
- xi) Domestic violence screening and follow-up;
- xii) Consultations and specialty referrals and follow-up;
- xiii) Diagnostics and results;
- xiv) Summaries of emergency services and care and follow-up;
- xv) Hospitalization – discharge summary and discharge plan and medically indicated follow-up;
- xvi) H&P examinations: the chief complaint or purpose of the visit, the objective diagnoses, medical findings or impression of the provider;
- xvii) Plan of treatment: diagnostic tests, and studies ordered, therapies administered and prescribed regimens, disposition, recommendations and instructions to the patient, evidence of whether there was follow-up and outcome of services;

QUALITY IMPROVEMENT

Section 9

- xviii) Documentation of member's input into treatment plan;
- xix) Documentation of services provided to its members by providers. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases.

Fraud and Abuse

The Plan is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. The Plan has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Effective detection tools have been developed to identify patterns of health care service use, including over-utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement and the Plan vigorously investigate incidents of suspected fraud and abuse. Service providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Providers' Current Procedural Terminology (CPT), the Health care Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement, may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

QUALITY IMPROVEMENT

Section 9

To report suspected fraud and abuse, please refer to your **Rapid Reference Guide** in this manual and call our confidential Trust Program Hotline.

Fraud and Abuse Definitions

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Some examples of health care fraud include, but are not limited to the following:

- Falsifying any medical record, note, diagnostic test result, report, claim, or any financial, administrative or clinical documents used to validate services.
- Billing for services, supplies, or equipment not actually furnished to any health plan member.
- Providing false and intentionally misleading information regarding health plan coverage, limitations, and exclusions to any health plan member.
- Misrepresentation of any date of service, frequency, duration, or description of any service, or the identity of the recipient of such services, or the identity of the service provider.
- Billing for non-covered or non-chargeable services, supplies, or equipment disguised as any covered or chargeable service.
- Duplicate billings (e.g., billing more than once for the same service, multiple providers billing for the same service for the same member on the same day, billing the health plan and the member for the same services, or submitting claims to both the health plan and other third parties without making full disclosure of relevant facts to all parties).

QUALITY IMPROVEMENT

Section 9

- Providing payment or other inducement to any health plan member in exchange for the use of their identification card or other member information with or without the permission of the health plan member for the purpose of obtaining wrongful payment.
- Receipt or offering of any unlawful kickback, gratuity or other inducement made with the intent to increase referrals.
- Reciprocal billing (e.g., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than claimed).
- Practicing medicine or other health care without a valid license, or with an expired or revoked license, or without proper credentials or while excluded from participation in any federal or state health care program.
- Any agreement or other arrangement between a provider and a health plan member that results in claims for unnecessary costs or charges to the health plan (e.g., providing health care services, supplies, or equipment to an ineligible person that is in possession of a health plan member's identification card, or any fraudulent scheme involving the use of member information to submit false claims).
- Any other intentional misrepresentation of a material fact regarding the provision of health care services for the purpose of obtaining wrongful payment.

Abuse is defined as provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

QUALITY IMPROVEMENT

Section 9

It also includes member practices that result in unnecessary cost to the Medicaid program.

Some examples of health care abuse include, but are not limited to the following:

- Unauthorized waiver or reduction of applicable member co-payment or deductible.
- Billing for services, supplies or equipment in any amount in excess of the applicable federal and/or state fee schedules, negotiated or contract rate.
- Direct or balance billing of health plan members where prohibited.
- Billing for services that are not medically necessary, or if medically necessary, not to the extent actually provided.
- Providing health care services of an inferior quality (i.e., services that do not meet generally accepted standards of care), or in an inappropriate setting, or at a level of care that is in excess to medical necessity.
- Failure to fully document services according to generally accepted standards (i.e., records must be legible, clearly document the services provided, etc.) and maintain adequate clinical, financial, and other records substantiating claims.

Special Investigations Unit

A corporate Special Investigations Unit (SIU) has been established according to federal and state statutory, regulatory and contractual requirements and includes management, investigators, analysts, medical coding auditors and claim review specialists. SIU capabilities include pre-payment and retrospective reviews, provider profiling models, performance metrics, data mining, analysis and reporting and specialized business partner arrangements to augment in-house resources.

QUALITY IMPROVEMENT

Section 9

The mission of the corporate SIU is outlined below:

- Comply with applicable federal and state statutory, regulatory, and contractual requirements regarding fraud, waste, and abuse;
- Effectively detect, investigate and report suspected fraud, waste, and abuse;
- Identify and recover overpayments caused by error, fraud, waste, or abuse;
- Assist in the development of anti-fraud plans, policies and procedures, and fraud and abuse awareness, education and training materials;
- Assist in conducting education and training for associates, providers, members, first-tier, delegated and related entities on fraud and abuse awareness and other related topics according to established training schedules; and
- Assist in conducting vulnerability assessments, auditing and monitoring activities of first-tier, delegated and related entities.

HEDIS Indicators

The Healthcare Effectiveness Data and Information Set (HEDIS)[®] is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS consists of 71 measures across eight domains of care.

The HEDIS measures are specifically defined and provide the plan with a means to assess provider and health plan success with provision of services and access to care. HEDIS results also assist the plan with success of efficacy with quality improvement initiatives as well as providing indications for future improvement initiative projects.

HEDIS measures address a broad range of important health issues.

QUALITY IMPROVEMENT

Section 9

Among them are the following:

- Asthma medication use
- Persistence of beta-blocker treatment after a heart attack
- Controlling high blood pressure
- Comprehensive diabetes care
- Breast and cervical cancer screening
- Antidepressant medication management
- Immunization, vaccination and well visit status
- Advising smokers to quit
- Colorectal cancer screening
- Access to care and availability of services

Provider Participation

If you would like to learn more about the Plan's Quality Improvement Program, work plans and initiatives please contact your local Quality Improvement Representative.