# SECTION 7 QUALITY MANAGEMENT

The Quality Management (QM) Program is designed to integrate quality clinical care and service within Health Alliance, the Carle System, health plan partners and contracted providers. Quality Management works in tandem with all departments to establish, coordinate and execute a structure to support Health Alliance members to improve their health and assess and evaluate the care and service provided.

## Definition of Quality

- Clinical quality is defined as minimum variation from evidence-based practice or expert consensus.
- Service quality is defined as meeting or exceeding the valid service requirements of our customers.

## Purpose

The purpose of the Quality Management Program is to design and implement quality improvement activities utilizing an integrative process of continuous assessment and monitoring that strives to improve medical and behavioral health care and service provided to all Health Alliance members across all product lines. Based on quality measurements and continuous evaluation of the program components as outlined in the annual QI Plan/Roadmaps, opportunities for improvement are identified and serve as the basis for restructuring/developing and/or initiating new tactics to enhance the quality of care and service provided to our members by improving efficiency, increasing the span of healthy life and reducing disparities in the healthcare provided. The Quality Management Department is committed to ensuring that the care delivered to our members is of the highest "value" with value defined as quality + service/cost.

## Goals

The goals of the Quality Management program include:

A. Identifying needs of the populations served through annual population assessment data.
B. Focusing on medical and behavioral health clinical care and service measures based on priority needs and adhering to NCQA, HPMS, CMS, state and health plan requirements.
C. Assessing performance, measuring the effectiveness of interventions and implementing actions as needed to improve medical and behavioral health care and service.

## Program Components

Oversight of the quality functions by the Quality Improvement Committee (QIC):

1. Monitor the information sources used for quality management core processes.
2. Facilitate a partnership between practitioners, providers, members, and Health Alliance for the purpose of maintaining and improving plan-wide care and service.
3. Develop and maintain approaches to support high-quality medical and behavioral health care, including disease management, clinical practice guidelines, utilization criteria and guidelines, complex case management, peer review, pharmaceutical management procedures, ambulatory medical record criteria, and processes to enhance communication and continuity of care between practitioners and providers.
4. Involvement of designated behavioral health care practitioner to address behavioral health issues.
5. Develop and maintain a utilization management (UM) program that incorporates nationally recognized criteria, use of appropriate clinical professionals, risk management, member and practitioner appeal rights, and appropriate handling of denials of service.
6. Develop and maintain a pharmaceutical management program that includes the development of policies and procedures, processes for restrictions and preferences, patient safety including medication therapy management and update of procedures, participation of pharmacists and physicians, notification to practitioners, and prior authorization processes including denials and appeals.
7. Provide access to information about patient safety to members and practitioners through the Health Alliance website and encourage accountability for patient safety with contracted providers through our adverse events and quality of care processes.
8. Develop and promote preventive health standards, family planning services and programs to encourage members and practitioners to utilize appropriate guidelines and early detection services for prevention of illness.
9. Provide an appeals process designed to protect the rights of the member, physician and hospital as fully as possible. Ensure that any member, provider or practitioner affected by an adverse

determination is given the opportunity to appeal through a verbal or written request for medical and administrative review.

10. Establish standards and processes for maintenance and oversight of delegated activities, as applicable.
11. Establish an annual QM Plan that describes specific activities undertaken each year to address the components of the QM program.

## Structure of Program

The Quality Management Program provides a comprehensive structure to identify, evaluate and improve clinical care and service provided to members individually and collectively. The Health Alliance Board has designated the day-to-day accountability of the quality and medical management program to the Health Alliance Chief Medical Officer and Director of Quality Management with reporting accountability to the QIC. Subcommittees, workgroups and operational teams of the QIC provide a focus on initiatives involving quality improvement such as members' rights and responsibilities, credentialing and pharmacy. In addition to committees, multiple departments and individual staff members/enrollees have key roles and responsibilities in the QM program.

## Technical Resources/Systems

There are a number of technical resources/systems available to support and implement the QI program:

A. Guiding Care is a technology system that provides condition identification, program identification/work list, identification of gaps in care, system alerts and messaging capabilities to support medical management services including utilization management, case management, disease management, complex case management as well as integration with wellness programs (i.e. health coaches) and documentation of member appeals.

B. InterQual® is an industry-leading evidence-based tool for determining the appropriateness of health care interventions and levels of care across the continuum. This program supports preauthorization, concurrent review and retrospective analysis of clinical appropriateness. The following guidelines are used:
Inpatient Services

- InterQual® Level of Care: Acute Criteria, Adult and Acute Criteria, Pediatric

- Prest & Associates, Inc. Review Criteria Mental Health
- American Society for Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders, (Second Edition – Revised) Outpatient Services
- InterQual® Care Planning: Procedures Criteria, Adult and Pediatric

InterQual® is a nationally respected vendor with clinical criteria based on best practice, clinical data and medical literature. Prest & Associates, Inc. is a nationally respected independent review organization that provides behavioral health criteria along with consultation and review services with board certified physicians in mental health and substance abuse. ASAM guidelines are a nationally accepted standard of care for the treatment of substance abuse disorders.

C. Inovolon is used to gather and report HEDIS. This includes data reported annually to NCQA, as well as at the provider specific HEDIS and prospective HEDIS work.D. MC400 - Managed Care 400 is a claim processing system from OAO Healthcare Solutions that retains member/enrollee eligibility information, applies provider contract and payment terms and adjudicates claims based on specific rules established for employer benefit packages.

E. PBM (Pharmacy Benefit Manager) - OptumRx offers customized products and uses an evidence-based approach to manage costs.

F. CACTUS Web - houses all data for credentialed providers and drives the re-credentialing process.

G. Ambulatory Review Database - an Access based system developed by Health Alliance staff that enables tracking, documentation and reporting of ambulatory review criteria and results.

H. Adverse Events Database - an Access based system developed by Health Alliance staff that enables tracking, documentation and reporting of adverse events (never events and sentinel events).

I. Wellness Rewards - available to all Health Alliance Commercial members/enrollees and provided free of charge via the Health Alliance website. Health Alliance Medical Plans offer web-based

wellness programs using current technologies to engage members in improving their health.

J. SPSS (Statistical Package for the Social Sciences) - allows users to sample, manipulate, and analyze data including statistical testing, correlations, and regression analysis.

K. SQL Query Analyzer - Allows users to query data from the data warehouse for reporting or producing mailing lists.

L. SAP Business Objects - Allows users to query data from the data warehouse for reporting or producing mailing lists.

M. MCNet - pulls member/enrollee information for the customer service representative from the member/enrollee number entered into the Cisco Systems IVR by the caller or when accessed manually by the representative. MCNet combines access to a call tracking process from another system by Onyx called Customer Center with data housed in the MC400. Calabrio's Work Force Management and Quality Management software are used for staff scheduling, call recording, and call monitoring.

N. Salesforce, a customer relationship management (CRM) service, is broadly used to manage our customer service, provider relations and member services. Salesforce also provides easy access to complete member information used to ensure more "first call resolution" service calls. The Custom Cloud allows the creation of powerful custom functionality in Salesforce, which works along with other services to automate many of our manual processes.

O. Carrot Health, Inc is an analytics software solution that provides Social Determinants of Health (SDoH), risk levels, quality data by utilizing claims, pharmacy and consumer data. Allows users to segment patient populations to help identify areas that need additional support and improved quality metrics. In addition, it is used to track system and provider level quality scorecards based on HEDIS and pharmacy metrics.

Descriptions of committees related to the Quality and Medical Management process are available upon request.

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## National Committee for Quality Assurance (NCQA) and HEDIS

In support of our commitment to quality, Health Alliance has voluntarily submitted to reviews by the National Committee for Quality Assurance (NCQA). The NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral health care organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations and disease management and other health-related programs. The mission of the NCQA is to improve the quality of health care delivered to people everywhere. NCQA accreditation evaluates how well a health plan manages all parts of its delivery system—physicians, hospitals, other providers and administrative services—to continuously improve health care for its members. At the health plan's request, NCQA sends a team of trained health care experts to conduct a rigorous on-site survey of the health plan. NCQA uses information from consumer surveys, interviews with health plan staff, plan documentation and performance results of selected HEDIS®* (Healthcare Effectiveness Data and Information Set) measures.

Our current NCQA accreditation status (through the fall of 2020) is:

- Health Alliance Medical Plans
    - Commercial HMO/POS combined – Commendable
    - Marketplace HMO/POS/PPO combined – Accredited
- Health Alliance Midwest, Inc.
    - Commercial HMO/POS combined – Commendable

NCQA's accreditation standards are publicly reported in five categories:

- Access and Service: Do health plan members have access to the care and services they need?
- Qualified Providers: Does the health plan assess each doctor's qualifications and what health plan members say about its providers?
- Staying Healthy: Does the health plan help members maintain good health and detect illness early?
- Getting Better: How well does the health plan care for members when they become sick?
- Living with Illness: How well does the health plan care for members when they have chronic conditions?

Consumers can easily access health plans' NCQA Accreditation statuses and other information on health care quality at ReportCard.NCQA.org or by calling NCQA's Customer Support at 1-888-275-7585.

Health Alliance has identified three major benefits of NCQA Accreditation:

- Preparation for the survey results in a strengthening of Health Alliance's internal management systems.
- NCQA Accreditation strengthens Health Alliance's position in the marketplace.
- NCQA Accreditation status is widely accepted and eliminates repetitive state and federal reviews.

## HEDIS

HEDIS is the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service. It is a set of standardized performance measures designed to ensure purchasers and consumers have the information they need to reliably compare health care quality.

The HEDIS expert panel, the Committee on Performance Measurement, has identified the following "domains" or categories of care for reporting HEDIS:

- Effectiveness of Care: Measures
- Access/Availability of Care
- Experience of Care: CAHPS®**
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems (ECDS)

### Audit Requirements

The HEDIS Compliance Audit™*** is a two-part program that consists of an overall information system capability assessment coupled with an evaluation of the MCO's ability to comply with HEDIS specifications. Auditors who are certified by NCQA use standard audit methodologies designed to help purchasers make more reliable comparisons between health plans.

### Hybrid Reviews

Plans reporting HEDIS data may draw information from four sources – administrative (i.e., claims), hybrid (combination of claims and medical record review) and survey (direct feedback from the member) and Electronic Clinical Data Systems (ECDS) – transactional data collected directly from practitioner/provider sources. The use of hybrid methodology is very time consuming and resource intensive. However, in measures where the

specifications and exclusions are complicated, hybrid review often results in improved rates, despite the amount of work involved.

Hybrid review requires the cooperation of a plan's practitioners. Health Alliance, or its designee, may request an appointment to visit a practitioner's office to review and copy medical records for members who are part of the sample population for a specific measure. Health Alliance may also contact practitioners' offices and ask to have specific portions of the medical record sent to our office as proof of compliance with specific measures (i.e., immunization records, proof of a colonoscopy, etc.).

## Access to Services

Health Alliance is committed to providing members with efficient, cost-effective and quality health care coverage. Health Alliance employees never encourage underutilization of care. We do not give financial inducements or set quotas for denying care or coverage; nor do we keep statistics identifying individual providers and their denial rates. Utilization decisions made by our medical directors, nurse coordinators, pharmacy coordinators and pharmacists are based only on appropriateness of care and service and the existence of coverage. There are no incentives, financial or otherwise, to deny access to services.

As a member of the medical community, Health Alliance understands and respects the need to meet HIPAA requirements and keep medical information regarding patients confidential. As part of the HEDIS review process, we may ask to copy specific portions of the medical record. This is necessary to provide proof of compliance for the measure in question to our auditors. Health Alliance keeps all medical information in confidential files accessible only on a "need to know" basis. No information is released to another party outside of the audit process. If you have any questions or concerns regarding the confidentiality of any documentation provided to our office for quality review purposes, please feel free to contact the Director of Quality Management at 217-902-8012.

HEDIS specifications for the Effectiveness of Care Measures are very explicit. Each measure specifies the ages involved for the measure as well as specific requirements each patient must meet in order to attain compliance. Please visit NCQA.org/HEDIS to access the current HEDIS measures.

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HEDIS is an effective tool that enables us to compare our health plan with other plans across the country. However, our success depends upon your cooperation. Please feel free to contact our Quality Management Department at 1-800-851-3379, ext. 28947 option 2 with questions/concerns about HEDIS, the audit and/or medical record reviews.

Remember: As a contracted provider you are expected to cooperate fully with Health Alliance Medical and Quality Management programs which include access to medical records for these purposes. For example, you may receive requests for medical information related to quality assurance audits from the Quality Management Department annually during HEDIS or other times during the year. Please contact the Quality Management Department with any questions or concerns at 1-800-851-3379, ext. 28947 option 2.

### Preventive Health

Health Alliance places a strong emphasis on providing a highly developed preventive care services program for its members.

One specific activity involves the implementation of preventive care guidelines to ensure members are properly screened and educated regarding a wide range of conditions. With the input of multiple physician teams and a review of national recommendations, Health Alliance uses several resources for prevention: Institute for Clinical Improvement (ICSI), the United States Preventive Services Task Force (USPSTF), the Center for Disease Control, the American College of Cardiology and the American Hospital Association. Clinical Guidelines are reviewed annually and updated to reflect new updates and evidence.

While clinical practice guidelines are useful aids in determining appropriate care practices for patients with specific clinical problems or prevention issues, the guidelines are not meant to replace the clinical judgment of the individual physician or establish a standard of care.

Health Alliance Clinical Guidelines are available on YourHealthAlliance.org for providers by choosing Clinical Guidelines from the resources at the bottom of the page. If you have questions, would like a paper copy of the guidelines, or would like to convey your recommendations please call the Health Alliance Quality Management Department at 1-800-851-3379, ext. 28947 option 2.

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### Immunization Schedules

The Centers for Disease Control website provides immunization schedules and updates them throughout the year. Please visit CDC.gov/Vaccines to find the most current immunization schedules for children, adolescents and adults.

## Serious Reportable Events

**Adverse Events**- It is the policy of Health Alliance to have a formal procedure to provide structure and guidance regarding the review of adverse events for any potential injury that occurs while a member is receiving health care services from a participating practitioner/provider.

**Sentinel Events**- Sentinel Events are quality of care concerns or occurrences that can be submitted orally, in writing or identified through the concurrent review process. Health Alliance employs a Member Relations Quality Improvement Coordinator, a registered nurse that works closely with a medical director to provide a review of the concerns and take action, if needed.