Quality Improvement Standards and Processes
Used by Select Public and Private Entities
to Monitor Performance of Managed Care Plans

A Summary

Prepared by
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NATIONAL ACADEMY
For State Health Policy

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The statements contained in this report are solely those of the author and do not necessarily reflect the views of policies of the
Health Care Financing Administration. The contractor assumes responsibility for the accuracy and completeness of the
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Background

Over the past several years, HCFA's Medicare and Medicaid offices have been engaged in concurrent initiatives to design and implement standards and strategies for quality improvement under managed care arrangements. Some of the more salient of these activities include:

- In July 1993, HCFA published guidelines for monitoring and improving the quality of care to Medicaid recipients served under managed care. These guidelines, *A Health Care Quality Improvement System for Medicaid Managed Care - A Guide to States*, create a systems approach to continuous quality improvement through the delineation of roles and responsibilities within state government, managed care plans and external quality review entities for detecting and correcting quality problems under Medicaid managed care arrangements.

- Companion manuals to HCFA's QI Guidelines are being developed to assist states in fulfilling their monitoring responsibilities. These include *Designing and Implementing Focused Clinical Quality of Care Studies*, reviewer guidelines for state surveys of plans' internal quality assurance programs, and greater specificity on how quality improvement efforts can be targeted at children's health services under the Early, Periodic, Screening, Diagnosis and Treatment program.

- With funding from the David and Lucille Packard Foundation, HCFA is working with states, the National Committee for Quality Assurance and others to adapt performance measurements developed for use by commercial purchasers to the specific needs of the Medicaid program.

- Under the Medicare Managed Care Quality Improvement Project (MMMQIP), new performance measurements have been developed for risk-based managed care plans contracting with the Medicare program. These standards shift the focus of PRO review from ransom case review to greater emphasis on patterns of care. A pilot project has been authorized to test these measures and processes beginning in Spring 1995.

Each of these efforts, while focusing on the federal and state role in quality improvement, bears directly on similar activities occurring within the private sector to enhance methods for monitoring and improving managed care services. The distinct, yet sometimes overlapping, interests of managed care regulators (e.g. Medicare and Medicaid programs), purchasers (public purchasers of care for Medicare and Medicaid beneficiaries and private purchasers) and accrediting bodies (e.g., National Committee for Quality Assurance and Joint Commission for the Accreditation of Healthcare Organizations) in quality monitoring become apparent to plans subject to their collective provisions. Plans express frustration over the time and resources necessary to comply with what are often perceived as redundant reviews.
which divert focus from activities believed to be more directly related to quality improvement.

HCFA is very much aware of the demands placed on managed care plans by outside review entities, especially those with dual Medicare/Medicaid contracts as well as commercial enrollment. As the principal sponsor of managed care within the public sector and a strong advocate for its advancement, HCFA has a vested interest in eliminating duplicative federal and state regulation and coordinating with private sector review bodies where feasible. In the process, however, the government is aware that caution must be exercised to preserve unique features of public reviews which protect the special circumstances and needs of Medicare and Medicaid enrollees of managed care arrangements.

Work is now underway at HCFA to examine opportunities for streamlining the review processes imposed on managed care plans in a manner that protects the public interests while recognizing the significant role played by the states and the private sector in quality monitoring. That undertaking has four principal components:

1. to assess the degree to which there is agreement among public and private review entities on quality standards;

2. to determine the similarities and distinctions in the processes used to review a plan’s compliance with the standards;

3. to evaluate how findings are reported and used by review bodies to assure continued quality improvement; and

4. to identify approaches and strategies for coordinating the public and private review processes in managed care.

Comparative Review of Quality Improvement Standards and Processes

A review entity’s standards provide several insights. First, in the aggregate, standards reveal a review entity’s focus and scope with respect to the elements and features of a managed care plan it chooses to monitor. Second, individual standards establish an expectation for performance and provide a useful measure for comparing the emphasis and importance a review entity places on any given element.

This document was prepared as a first step in understanding the present scope of reviews conducted by public and private entities in fulfilling their quality improvement monitoring responsibilities. This is a reference document of existing standards and is intended as a foundation for the more analytic and evaluative assessments to be conducted by federal, state and other policymakers in the coming months.
The next sections of this report describe the methods for defining, collecting and abstracting quality improvement standards used by a select group of public and private review entities. This is followed by an abstraction of the standards themselves.

Selection of Elements for Abstraction

Since this preliminary work focused on comparing quality improvement standards employed by public and private review entities, it was necessary to first define those aspects of a review entity’s process which pertain to “quality improvement.” While arguments can be made that a entity’s entire review, broadly speaking, relates to quality, a more specific definition was required. For example, should quality be defined so broadly so as to include elements of a plan’s financial solvency or the health and safety conditions of its physical facilities? Or should this project focus more specifically on the elements of a plan’s operation affecting the provision of direct client care? This difficult but essential task set the boundaries for the project and assured that comparable information was collected from each review entity. To be of most use to HCFA in assessing how its own standards compare to those of other federal agencies, states and the private sector, the elements of quality improvement were generally defined according to HCFA terminology. While this definition may seem somewhat self-serving, efforts were made to add elements which push the borders of quality improvement beyond the scope of existing HCFA standards.

Table 1 presents the list of elements reviewed and their working definition for purposes of this project.

Selection of Review Entities

Ten programs/entities were selected for review. These included:

- Medicare risk contracting
- Federal qualification
- Federal Medicaid program
- Bureau of Primary Health Care, Public Health Service
- National Association of Insurance Commissioners
- Joint Commission for the Accreditation of Healthcare Organizations (Network component only)
- National Committee of Quality Assurance
- Minnesota (Departments of Commerce, Health, and Human Services)
- Ohio (Departments of Health, Insurance and Human Services)
- Pennsylvania (Departments of Health, Insurance and Public Welfare)
Table 1

Quality Improvement Elements

I. ORGANIZATION AND PROCESS

I.A. Type of organization/background/purpose: the nature of the review organization, its focus and mission, and authority with respect to quality monitoring for managed care.

I.B. Frequency of review/period of effectiveness: how often the review organization conducts its quality reviews.

I.C. Review team requirements: who conducts quality reviews, their qualifications and the composition of teams.

I.D. Review process/components of review: the scope and content of the review conducted by the organization with respect to the quality improvement aspect of the review.

I.E. Status conferred: the status granted to the managed care plan as a result of the review agency’s evaluation.

I.F. Release of information: the extent to which information obtained by the review organization in the course of its reviews is available to the public.

I.G. Fee: the cost to the plan of seeking review by the specified entity.

II. OPERATIONS

II.A. Enrollment composition: restrictions or requirements placed on the size or distribution of the plan’s enrollment.

II.B. Incentive arrangements: controls on the types of financial incentives a plan may offer to providers to control utilization and/or review requirements to monitor the impact of such arrangements.

II.C. Network adequacy: the number, type, and qualifications of institutional providers and practitioners participating in the plan’s network.
II.D. **Access**: requirements pertaining to the distribution of institutional providers and practitioners participating in the plan's network, their proximity to enrollees and availability to meet enrollee needs within a timely manner.

II.E. **Preventive health**: services, activities, and incentives provided by the plan to promote and monitor the use of preventive health care services.

II.F. **Medical records**: specifications for the design, maintenance, retrieval and review of medical records within the plan's network.

II.G. **Continuity of care**: protections to assure that an enrollee's care is provided by the same set of clinicians when possible or is properly coordinated among providers in the same or different levels of care, including the availability of information to promote such coordination and follow-up.

II.H. **Quality assurance program**

1. **Program description**: specific requirements of the quality assurance program, its scope and activities, and the use of indicators, practice guidelines, and special studies.

2. **Written plan**: specifications that require a plan to describe its quality assurance program, workplans, activities, findings or follow-up actions in writing.

3. **Structure**: requirements for organizing and staffing the quality assurance program, including the specification of committees and reporting relationships.

4. **Resources, people and materials**: criteria for determining the adequacy of plan support for the quality assurance program and activities.

5. **Performance measurement**: the use of standardized indicators for evaluating the performance of a managed care plan (e.g., Health Plan Employer Data and Information Set).

6. **Systematic data collection**: requirements for the collection of data, analysis of that data and dissemination of findings.

7. **Peer review/practitioner participation**: expectations for involving clinicians and other practitioners within the network in quality assurance activities, including participation on committees, analysis of data,
dissemination of quality assurance findings, and feedback on opportunities for improvement.

8. **Effectiveness assessment**: actions to be taken to assess the overall effectiveness of the quality assurance system.

II.I. **External review**: requirements for an independent assessment of the quality of care other than that which is conducted by the review organization itself.

II.J. **Practitioner credentialing/recredentiaing**

1. **Frequency**: after initial credentialing, how often a practitioner is subject to the recredentialing process.

2. **Verification**: requirements for qualifying a clinician to participate in the plan’s provider network, including eligibility criteria and the process for verifying compliance to those criteria.

II.K. **Utilization management**: standards for assessing and promoting the appropriateness of care and proper use of medical care resources by enrollees and plan clinicians.

II.L. **QI integration into operations**: mechanisms for assuring that the activities and findings of the QI program are incorporated where appropriate into other functions within the plan, including management, enrollment, provider relations, management information systems, administrative policies, and contracts.

II.M. **Complaint resolution**: methods for receiving, analyzing, resolving and tracking enrollee complaints and grievances with respect to the availability, accessibility and quality of care, benefits, coverage, payment, denials and other issues brought to the attention of the plan.

II.N. **Rights and responsibilities - plan**: obligations of the plan to notify enrollees regarding covered services, access to those services, use of out-of-plan providers, instructions for receiving emergency and urgent care services, and other information concerning an enrollee’s ability to make informed choices regarding his or her medical care.

II.O. **Rights and responsibilities - members**: rights and obligations of the enrollee with respect to his or her medical care, including choice of provider, advance directives, treatment options, privacy and confidentiality of treatment.
II.P. **Member satisfaction:** mechanisms for soliciting, analyzing, reporting and tracking an enrollee’s level of satisfaction with the availability, accessibility and quality of medical care.

II.Q. **Accountability:** the oversight responsibility of the governing body, committee and/or individuals with respect to quality improvement activities within the plan.

II.R. **Delegation:** restrictions placed on a plan to grant authority to another entity to perform quality improvement functions on its behalf.

II.S. **Provider contracts:** specifications placed on providers with whom the plan contracts regarding their roles and responsibilities for participation in quality improvement activities.

II.T. **Information system adequacy:** criteria for assessing the effectiveness of a plan’s information system in supporting the data collection, analysis and dissemination activities of the quality improvement program.

II.U. **Confidentiality:** protections placed on the collection, use, retrieval and storage of data.

II.V. **Cultural sensitivity:** mechanisms for enhancing the understanding of a plan and its practitioners of differences in enrollee characteristics which may impact their access to care, provision of care, and outcome of care.

II.W. **Consumer participation:** measures for assessing the degree to which a plan provides opportunities for consumers to actively participate in the plan’s decision making processes, especially those relating to the quality improvement program other than the grievance process.
A description of each of these programs/entities is presented in Section I.A of the Abstraction which follows. These programs represent the major organizations with quality improvement oversight responsibility for managed care plans serving public and commercial populations. Since it was beyond the resources of this project to survey all states, three states were selected which offer a strong commercial and Medicaid managed care environment.

Data Collection and Method of Abstraction

The following requests for source documents were made to the review entities:

<table>
<thead>
<tr>
<th>Name of Entity</th>
<th>Source Documents Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>Statutes, regulations, policies and official guidelines</td>
</tr>
<tr>
<td>Federal Qualification</td>
<td>Protocol for Primary Care Effectiveness Review</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Accreditation Manual for Health Care Networks</td>
</tr>
<tr>
<td>Bureau of Primary Health Care, PHS</td>
<td>Standards for accrediting managed care organizations</td>
</tr>
<tr>
<td>JCAHO</td>
<td>Draft working documents of proposed model legislation in 5 areas: quality assurance, utilization review, data reporting, complaint procedure and provider contracting as well as copies of the existing NAIC Model Act and Model Regulations for HMOs.</td>
</tr>
<tr>
<td>NCQA</td>
<td></td>
</tr>
<tr>
<td>NAIC</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>Statutes, regulations, policies and official guidance for managed care plans seeking to operate within the state or wishing to serve Medicaid recipients. Since standards for the latter often do not become part of formal rulemaking, copies of Request for Proposals and contracts were also requested for review.</td>
</tr>
<tr>
<td>Ohio</td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td></td>
</tr>
</tbody>
</table>
For the Medicare, Federal Qualification and Federal Medicaid programs, standards were abstracted by statute, regulation, policy and guidelines. Abstractions for the three states divided standards according to those required of "All Plans" and the distinct additional standards required of plans serving "Medicaid" recipients. Citations are provided for all standards indicating the specific source documents used in their abstraction.

Limitations of the Review

The reader is cautioned to consider the following limitations when reviewing the compilation of abstracted standards in the next section.

- This document presents abstractions only of regulations, policies, procedures and standards. The abstractions are not necessarily direct or full quotations of the original materials and should not be construed as such.

- The list of standards is not exhaustive but identifies major components considered by the review entity under any given element.

- Placement of standards under each element was a judgment of the author and may not necessarily correspond to the review entity's own classification system.

- The abstraction pertains only to the quality improvement aspects of a review process and is by no means a definitive statement of a review entity's total monitoring function.

As previously noted, this is a reference document and does not include an analysis of the comparative features of the standards. Separate efforts are underway to assess the implications of this work to HCFA's broader interest in identifying opportunities to better coordinate the public and private review processes for managed care.
Abstraction

Quality Improvement Standards
I.A. Type of organization/background/purpose

**MEDICARE**

These standards identify the quality assurance requirements an organization must meet to enter into a Medicare contract with HCFA, under Section 1876 of the Social Security Act, as a federally qualified Health Maintenance Organization (HMO) or a Competitive Medical Plan (CMP). At a minimum, contracting HMOs/CMPs must provide the full range of Part A and Part B services to entitled beneficiaries who are enrolled with the HMO or CMP. In addition to items referenced in this document, requirements are also in place for administration and management, fiscal soundness, marketing, enrollment, claims processing and HCFA payments to risk- and cost-based contractors.

**FEDERAL QUALIFICATION**

The Federal government promulgates statutes, regulations, and policy for Federal qualification designation of managed care organizations. Federal requirements cover legal/state licensure and fiscal soundness issues, as well as all aspects of operations of managed care organizations. Federal qualification is strictly voluntary and frequently is requested due to the competitive nature of the plan’s environment, including requests by employers.

**MEDICAID**

The rules, regulations, and guidelines included in this analysis have been developed by the federal government and apply to managed care plans wishing to contract with state Medicaid agencies to provide services to enrolled Medicaid recipients. State Medicaid agencies or other state offices may develop their own monitoring strategy, following guidelines established by HCFA, as long as the state complies with the statutory and regulatory requirements cited.

**BUREAU OF PRIMARY HEALTH CARE**

The Bureau of Primary Health Care has oversight responsibilities for the following Public Health Service grants: section 330 Community Health Program, section 329 Migrant Health Program, section 329/330 Comprehensive Perinatal Care Program (CPCP) and Special Infant Mortality Reduction Initiative (SIMRI), the section 340 Health Care for the Homeless program (HCH), the section 340A Primary Care to Residents of Public Housing and the Ryan White Title III (b) HIV/Early Intervention Services program. Standards reflected in this analysis are part of the Primary Care Effectiveness Review (PCER) process conducted by the Bureau of Primary Health Care as part of the final year evaluation of an approved project. This review consolidates the review activity for centers with multiple grants under the jurisdiction of the Bureau of Primary Health Care.

**NAIC**

NAIC proposes model legislation to state insurance commissioners or other state agencies (e.g., Department of Health) for use in establishing their legislative and regulatory requirements for issuance of a certificate of authority, license or registration to a "health carrier," defined as an entity "that contracts or offers to contract on a risk-assuming basis to provide, deliver, arrange for, pay for, or reimburse any of the cost of health care services." The model standards encompass all varieties of managed care entities and may be augmented with state standards specific to the type of entity which is applying for a certificate of authority, license or registration. Model standards abstracted here are in draft form, not yet approved by the NAIC, and are likely to undergo further changes. Draft standards include sections pertaining to credentialing, complaint procedure, provider contracting, data reporting, quality assurance, and utilization review.
I.A. Type of organization/background/purpose (cont’d.)

NAIC (cont’d.)

In addition, portions of NAIC’s existing HMO Model Act and Model Regulations have been abstracted to provide the administrative context within which these draft modules are being applied within the states.

States have the flexibility to use and/or adapt these model requirements to address their own individual needs and circumstances.

ICAHO

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) is a not-for-profit organization whose major functions include the development of standards and performance measures, the award of accreditation status and the provision of educational and consultation services to health care organizations. The JCAHO accredits ambulatory care organizations, laboratories, hospitals, home care organizations, nursing homes, mental health care programs and recently has published standards and processes for accrediting health care networks. A network is defined as “an entity that provides, or provides for, integrated health care services to a defined population of individuals... and is characterized by a centralized structure that coordinates and integrates services provided by component organizations and practitioners participating in the network.” Network accreditation does not constitute accreditation of individual component entities which must receive such accreditation by virtue of their separate survey process (e.g. hospital, home health agency).

Due to the complex and varying nature of the types of entities subject to review under these standards, standards focus primarily on leadership and central organizational structure. Standards have been developed in each of the following 7 categories, only portions of which have been abstracted for purposes of this analysis: Rights, Responsibilities and Ethics; Continuum of Care; Education and Communication; Leadership; Management of Human Resources; Management of Information; and Improving Network Performance.

An accreditation survey may be performed at the request of a health care network or an evaluation survey may be performed at the request of a third party. The same standards are applied in both surveys.

NCQA

NCQA is an independent organization established to review the quality and medical management systems of managed care organizations or similarly organized pre-paid health programs.

Reviews can be done at the request of an organization seeking NCQA accreditation or as part of an external quality review required by a regulatory agency to determine compliance with applicable state or federal requirements. Standards for external quality reviews and review determinations may be different from NCQA’s standards [NCQA Accreditation Standards, Accreditation and Appeals Procedures, 1994, Section XIII, p. 9].

2 Summary, Quality Improvement Standards and Processes
I.A. Type of organization/background/procedure (cont’d.)

MINNESOTA

The State of Minnesota promulgates rules and regulations governing the operation of HMOs within the state. Authority rests with the Department of Health to issue a certificate of authority, based on a review of organizational stability and financial solvency, network capacity, provider and organizational capacity to deliver the proposed range of services and ongoing monitoring of plan performance. Changes in the procedures and programs to monitor the quality of care must be submitted to the Department of Health for approval prior to implementation. The Minnesota Department of Human Services establishes contract specifications and compliance for plans enrolling Medicaid beneficiaries.

Similar overall authority to issue licenses, require quality assurance procedures and monitor plan performance exists for newly created "community integrated service networks" (CISN). Pursuant to Minnesota Statutes, these entities are defined as "a community based and governed organization responsible for providing or arranging the provision of comprehensive health care services on a prepayment basis to a voluntarily enrolled population of 50,000 or fewer." CISNs were allowed to submit applications for licensure as of July 1, 1994, and began providing care on January 1, 1995. Notation is made in this analysis wherever a given standard does not apply to the CISN. Separate regulations are also scheduled for adoption by January 1, 1996, for integrated service networks (ISN), a new kind of health care coverage company that will be responsible for providing a full array of health services to its enrollees for a fixed price and held publicly accountable for the cost and quality of the services provided to enrollees.

OHIO

The State of Ohio promulgates rules and regulations governing the operation of managed care plans within the state. Authority rests with the Department of Insurance to issue a certificate of authority based on a review of organizational stability and financial solvency as well as findings from the Department of Health; the Department of Health assesses network, provider and organizational capacity to deliver the proposed range of services and conducts ongoing monitoring of plan performance; and the Ohio Department of Human Services establishes minimum contract specifications and compliance for plans providing services to Medicaid enrollees.

PENNSYLVANIA

The following sections include statutes, regulations and guidelines pertaining to the quality assurance provisions for operating managed care organizations within Pennsylvania. Principal enforcing agencies include the Department of Insurance, which, jointly with the Department of Health, issues a certificate of authority for a plan to conduct business within the state and monitors all financial solvency requirements; the Department of Health, responsible for ongoing monitoring of plan performance against established quality assurance standards and consumer grievances; and the Department of Public Welfare, which serves as the contracting entity for plans wishing to provide services to Medicaid recipients. For purposes of this analysis, Medicaid standards pertain to those required of the state's HealthPASS mandatory program. Although HealthPASS is currently a Health Insuring Organization (HIO) not subject to the requirements for health maintenance organizations specified in the "all plans" sections of this analysis, it is in the process of applying for an HMO license.

Summary, Quality Improvement Standards and Processes 3
I.B. Frequency of review/period of effectiveness

**MEDICARE**

After a Medicare contract is awarded, HMOs and CMPs are subject to biennial review to monitor plan performance.

**Regulation:** HCFA is responsible for overseeing an entity's continuing compliance with the definition of an HMO or CMP [42 CFR 417.406(h)].

HCFA may evaluate, through inspection or other means, the quality, appropriateness and timeliness of services furnished under the contract to its Medicare enrollees [42 CFR 417.482(a)]. See also External Review

**FEDERAL QUALIFICATION**

Plans remain federally qualified indefinitely unless the plan requests relinquishment of its Federal status, or HCFA revokes such status for cause.

**MEDICAID**

**Regulation:** For prepaid health plans, the state establishes a system of annual periodic medical audits to ensure that each contractor furnishes quality and accessible health care to enrolled recipients which, at a minimum, collects data on the reasons for enrollment and termination and the use of services [42 CFR 434.53]. See also external review.

**BUREAU OF PRIMARY HEALTH CARE**

A Primary Care Effectiveness Review is an on-site review for all BPHC grantees that are in the final year of an approved project period, usually the third year of a grant.

**NAIC**

The commissioner (of insurance) may make an examination of the affairs of any plan and providers with whom such organization has contracts, agreements or other arrangement as often as is reasonably necessary for the protection of the interests of the people of the state, but not less frequently than once every 3 years [NAIC, Health Maintenance Organization Model Act, Model Regulation Service - January 1990, Section 19.A].

The commissioner of public health may make an examination concerning the quality assurance program of the plan and of any providers with whom such organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of the state, but not less frequently than once every 3 years [NAIC, Health Maintenance Organization Model Act, Model Regulation Service - January 1990, Section 19.B].

**JCAHO**

Accreditation is awarded for three years following successful completion of a full survey. Interim reviews during the three-year cycle may be necessary if the health care organization was found to have type "1" deficiencies which are indications of insufficient compliance in a performance area(s).
I.B. Frequency of review/period of effectiveness (cont’d.)

JCAHO (cont’d.)

Either an unscheduled or an announced survey may take place when the Joint Commission becomes aware of circumstances in an accredited network that suggest a potentially serious standards compliance problem.

The Joint Commission conducts mid-cycle, unannounced surveys for a 5% random sample of accredited networks focused on the 5 performance areas that the previous year’s aggregate survey data have identified as being most problematic.

NCQA

Full accreditation is awarded for a three-year period, unless revoked. More frequent reviews may be conducted in cases of less than full accreditation, or at the request of the plan [NCQA Accreditation and Appeals Procedures, 1994, Section VIII, p. 7]. Change in operational or organizational status may be grounds for a discretionary survey [NCQA Accreditation and Appeals Procedures, 1994, Section XI, p. 8].

An organization may elect to undergo the survey as a pre-accreditation review that does not result in an accreditation determination [NCQA Accreditation and Appeals Procedures, 1994, Section XIV, p. 9].

MINNESOTA

All plans: The Department of Health may make an examination of the affairs of a plan as often as the commissioner of health deems necessary for the protection of the public interests, but not less frequently than once every 3 years [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.14, Subd.1].

Medicaid: The Department of Human Services or its agents evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services performed under its contract with the plan [Minnesota Department of Human Services Rules, 9500.1460 Subp.17]. The frequency of these reviews is not specified.

OHIO

All plans: Certificates of authority are issued for an indefinite period based on the submission of annual reports and continuing compliance with all requirements.

The Department of Health may make an on-site examination concerning compliance with state requirements as often as considered necessary for the protection of the interest of the public, but no less frequently than once every 3 years [Ohio Revised Code, 1742.21].

Medicaid: Provider agreements to enroll Medicaid recipients are negotiated annually based on a request for proposal process.

The Ohio Department of Human Services or its designee may conduct on-site audits and reviews as deemed necessary based on periodic analysis of financial, utilization and other information [Ohio Administrative Code, Chapter 5101:3-26-06(B)].

The Ohio Department of Human Services conducts quarterly meetings with the plans to monitor progress with the plan’s corrective action plan resulting from an independent comprehensive quality assurance survey, as applicable [Ohio Administrative Code, Chapter 5101:3-26-07(C)(6)(d)].
I.B. Frequency of review/period of effectiveness (cont’d.)

All plans: The Department of Health, in conjunction with an independent Quality Review Organization, conducts on-site reviews of plan performance within 1 year of receipt of a certificate of authority, and every 3 years thereafter.

The Department of Health may conduct on-site inspections of the plan’s facilities and records to determine the quality of care rendered by the plan.

Medicaid: Medicaid risk-based plans are required to have an annual independent external quality review (see external review).
I.C. Review team requirements

**MEDICARE**

Review team members consist of HCFA personnel from the Office of Managed Care, Regional Offices and HCFA consultants as required.

**FEDERAL QUALIFICATION**

There are no standards. HCFA personnel from the Office of Managed Care conduct application review and ongoing monitoring activity.

**MEDICAID**

Guidelines: Review of the health plan's internal quality assurance program is conducted by the state agency. States may perform this monitoring directly themselves, utilizing Medicaid or other state resources, or they may secure monitoring services through a contractor that is not in a conflict-of-interest position; e.g., a managed care organization or an association of managed care organizations [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Element B, p. 9].

**BUREAU OF PRIMARY HEALTH CARE**

The review team includes the Project Officer, a member of the regional clinical staff, and a representative of the Office of Grants Management. In cases where regional office resources have insufficient resources, some or all of the team members may be replaced by technical assistance contract consultants or through the use of peer review procedures.

**NAIC**

No standard specified.

**JCAHO**

The composition of the survey team is not specified but is designed to meet the specific network characteristics or the need to survey a network component that is not already accredited or certified.

**NCQA**

Survey team members are practicing professionals from managed care organizations who typically have experience in, and responsibility for, quality assurance in their own organizations. All surveyors must complete an NCQA surveyor training program. At a minimum, a survey team includes one physician surveyor and one administrative surveyor. Criteria are established for selecting the physician and administrative representative on the survey team.

The size and composition of the survey team may vary depending on the size of the managed care organization, the specifics of the review process, and the number of medical records to be reviewed [NCQA Administrative Policies and Procedures, 1994, p. 2-3].
I.C. Review team requirements (cont'd.)

MINNESOTA

All plans: Conducted by staff within the Department of Health.

Medicaid: Conducted by staff within the Department of Human Services and the Department of Health.

OHIO

All plans: The Department of Health conducts periodic audits.

Medicaid: The Department of Human Services schedules quarterly meetings to review utilization data submissions and the plan's progress with its individual quality assurance corrective action plan.

PENNSYLVANIA

All plans: The independent Quality Review Organization conducting on-site reviews includes survey team members who are IPA and/or group/staff physicians (and ancillary staff as appropriate) who are specially trained to conduct evaluations. Strict provisions are enacted to ensure team members have no conflict of interest. Department of Health representatives are present during each external assessment and have the right to participate as full team participant [Invitation to Qualify as an Approved HMO Quality Review Organization, Pennsylvania Department of Health, Appendix II, p. 16].

Survey team members undergo an acceptable training program which ensures uniform application of standards and criteria [Invitation to Qualify as an Approved HMO Quality Review Organization, Pennsylvania Department of Health, Part 1, p. 6].
I.D. Review process/Components of review

**MEDICARE**

Statute: The Secretary or designee has the right to evaluate the quality, appropriateness and timeliness of services when there is evidence that such an inspection is needed [Section 1876(i)(3)(A)(i) of the Social Security Act].

The review process includes the analysis of an application which must be processed within certain time frames. HCFA staff conduct an in-house review prior to doing an on-site visit. All aspects of a plan's operation are reviewed. Deficiencies are corrected prior to contract award. Once awarded, monitoring of plan performance is conducted through biennial on-site visits and ongoing monitoring of the plan’s activities. There is a process for denial of applications and termination of contracts if necessary.

**FEDERAL QUALIFICATION**

The review process includes analysis of an application which must be processed within certain time frames. HCFA staff conduct an in-house review prior to doing an on-site visit. All aspects of a plan’s operation are reviewed. Deficiencies are corrected prior to qualification. There is a process for denial, if necessary.

**MEDICAID**

**Guidelines:** States are to monitor each plan to assess to what extent its quality assurance program meets state-specified standards. States may employ a variety of monitoring approaches, including the submission to the state of specific data and/or reports on a periodic basis, using on-site monitoring inspections, or a combination of these.[A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Element B, p. 9].

**BUREAU OF PRIMARY HEALTH CARE**

The Primary Care Effectiveness Review protocol includes five modules: administration, governance, finance, clinical and management information systems. Each of these modules includes elements that are either required by law, regulation, or program expectations, or recommended as good practice. Four basic functions of the review include:

**Monitoring:** The review examines compliance with mandated performance standards and factors that can enhance the establishment and maintenance of a strong, viable organizational environment.

**Identification of strengths and weaknesses:** While on-site, the review team focuses on identifying health center strengths and weaknesses. Program weaknesses are addressed by establishing a timetable for completing and implementing a corrective action plan.

**Establishment of a technical assistance plan:** Programs with deficiencies may receive technical assistance from Bureau staff to aid in correcting weaknesses and coming into compliance.

**Information exchange:** The peer review process provides team members with the opportunity to learn from the health center they are reviewing, while also providing the health center with the benefit of the team’s experience.

Prior to the 3-day site visit, a document review is conducted of the prior grant application, the funding history of the health center, the professional (clinical) staff profile, prior on-site review materials and the most recent external audit.

Summary, Quality Improvement Standards and Processes 9
Review process/Components of review (cont’d).

NAIC

A plan is reviewed for compliance with all applicable rules and regulations.

JCAHO

The purpose of a Joint Commission accreditation survey is to assess the extent of a network’s compliance with applicable Joint Commission standards. Compliance is assessed through one or more of the following means:

- receipt of verbal information concerning the implementation of standards, or examples of their implementation, enabling a judgement of compliance to be made;
- on-site observations by Joint Commission surveyors; and
- review of documents that demonstrate compliance and assist in orienting surveyors to the network’s operation.

The 4 basic elements of the network survey process include:

Survey of the network central office, using standards in the Accreditation Manual for Health Care Networks. Activities included in this review include: Chief Executive Officer interview, competency review, credentials/privilege review, daily briefings, document review, information management interview, leadership interview, member group interview, member relations staff, opening conference, performance improvement oversight group interview, practitioner group interview, practitioner relations staff interview, purchaser group interview, risk management staff interview, site visit staff interview, team meetings, and utilization management staff interviews.

Survey of practitioner site(s), using selected network standards. The on-site survey of a sample of practitioner sites includes a review of appropriate documents, practitioner and staff interviews, observation of office operations and environment, and medical record review.

Survey of components, using standards selected from the appropriate standards manual and standards selected from the Accreditation Manual for Health Care Networks. This element of the survey process focuses on a sample of unaccredited components of the network, which includes a significant sample of components providing high-risk services (e.g., sites that administer anesthesia; sites with overnight patients; sites that provide dialysis, infusion therapy, ventilator care, contrast imaging studies, radiation oncology services, or 24-hour recovery services; and birthing centers) and low-risk services (e.g., hospice, physical rehabilitation services, or sites where members of the network constitute greater than 50% of the individuals served at the site).

Leadership briefing at the network central office to review network accreditation survey findings.

Anyone who has information about a network’s compliance with the accreditation standards may request a public information interview during the survey process. The network must post in public places on its premises the official Joint Commission announcement of the date of the survey and of the opportunity for a public information interview. Requests for a public information interview are to be made in writing and will be scheduled within the network’s survey agenda.
Review process/Components of review (cont’d.)

NCQA

NCQA reviews the organization’s quality-related systems to assess the extent to which they are in compliance with NCQA’s standards. Systems under review include, but are not necessarily limited to, quality management, utilization management, credentialing, and preventive health services programs.

NCQA assesses compliance with its standards through:
- review of written documentation and records;
- on-site observations and interviews;
- information obtained during relevant interviews with members of the organization;
- review of medical records; and
- assessment of member service systems.

At the completion of the 2-4 day site visit, a summation conference verifies the team’s fact finding and clarifies any inconsistencies in information [NCQA Administrative Policies and Procedures, 1994, Section V and VI].

After the survey, the surveyors prepare a draft report of findings and recommendations. This draft report is submitted to the organization reviewed which has up to 30 days to submit comments regarding any factual errors or omissions [NCQA Accreditation and Appeal Procedures, 1994, Section I, p. 13]. NCQA’s Review Oversight I.C. Committee makes the final accreditation determination [NCQA Accreditation and Appeal Procedures, 1994, Section II, p. 13].

MINNESOTA

All plans: Examination of plans is limited to the dealings of the Department of Health with the plan, except that examinations may include inspection of the plan’s financial statements. The Department has the right to:
- inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed;
- audit and inspectany books and records which pertain to services performed;
- require persons or organizations under examination to be deposed and to answer interrogations; and
- employ site visits, public hearings or other procedures considered appropriate to obtain information [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.14, Subd.1].

Medicaid: The state monitoring function includes:
- review of plan’s quality assurance system to determine compliance with state requirements;
- review of plan complaints;
- service delivery review; and
- independent quality assurance review of health plans (see External Review) [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, ll.D.1-4].

OHIO

All plans: The Director of Health may make an on-site examination concerning compliance with state requirements as often as considered necessary for the protection of the interest of the public. No further specification is given on the scope or components of this review.

Medicaid: The purpose of quarterly meetings is to review a plan’s progress with respect to any corrective action plan as a result of a comprehensive quality assurance survey.
All plans: Prior to granting a license, the Department of Health conducts on-site reviews of the plan to determine if the managed care network and system is sufficiently developed to serve members in the specified service area. Department of Health staff participate in tri-annual reviews of all health plans with the external review entity (see Section II.I). More frequent reviews are conducted when problems are identified through the external review process or as part of ongoing monitoring activities within the Department of complaints and utilization data. On-site visits may also be conducted for acquisitions or mergers of licensed plans.

Medicaid: The Department of Public Welfare conducts periodic onsite reviews, but no less than monthly, to determine compliance with contract requirements, including the status of corrective action plans, study processes, audit feedback to participating providers and utilization review activities [Pennsylvania Department of Public Welfare, Operating Agreement, Section 18, General Terms and Conditions, 18.5].
Status conferred

MEDICARE

Statute: HCFA determines that a plan is an eligible organization for Medicare contracting if it is a Federally qualified health maintenance organization (HMO) or meets the requirements of a Competitive Medical Plan (CMP) [Section 1876(b)(2) of the Social Security Act].

Regulation: In order for an entity to participate as an HMO or CMP in Medicare contracting, HCFA determines that the entity is a qualified HMO or CMP and satisfies the contract requirements for an HMO or CMP [42 CFR 417.404(a)].

FEDERAL QUALIFICATION

Regulation: In determining an organization's approval as a Federally qualified health maintenance organization, HCFA makes one of the following determinations:

Operational qualified HMO: the organization provides basic and supplemental services in accordance with all applicable requirements
Preoperational qualified HMO: the organization, when it becomes operational, within 60 days will be in full compliance with all applicable requirements
Transitionally qualified HMO: applies to a prepaid health care delivery system that HCFA has determined meets all applicable requirements, other than benefits and premium rating in force for group policies [42 CFR 417.141].

Federal qualification may be revoked for-cause, or upon request of the HMO to relinquish the status.

MEDICAID

A plan enters into a contractual agreement with the state Medicaid agency to enroll Medicaid recipients for the provision of covered services.

BUREAU OF PRIMARY HEALTH CARE

The review is prerequisite to the award of continuation grants. Key findings and material deficiencies found during the Primary Care Effectiveness Review are reported to the grantee in the pre-application guidance letter drafted by the Project Officer in the Public Health Service Regional Office. The grantee has the time from receipt of the guidance letter to submission of the renewal application to make necessary corrections or improvements, or to submit an appropriate plan to respond to adverse issues.

NAIC

Applicants are granted certificates of authority, a license or registration to operate as a managed care organization within the state.
I.E. Status conferred (cont’d.)

ICAHO

The accreditation process may result in one of six possible recommendations:

Accredit with commendation
Accredit with or without type 1 recommendations
Conditionally accredit the network
Deny accreditation to the network
Provisionally accredit the network
Not accredit the network

NCQA

The accreditation process results in one of six compliance level designations:

Full accreditation: accreditation for a three-year period.
Accreditation with recommendations: the agency must take action on deficiencies and report back to NCQA within 90 days. Based on the report, NCQA will determine if the organization has taken satisfactory action to comply with the recommendations, and can be moved to full accreditation.
One-year accreditation: the managed care organization is in significant compliance with the standards. The decision will be effective for 15 months, and the managed care organization is resurveyed within 12 months.
Provisional accreditation, lasting for 15 months, and requiring a resurvey. If deficiencies have not been corrected, provisional status may be extended an additional year.
Denial or revocation of accreditation.
Deferral of accreditation pending receipt of additional information [NCQA Accreditation and Appeal Procedures, 1994, Section III pp. 13-15].

MINNESOTA

All plans: The Commissioner of Health issues a certificate of authority or license (in the case of a community integrated service network) to operate within the state of Minnesota.

Medicaid: The Department of Human Services enters into a contract with the plan to provide covered services to Medicaid enrollees.

OHIO

All plans: The Department of Insurance issues a certificate of authority for a plan to offer services within the state.

Medicaid: The Ohio Department of Human Services enters into a contract with the plan to provide covered services to Medicaid-eligible individuals.
I.E. Status conferred (cont’d.)

All plans: The State of Pennsylvania issues an initial Certificate of Authority for plans to provide services in specific geographic areas. Continued authority to operate within the state is based on compliance with all relevant rules and regulations as monitored by the Department of Health through reports and findings from the independent review conducted by the Quality Review Organization.

Following a plan review by a Quality Review Organization, the Department of Health issues a final report indicating areas of deficiencies and required follow-up actions. The plan submits annual progress reports covering activities, problems and recommendations to the state for monitoring purposes [Invitation to Qualify as an Approved HMO Quality Review Organization, Pennsylvania Department of Health, Appendix II, External Assessment Process, Responsibilities of Review Organizations].

Medicaid: A plan is approved by the Department of Public Welfare as a provider of care to Medicaid recipients.
I.F. Release of information

**MEDICARE**

**Regulation:** The release of information with regard to reviews and application materials is subject to the Freedom of Information Act unless determined that portions of the material should be considered privileged [42 CFR 417.406(a)(2)(i)].

**FEDERAL QUALIFICATION**

**Regulation:** All application and review materials are subject to the Freedom of Information Act unless it is determined that portions of the material should be considered privileged [42 CFR 417.143(b)].

**MEDICAID**

The release of information with regard to reviews and applications is subject to the Freedom of Information Act.

**BUREAU OF PRIMARY HEALTH CARE**

Findings of the Primary Care Effectiveness Review are not publicly released.

**NAIC**

Information pertaining to the diagnosis, treatment or health of any enrollee is disclosed only to authorized persons to carry out the obligations of the health plan. Release of information otherwise will be permitted with the express consent of the enrollee, or pursuant to court order for the production of evidence or discovery, or as otherwise provided by law [NAIC, Draft Standards, Utilization Review Model Regulation, Draft: 6/13/94, Section 10.B].

Information on a plan's quality assurance program and activities are available for review by the public, upon request [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 6.B(2)].

**JCAHO**

The JCAHO, upon request, will publicly release: current accreditation status of a network; the number and nature of type 1 recommendations; applicable standards under which an accreditation survey was conducted; network and operational components included in the accreditation survey; the number and nature of substantive written complaints filed against a network since its last survey that were substantiated by the JCAHO; and whether, at the time a network withdrew from accreditation, there were any type 1 recommendations for which the JCAHO had no or insufficient evidence of resolution and the nature of these recommendations.

The JCAHO reserves the prerogative to publish, or otherwise release publicly, aggregate performance data that are not network specific, as well as network-specific performance information, provided that the data are portrayed within a context that includes accompanying explanations of their reliability and source and comparisons with national or other statistically valid performance data. When a serious situation that may jeopardize the safety of members of the public is identified during a survey and network leaders have been advised of the situation, local, state, and federal authorities having jurisdiction over the network will be notified.
NCQA

If surveyors identify a deficiency in an organization's operations that poses a threat to public health or safety, or the health and safety of members in the organization, NCQA may notify applicable regulatory agencies [NCQA Accreditation and Appeal Procedures, 1994, Section XII, p. 8].

NCQA will periodically publish the organization's accreditation status. NCQA will not release survey reports to any third parties unless the organization reviewed gives its prior written authorization, as otherwise required by law or NCQA's Administrative Policies and Procedures. NCQA reserves the right to release and publish aggregate data obtained as a result of accreditation surveys it has conducted [NCQA Administrative Policies and Procedures, 1994, Section XII, p. 8].

MINNESOTA

All plans: All government data collected and maintained by a state agency is considered public data, except for data on individuals, which is considered private and confidential [Minnesota Statutes, Chapter 13, Minnesota Government Data Practices Act].

Contract information filed with the commissioner is confidential [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.14, Subd.4(g)].

Filings and reports are public documents [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.23].

OHIO

All plans: Information collected by the State as part of the certificate of authority function and related monitoring activities is subject to public disclosure unless otherwise in violation of patient confidentiality provisions.

Medicaid: Information provided in provider proposals are held in confidence and are not revealed or discussed with competitors prior to award [Request for Proposals for Health Maintenance Organizations to Provide Medicaid Covered Services to the Aid to Dependent Children and Healthy Start Eligible Populations in Ohio, State of Ohio Department of Human Services, May 19, 1994, V.III.3, p. 33].

PENNSYLVANIA

All plans: Information collected by the State as part of the certificate of authority function and related monitoring activities is subject to public disclosure provisions except as otherwise violating patient confidentiality provisions.
I.G. Fee

MEDICARE

There is no charge to enter into a Medicare contract.

FEDERAL QUALIFICATION

Regulation: HCFA determines the set application fee which is reasonably related to the cost of qualifying an entity and may vary based on the type of application. These fees are: $3,100 for a CMP seeking Federal qualification; $6,900 for an HMO seeking expansion of service; $18,400 for an entity seeking qualification as an HMO or qualification as a regional component of an HMO (if no site visit, $8,000 is returned) [42 CFR 417.143(c)].

MEDICAID

There is no cost to enter into a contractual relationship with a state Medicaid agency to provide services to Medicaid recipients.

BUREAU OF PRIMARY HEALTH CARE

There is no fee for the Primary Care Effectiveness Review.

NAIC

Fees are established for filing:
- an application for a certificate of authority or amendment thereto;
- an amendment to the plan documents that require approval;
- an amendment for "information only"; and

The expenses of the examination are assessed against the plan being examined and remitted to the commissioner of insurance or commissioner of public health for whom the examination is being conducted [NAIC, Health Maintenance Organization Model Act, Model Regulation Service - January 1990, Section 19.D].

JCAHO

Each network is charged a base fee of $10,000 which covers the survey of the network and up to eight practitioner sites. Additionally, a fee of $2,390 per surveyor per day is charged for each unaccredited component and high risk practitioner that is surveyed. The estimated survey fee for a network consisting of a central administrative operations, 1 hospital, 6 home care programs, 2 free-standing ambulatory care clinics, and 50 practitioner offices would be $48,240, assuming that none of these components was already accredited.

The Joint Commission absorbs all costs of conducting unannounced surveys.
I.G. Fee (cont’d.)

NCQA

The application fee is $7,500, which is applied to the survey fee. The survey fee is based on the size and complexity of the organization reviewed. The base cost for a review ranges from $29,000 to $32,000 plus 10 cents per member for plans with greater than 50,000 members [NCQA Administrative Policies and Procedures, 1994, p. 2].

MINNESOTA

All plans: The plan is subject to the following fees: filing an application for a certificate of authority ($1,500); and filing an amendment to a certificate of authority ($90) [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.2800, Subp.1].

Plans are charged a renewal fee of $16,000 plus 46 cents per person enrolled in the plan on December 31 of the preceding year [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.2800, Subp.2].

Medicaid: There is no fee for entering into a contract with the State to serve Medicaid recipients.

OHIO

All plans: There is a $200 application fee for a certificate of authority. Additional fees are charged for expansion of service area ($25); major modifications ($25); filing of annual report ($25) [Ohio Revised Code, 1742.28(A)(B)(C)(D)].

Pennsylvania

All plans: There is a $1,200 fee for the initial filing of an application for a certificate of authority. Costs associated with the required external review every three years are borne by the plan directly and may range from $20,000-$30,000 depending on the size and scope of the plan.
II.A. Enrollment composition

**MEDICARE**

**Statute:** The plan has an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under Title XVIII (Medicare) or XIX (Medicaid) [Section 1876(f)(1) of the Social Security Act].

**Regulation:** No more than 50% of an HMO's or CMP's enrollment may be Medicare beneficiaries and Medicaid recipients. HCFA may waive these requirements under certain circumstances [42 CFR 417.413(d)].

**FEDERAL QUALIFICATION**

No standard specified.

**MEDICAID**

**Regulation:** Medicare and Medicaid recipients constitute less than 75% of the total enrollment of the plan [42 CFR 434.26(a)] except as waived under certain circumstances [42 CFR 434.26(b)].

**BUREAU OF PRIMARY HEALTH CARE**

No standard specified.

**NAIC**

No standard specified.

**JCAHO**

No standard specified.

**NCQA**

No standard specified.

**MINNESOTA**

No standard specified.
II.A. Enrollment composition (cont'd.)

**OHIO**

Medicaid: Enrollment opportunities remain open as long as the enrollment maximums determined by the state and found in the provider agreement are not exceeded [Ohio Administrative Code, Chapter 5101:3-26-02(B)(1)(0)].

No more than 75% of enrollees within a plan's contiguous service area may be Medicare and/or Medicaid eligible individuals except as waived [Ohio Administrative Code, Chapter 5101:3-26-02(B)(1)(g)].

**PENNSYLVANIA**

No standard specified.
II.B. Incentive arrangements

**MEDICARE**

Statute: The plan does not operate a physician incentive plan unless the following requirements are met: (1) no payment is made directly or indirectly as an inducement to reduce or limit medically necessary services to a specific individual; (2) if the plan places physicians at substantial financial risk, the organization provides adequate stop-loss protection for physicians and conducts periodic surveys of current and prior members to determine access to services and the degree of satisfaction with the quality of services; and (3) the organization provides HCFA with descriptive information regarding the plan [Section 1876(i)(8) of the Social Security Act].

Policy: The plans consider the effect on patient care and health outcomes of physician compensation arrangements that encourage physicians to control use of services [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No.1, November 1989, 4201.2.C].

**FEDERAL QUALIFICATION**

Regulation: Plans have effective procedures to monitor utilization and to control cost of basic and supplemental health services and to achieve utilization goals, which may include mechanisms such as risk sharing, financial incentives, or other provisions agreed to by providers [42 CFR 417.103(b)].

Policy: Plans consider the effect on patient care and health outcomes of physician compensation arrangements that encourage physicians to control use of services [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.2.C]

**MEDICAID**

Statute: Physician incentive plans do not provide direct or indirect payments as inducements for reducing or limiting medically necessary services. If plans place physicians at substantial financial risk, the managed care contractor must provide stop-loss protection, and periodically survey enrolled and disenrolled individuals on access and satisfaction with quality of care [Section 1903(m)(2)(A) of the Social Security Act].

**BUREAU OF PRIMARY HEALTH CARE**

No standard specified.

**NAIC**

Provider contracts describe a plan's payment obligations to the provider, including any financial risk arrangements assumed by the provider [NAIC, Draft Standards, Health Care Provider Contracting Model Regulation, 7/29/94; Technical changes: 8/27/94, Section 6.T].

**JCAHO**

No standard specified.
II.B. Incentive arrangements (cont’d.)

**NCQA**

No standard specified.

**MINNESOTA**

All plans: Physician reimbursement arrangements are identified as a component for review under the ongoing quality evaluation program [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1115, Subp.1].

Incentive payments to providers of services is expressly permitted [Minnesota Statutes, Section 62D.12, Subd.9].

**OHIO**

All plans: The state reviews the method of provider reimbursement, including any risk-sharing or other incentive arrangements, to assess the potential of such policies and arrangements to adversely affect the accessibility and/or quality of health care services provided to enrollees [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.8].

The quality assurance program assures that needed and appropriate health care is not being withheld or delayed for any reason, including because of any financial incentives/disincentives to its providers [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.15].

**PENNSYLVANIA**

No standard specified.
II.C. Network adequacy

Statute: Services are available and accessible to each enrollee within the areas served by the plan [Section 1876(c)(4)(A) of the Social Security Act].

Regulation: Services are considered available if the sources are located within the plan's geographic area or if it is common practice to refer patients to sources outside that geographic area [42 CFR 417.414(b)(2)].

There are written agreements executed between the plan and another entity in which the other entity agrees to furnish specified services to Medicare enrollees of the plan [42 CFR 417.401].

The plan ensures that the required services, additional services, and any other supplemental services for which the Medicare enrollee has contracted are available [42 CFR 417.416(a)].

Hospitals, SNFs, home health agencies, comprehensive outpatient rehabilitation facilities, and providers of outpatient physical therapy or speech pathology services meet applicable conditions of participation in Medicare. Suppliers meet conditions of coverage or conditions for certification of their services [42 CFR 417.416(b)].

Policy: There is a system in place for monitoring the need for additional providers/suppliers and a system for recruitment [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 10, April 1992, 2303.5].

The plan provides, either directly or through arrangements, the same Medicare services as are available to other Medicare beneficiaries who live in the same geographic area but are not enrolled in the plan. If a Medicare covered service is not procurable in the area because a facility or specialist is not available, the plan is required to arrange for these services outside the service area [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 10, April 1992, 2303].

Provider/supplier networks are sufficient to deliver inpatient and outpatient primary and specialty services to current and expected Medicare members in the plan [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 10, April 1992, 2303].

The provider/supplier network for Medicare enrollees is from the same network a plan uses for commercial members. However, the Medicare network may be a subset of a larger commercial network as long as there are not Medicare only providers/suppliers [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 10, April 1992, 2303.1.B].

Providers/suppliers are located throughout the geographic service area [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 10, April 1992, 2303.1].

FEDERAL QUALIFICATION

Statute: Basic health services and contracted services are available within the service area. Basic services which are not primary care or emergency health care services may be located outside the service area of non-metropolitan plans if there are insufficient providers within the service area [Title XIII of the Public Health Service Act, Section 1301(b)(4)].
H.C. Network adequacy (cont’d.)

FEDERAL QUALIFICATION (cont’d.)

Regulation: Same as above statute [42 CFR 417.106(b)(1)(2)].

Staffing patterns of the plan are within generally accepted norms for meeting the projected enrollment needs [42 CFR 417.106(b)(3)(i)].

The plan assures that its affiliated providers meet the following conditions: (1) in the case of hospitals, are either accredited by the JCAHO, or certified by Medicare; (2) in the case of laboratories, are either CLIA-exempt, or have in effect a valid certificate of one of the following types: registration certificate, certificate of waiver, certificate of accreditation; (3) in the case of other affiliated institutional providers, are certified for participation in Medicare and Medicaid [42 CFR 417.124(b)].

Policy: Staffing patterns are within generally accepted norms for meeting projected membership needs [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 2, April 1992, 4005].

Staffing patterns reflect the utilization and needs of special groups of members [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 2, April 1992, 4005.4].

Monitoring the availability and accessibility of care can be done through the credentialing process for physicians [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 2, April 1992, 4005.8].

MEDICAID

Regulation: The plan makes the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration and scope) as those services are to non-enrolled Medicaid recipients within the area served by the HMO [42 CFR 434.20(b)(2)].

The plan provides assurances that it can furnish the health services required by enrolled recipients effectively [42 CFR 434.50(b)].

Guidelines: Standards/guidelines used by the plan focus on the process and outcomes of health care delivery, as well as access to care [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II.C.3].

BUREAU OF PRIMARY HEALTH CARE

Policy: The number and mix of clinical and support staff are appropriate to provide comprehensive health care services for all sites and services [Primary Care Effectiveness Review, Clinical Protocol, II.B.7].

NAIC

A health plan has "sufficient numbers and types" of providers [NAIC, Draft Standards, Health Care Provider Contracting Model Regulation, 7/29/94; Technical changes: 8/27/94, Section 4.A].

II.C. Network adequacy (cont’d.)

Health care services provided directly or by arrangement are appropriate in breadth and depth to meet the needs of the population served [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 3.1].

Health care services are appropriate to meet the breadth and depth of the needs of the population served and its socio-cultural characteristics; and adequate to fulfill the network’s mission and its contractual obligations [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 3.4].

The network determines and provides the appropriate type of practitioner mix (by health care discipline and specialty) to meet member health care needs [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 5].

The network allocates adequate resources to meet member care needs throughout the network [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 2.4.6.1].

The network accommodates the geographic dispersion of its members [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 2.4.6.1].

NCQA

Managed care organizations should develop standards for the availability of primary care providers and assess performance against those standards [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI 7.0].

The plan has written policies and procedures for the initial quality assessment of health delivery organizations (e.g., hospitals, home health agencies, nursing homes and free-standing surgical centers) with which it intends to contract to confirm that the organization has been reviewed and approved by a recognized accrediting body; and is in good standing with state and federal regulatory bodies [NCQA Accreditation Standards, Credentialing, 1994, CR 9.0].

MINNESOTA

All plans: Health care services are provided in such a manner as to enhance and assure both availability and accessibility of adequate personnel and facilities [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.04, Subd.1(a)].

The plan provides reasonable provisions for emergency and out-of-area health care services [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.04, Subd.1(d)].

If the Department of Health determines that there are not enough providers to assure that enrollees have accessible health care services, corrective action may be taken requiring the plan to:

- make payment to nonparticipating providers;
- discontinue accepting new enrollees; and
- reduce its geographic service area [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.121 Subp.7].

26 Summary, Quality Improvement Standards and Processes
II.C. Network adequacy (cont’d.)

The plan has available, either directly or through arrangement, appropriate and sufficient personnel, physical resources and equipment to meet the projected needs of its enrollees for covered health care services [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.2].

The plan develops and implements written standards or guidelines which address the assessment of provider capacity to provide timely access to health care services [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.2.A.(2)].

The plan provides or contracts with a sufficient number of primary care physicians to meet the projected needs of its enrollees [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.2.A.(2)].

Medicaid: The plan contracts with providers as necessary to meet the health service needs of its enrollees [Minnesota Department of Human Services Rules, 9500.1460 Subp.6].

The plan makes services at least as accessible to enrollees as those services are to non-Medicaid enrollees within the plan’s service areas, in terms of timeliness, amount, duration and scope [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.A.2].

OHIO

All plans: A plan has arrangements to assure that its enrollees have reliable access to qualified providers in those specialties which are available within the service area and which are necessary to provide the health services described in its evidence of coverage [Ohio Revised Code, 1742.04(2)].

Arrangements are made for short-term emergencies within the service area, 24 hours per day, 7 days a week, and adequate coverage for out-of-area emergency [Ohio Revised Code, 1742.04(3)].

The plan has provisions for the enrollee to obtain health care services on a 7 days a week, 24 hour a day basis [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.2].

Provisions for health care services are consistent with community standards of access to primary, specialty and acute care services [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.3].

The plan establishes and maintains an adequate full-time equivalent physician-to-enrollee ratio depending upon the population enrolled, their medical needs and location of service areas [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.3].

Medicaid: All covered services required on an emergency basis are available 24 hours a day, 7 days a week in the enrollee’s county of residence [Ohio Administrative Code, Chapter 5101:3-26-03(C)].

The plan must have a contract with obstetricians, gynecologists, pediatricians, dentists, pharmacists, vision care providers, other specialists and at least one hospital located in the county of operation [Ohio Administrative Code, Chapter 5101:3-26-05(A)(5)].
II.C. Network adequacy (cont’d.)

A plan’s primary care provider network ensures availability and access to a minimum of 25% of all eligible individuals in a mandatory county and 20% of all eligible individuals in a voluntary county [Request for Proposals for Health Maintenance Organizations to Provide Medicaid Covered Services to the Aid to Dependent Children and Healthy Start Eligible Populations in Ohio, State of Ohio Department of Human Services, May 19, 1994, V.I.C, p. 15].

There is a minimum ratio of one full-time equivalent primary care physician for each 2000 Medicaid enrollees to be served [Request for Proposals for Health Maintenance Organizations to Provide Medicaid Covered Services to the Aid to Dependent Children and Healthy Start Eligible Populations in Ohio, State of Ohio Department of Human Services, May 19, 1994, V.I.C.2, p.16].

PENNSYLVANIA

All plans: The plan demonstrates the ability to assure both availability and accessibility of adequate personnel and facilities in a manner enhancing availability, accessibility and continuity of service [State of Pennsylvania, Health Maintenance Organization Act, Title 40, Section 1555.1(b)(1)(i)].

A plan has and maintains adequate arrangements to provide the health services contracted for by its enrollees [28 Pa. Code, Section 9.75(a)].

The plan has at least the equivalent of one full-time primary care physician per 1600 enrollees and an overall ratio for all physicians serving the plan of at least the equivalent of one full-time physician per 1200 enrollees. For the purposes of these calculations, a physician extender counts as 1/2 physician [28 Pa. Code, Section 9.76(a)].

There may not be more than 2 physician extenders per primary care physician [28 Pa. Code, Section 9.76(a)(4)(iii)].

Medicaid: The plan at all times has satisfactory written agreements with a sufficient number of providers in and adjacent to the service area to ensure enrollee access to all medically necessary services based on standards established by the state [Pennsylvania Department of Public Welfare, Operating Agreement, Section 9, Provider Enrollment and Handbooks, 9.1].
II.D. Access/Timeliness of service

**MEDICARE**

**Statute:** Services are available and accessible within the service area of the organization with reasonable promptness, 24 hours a day and 7 days a week [Section 1876(c)(4)(A) of the Social Security Act].

The plan conducts periodic surveys of current and past enrollees to determine the degree of access to services [Section 1876(c)(8)(A)(ii)(II) of the Social Security Act].

**Regulation:** The plan ensures that the required services and any other services for which Medicare enrollees have contracted are accessible, with reasonable promptness, to the enrollee with respect to geographic location, hours of operation, and provision of after-hours services [42 CFR 417.416(e)].

Medically necessary emergency services are available 24 hours a day, 7 days a week [42 CFR 417.416(e)].

**Policy:** Services are considered accessible if they reflect usual practice and travel arrangements in the local areas. Generally, hospital and primary care physician services are within 30 minute travel time from the beneficiary’s residence [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 10, April 1992, 2303.1.A].

Hours of operation for health services are convenient to the population and must reflect patterns of care in the geographic area [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 10, April 1992, 2303.2].

The plan has systems in place to collect data and evaluate the availability and accessibility of services with respect to:

- waiting times to obtain appointments for routine scheduled and urgent care;
- waiting times to receive services at physician offices and clinical and diagnostic facilities;
- telephone access to the plan and primary care physician for routine and urgent care, as well as in emergencies, both during and after hours;
- inappropriate use of emergency services as an indicator of lack of availability and accessibility of plan services;
- number of requests, as well as reason for requests, to change primary care physicians;
- number of physician requests to close their practice to new patients;
- physician back-up and on-call arrangements for primary care physicians; and

**FEDERAL QUALIFICATION**

**Statute:** Services are available and accessible within the service area of the organization with reasonable promptness, 24 hours a day and 7 days a week [Title XIII of the Public Health Service Act, Section 1301(b)(4)].

**Regulation:** Geographic location, hours of operation, and arrangement for after-hours services assure reasonable promptness of service [42 CFR 417.106(b)(3)(ii)].

Medically necessary emergency services are available 24 hours a day, 7 days a week [42 CFR 417.106(b)(3)(ii)]. A plan does not impose copayment charges that exceed 50% of the total cost of providing any single service to its enrollees, nor in the aggregate more than 20% of the total cost of providing all basic health services [42 CFR 417.104(a)(4)(i)].
II.D. Access/Timeliness of service (cont’d.)

To ensure that copayments are not a barrier to the utilization of health services or enrollment in the plan, the plan does not charge copayments that will exceed 200% of the total annual premium cost of an option with no copayments in any given year [42 CFR 417.104(a)(4)(ii)].

Policy: Services are considered accessible if they reflect usual practice and travel arrangements in the local areas. Generally, hospital and primary care physician services must be within 30 minute travel time for members [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 2, April 1992, 4005.1.A].

Hours of operation for health services are convenient to the population and must reflect patterns of care in the geographic area [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 2, April 1992, 4005.2].

The plan has systems in place to collect data and evaluate the availability and accessibility of services with respect to:
• waiting times to obtain appointments for routine scheduled and urgent care;
• waiting times to receive services at physician offices and clinical and diagnostic facilities;
• telephone access to the plan and primary care physician for routine and urgent care, as well as in emergencies, both during and after hours;
• inappropriate use of emergency services as an indicator of lack of availability and accessibility of plan services;
• number of requests, as well as reason for requests, to change primary care physicians;
• number of physician requests to close their practice to new patients;
• physician back-up and on-call arrangements for primary care physicians; and
• volume of out-of-plan referrals by specialty and service [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 2, April 1992, 4005.7].

Regulation: All covered emergency medical services are provided directly or through arrangement 24 hours a day, 7 days a week [42 CFR 434.30(a)].

The plan makes the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration and scope) as those services are to nonenrolled Medicaid recipients within the area served by the HMO [42 CFR 434.20(b)(2)].

Health services are furnished as promptly as is appropriate [42 CFR 434.52(a)].

Guidelines: The plan promotes accessibility of services by: identifying points of access to primary care, specialty care and hospital services; providing information to members about how to obtain regular, emergency and after-hours care; and providing information on how to obtain the names, qualifications and titles of providers [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard X.G, p. 26].

The plan establishes standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and member service lines) and assesses performance against these standards [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard XI, p. 28].
II.D. Access/Timeliness of Service (cont’d.)

Policy: Clinic hours assure access and include at least one 3-hour evening and/or weekend session per week.

There are appropriate policies and procedures for after-hours and emergency coverage.

There are principles of practice which address triage, walk-ins and telephone triage [Primary Care Effectiveness Review, Clinical Protocol, II.A.1].

Waiting times in the health center for appointments and office visits are reasonable [Primary Care Effectiveness Review, Clinical Protocol, IV.A.1].

The quality improvement program includes an evaluation of the accessibility of health care services according to standards established by statute or regulation or the commissioner [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.B(2)].

Providers provide covered services on a 24-hours, 7 days-a-week basis. Alternate coverage arrangements during times of non-availability are documented [NAIC, Draft Standards, Health Care Provider Contracting Model Regulation, 7/29/94; Technical changes: 8/27/94, Section 6.O].

The plan maintains data on:
- distance to primary care providers in urban and rural areas;
- number of enrollees who have registered or seen a primary care physician in the past 12-month period;
- waiting times for non urgent care, urgent care, emergency room, mental health/SA, and other providers;
- waiting times for appointments with non urgent care (office visits), urgent care, mental health/substance abuse, and other providers; and
- telephone access to urgent and non urgent care providers [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/94, Section 3.D].

Certification time frames are established for each of the following:
- certification decisions regarding proposed admissions, service or procedure within 2 business days;
- certification notices are provided within 24 hours by telephone or in writing to the provider or facility and to the enrollee; and
- concurrent review certifications of a continued stay in a facility or additional health care services are communicated via telephone within 24 hours [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 7].
II.D. Access/Timeliness of service (cont’d.)

**JCAHO**

Services are available in a timely manner appropriate to the setting and consistent with the member’s needs [1994 Joint Commission Standards for Health Care Networks, *Continuum of Care*, CC 2.3.1 and 2.3.2].

**NCQA**

The plan has standards for access, including routine, urgent, and emergency care, telephone appointments, advice and member service lines [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI 7.0].

The plan takes steps to ensure that services offered are accessible to members [NCQA Accreditation Standards, *Members’ Rights and Responsibilities*, 1994, RR 5.2].

The points of access to primary care, specialty care and hospital services are identified for members [NCQA Accreditation Standards, *Members’ Rights and Responsibilities*, 1994, RR 5.2.1].

Members are informed about how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care [NCQA Accreditation Standards, *Members’ Rights and Responsibilities*, 1994, RR 5.2.2].

Members are provided a written statement that includes information about provisions for after-hours and emergency coverage [NCQA Accreditation Standards, *Members’ Rights and Responsibilities*, 1994, RR 5.0].

**MINNESOTA**

All plans: Services are available and accessible, including emergency services, 24 hours a day and 7 days a week [Minnesota Statutes, Chapter 62D, *Health Maintenance Organizations*, 62D.07].

Primary care physician services are available and accessible 24 hours per day, 7 days per week, within the plan’s service area as provided through regularly scheduled appointments during normal business hours; after-hours clinics; use of a 24-hour answering service with medically appropriate call-back times; back-up coverage; and referrals to urgent care centers [Chapter 4685, Department of Health, *Health Maintenance Organizations*, 4685.1010, Subp.2.A.(I)].

Specialty physician services are available and accessible 24 hours per day, 7 days per week, within the plan’s service area, as provided through regularly scheduled appointments during normal business hours; after-hours clinics; use of a 24-hour answering service with medically appropriate call-back times; back-up coverage; and referrals to urgent care centers [Chapter 4685, Department of Health, *Health Maintenance Organizations*, 4685.1010, Subp.2.B.(I)].

Hospital services are available and accessible, on a timely basis consistent with generally accepted practice parameters, 24 hours per day, 7 days a week [Chapter 4685, Department of Health, *Health Maintenance Organizations*, 4685.1010, Subp.2.C].

The plan contracts with sufficient numbers of providers of ancillary services and mental health and chemical dependency services to meet the projected needs of its enrollees and consistent with generally accepted practice parameters [Chapter 4685, Department of Health, *Health Maintenance Organizations*, 4685.1010, Subp.2.D.E].

The travel distance or time within the plan’s service area to the nearest provider of primary care services or to the nearest general hospital provider is the lesser of 30 miles or 30 minutes [Chapter 4685, Department of Health, *Health Maintenance Organizations*, 4685.1010, Subp.3.A].
II.D. Access/Timeliness of service (cont’d).

The maximum travel distance or time within the plan’s service area to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services is the lesser of 60 miles or 60 minutes [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.3.B].

The plan provides access to emergency care [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.7].

The plan or its participating providers have appointment scheduling guidelines based on type of health care service [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.6.B].

Medicaid: The plan demonstrates that access to the nearest primary care physician or hospital facility does not exceed 30 miles or 30 minute travel distance or time for any enrollees in the plan [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.3].

The plan demonstrates adequate geographic access to all other types of services and providers [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.3].

The plan continually monitors the geographic accessibility of the services it provides and contracts with additional providers as needed [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.3].

The plan establishes clinically appropriate scheduling guidelines for various types of appointments including: routine physicals, prenatal care, diagnosis of acute pain or injury, and follow-up appointments for chronic conditions and communicates these guidelines in writing to the provider network. The plan monitors, and corrects when appropriate, the actual time that enrollees must wait to be seen by the office or clinic [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.4].

Primary care physician services are available 24 hours per day, 7 days a week, within the service area [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.A.8].

There is a written protocol which contains standards for regular access to care during normal business hours; provision of care after hours; use of 24-hour answering service with maximum call-back response time based on medical needs; back-up coverage by another participating primary care physician; and referrals to urgent care centers where available and the hospital emergency room when appropriate [Request for proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II].
II.D. Access/Timeliness of service (cont’d.)

**OHIO**

**All plans:** The plan demonstrates that health care services will be provided as promptly as is appropriate (Ohio Revised Code, 1742.04(1)).

Arrangements are made for short-term emergencies within the service area, 24 hours per day, 7 days a week, and adequate coverage for out-of-area emergencies (Ohio Revised Code, 1742.04(3)).

The plan has a process for monitoring and evaluating accessibility of care and for addressing problems which develop (Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.3).

The plan establishes, implements and reviews internal standards and policies pertaining to the schedule capacity of primary care physicians and specialists; reasonable waiting times for routine care; and timeliness of urgent and emergency care delivered during and after hours (Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, pp.4-5).

**Medicaid:** The plan and/or primary care provider sites have written triage procedures that assure:
- emergency needs are triaged immediately upon presentation at the primary care provider site;
- urgent needs are triaged within 1 hour upon presentation at the primary care provider site; and
- persistent symptoms are treated within 48 hours after initial contact with the primary care provider site
- requests for routine care have appointments scheduled within 3 weeks (Ohio Administrative Code, Chapter 5101:3-26-075(C)).

Providers are accessible if within 30 minute travel time from recipients (Request for Proposals for Health Maintenance Organizations to Provide Medicaid Covered Services to the Aid to Dependent Children and Healthy Start Eligible Populations in Ohio, State of Ohio Department of Human Services, May 19, 1994, V.I.C., p. 15).

**PENNSYLVANIA**

**All plans:** As part of a plan’s initial credentialing process of a practitioner, a site visit is made to all primary care physicians to assess the availability and accessibility of services for new members. Evidence must be documented through a review of the appointment book (e.g., the average number of patients seen per hour; availability of emergency appointments) (HMO Applications Technical Advice and Assistance, p. 1).

The plan has written procedures governing the availability of frequently utilized services, including at least: well-patient examinations and immunizations; emergency telephone consultation on a 24 hour per day, 7 day a week basis; treatment of acute emergencies; treatment of acute minor illness; and treatment of chronic illness (28 Pa. Code, Section 9.75(a)).

**Medicaid:** Emergency services are available on a 24-hour a day, 7 days a week basis (Pennsylvania Department of Public Welfare, Operating Agreement, Section 4, Medical Services, 4.2).

Primary care sites are encouraged to contact enrollees who have not had an encounter during the past year, based on information provided by the state (Pennsylvania Department of Public Welfare, Operating Agreement, Section 6, Recipient Services, 6.6).
II.E. Preventive health

**MEDICARE**

**Statute:** A risk contracting HMO or CMP provides enrolled members at least physician services, inpatient hospital services, laboratory, X-ray, emergency and preventive services [Section 1876(b)(2) of the Social Security Act].

**Regulation:** HMOs and CMPs furnish to Medicare enrollees (directly or through arrangements with others) all the Medicare services to which those enrollees are entitled that are available to Medicare beneficiaries who reside in the service area but are not enrolled in the HMO or CMP [42 CFR 417.414(b)].

**FEDERAL QUALIFICATION**

**Statute:** Preventive services are available, including immunizations, well-child care from birth, periodic health examinations for adults, voluntary family planning services; infertility services; and eye and ear examinations for children through age 17 [Title XIII of the Public Health Service Act, Section 1302(a)(1)(H)].

**Regulation:** Preventive services are available and include at least the following: a broad range of voluntary family planning services; services for infertility; well-child care from birth; periodic health examinations for adults; eye and ear examinations for children through age 17; and pediatric and adult immunizations in accord with accepted medical practice [42 CFR 417.101(a)(8)(i-v)].

**MEDICAID**

**Guidelines:** Standards/guidelines used in the quality assurance program address preventive health services [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II.C.6].

Priority clinical areas of concern suggested for quality of care studies include many areas of prevention (e.g., childhood immunization, mammography, pap smears, lead toxicity, well-child assessment, HIV, pregnancy prevention, cholesterol screening and management, prevention of influenza, smoking cessation, dental screening) [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Chapter III].

**BUREAU OF PRIMARY HEALTH CARE**

**Policy:** There are tracking systems in place for routine preventive services (e.g., chronic disease care, abnormal pap smears, immunization) [Primary Care Effectiveness Review, Clinical Protocol, III.B.5].


The health center provides education to parents and guardians about immunizations, including the risks and benefits of immunization [Primary Care Effectiveness Review, Clinical Protocol, IV.C.1].
II.E. Preventive health (cont’d.)

BUREAU OF PRIMARY HEALTH CARE (cont’d.)

Policy: The health center routinely evaluates all children for lead poisoning risk and provides referrals for lead abatement programs for the homes of at-risk patients [Primary Care Effectiveness Review, Clinical Protocol, IV.C.5].

Patient education services are offered in: childbirth, parenting skills, smoking cessation, substance abuse, nutrition, family planning, pre- and intraconceptual counseling and care [Primary Care Effectiveness Review, Clinical Protocol, IV.G.2].

NAIC

Health care services that are preventive in nature are tracked and reported through the encounter and claims data [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/95, Section 3.H(2)].

JCAHO

Providers develop effective mechanisms that address members’ education needs, including, when applicable, health promotion and disease prevention [1994 Joint Commission Standards for Health Care Networks, Education and Communication, ED 3.2].

Process measures encompass preventive services and health promotion programs [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PI 3.4.2.4].

NCQA

The plan takes an active role in improving the health status of its members [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI 8.0].

The plan facilitates effective health promotion and health management [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI 8.1, 8.2].

The plan informs and educates providers about using the health promotion and management program for members assigned to them [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI 8.3].

There are practice guidelines for the use of preventive health services that are based on reasonable medical evidence, developed or adopted with the participation of plan providers, and updated periodically [NCQA Accreditation Standards, Preventive Health Services, 1994, PH 1.0].

Practice guidelines are developed for the full spectrum of populations enrolled in the plan [NCQA Accreditation Standards, Preventive Health Services, 1994, PH 1.4].

The plan informs its providers about preventive health guidelines [NCQA Accreditation Standards, Preventive Health Services, 1994, PH 2.0].

The plan takes steps to inform members of the practice guidelines for the use of preventive health services and ensure that members use recommended preventive health services at appropriate intervals [NCQA Accreditation Standards, Preventive Health Services, 1994, PH 3.0].
II.E. Preventive health (cont’d.)

NCQA (cont’d.)

The plan assesses its performance in the use of preventive health services through the QI program and, at least annually, monitors and evaluates a minimum of two preventive health services and takes action to improve the use of preventive services as appropriate [NCQA Accreditation Standards, Preventive Health Services, 1994, PH 4.0].

MINNESOTA

All plans: Preventive health services are available and accessible based upon accepted medical standards [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.080, Subp.8].

Medicaid: A plan notifies eligible enrollees once annually of the availability of Child and Teen Checkup services and has a tracking system for monitoring utilization of such services [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.B.2].

A plan develops a service delivery plan for the provision of prenatal care services to its enrollees, including a procedure for assessing prenatal risk [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, I.B.1].

A plan creates a system that ensures that children of all geographic areas, racial and ethnic groups, and socioeconomic strata receive age-appropriate immunizations against DPT, polio, MMR, Hib, and hepatitis B such that 90% are up to date when measured within 2 months of the dates on which they were to be vaccinated [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, I.B.3].

OHIO

Medicaid: The plan or primary care provider designates a staff person who is responsible for planning, implementing and integrating education activities in the overall preventive health care program for members [Ohio Administrative Code, Chapter 5101:3-26-073(C)(2)].
II.E. Preventive health (cont’d.)

Medicaid: The plan is required to provide enrollees with:
• information regarding pregnancies which conveys the importance of prenatal care;
• information about family planning services;
• information stressing preventive care and periodic visits to primary care physicians; and
• information on the availability and access to EPSDT services for members under 21 [Pennsylvania Department of Public Welfare, Operating Agreement, Section 6, Recipient Services, 6.4].

The plan identifies the health education needs of enrollees and implements plans to meet those needs [Pennsylvania Department of Public Welfare, Operating Agreement, Section 6, Recipient Services, 6.6].

The plan implements an enrollee education and outreach program which includes:
• a health education program focusing on the leading causes of hospitalization and emergency room use; and
• health initiatives that target high-risk population groups with integrated, multi-faceted preventive approaches [Pennsylvania Department of Public Welfare, Operating Agreement, Section 6, Recipient Services, 6.8].

The plan establishes a Health Education Advisory Committee that includes members qualified to advise on the health education needs of enrollees [Pennsylvania Department of Public Welfare, Operating Agreement, Section 6, Recipient Services, 6.9].

The plan establishes and funds a Community Foundation in its service area to develop initiatives that address the health care and quality of life issues that are most critical to the community [Pennsylvania Department of Public Welfare, Operating Agreement, Section 6, Recipient Services, 6.10].
II.F. Medical records

**MEDICARE**

Regulation: A medical record keeping system is maintained through which pertinent information relating to the health care of enrollees is accumulated and is readily available to appropriate professionals [42 CFR 417.416(e)(2)].

**FEDERAL QUALIFICATION**

Regulation: The confidentiality of the health and medical records of enrollees is assured [42 CFR 417.106(d)].

There is a system of medical records that accumulates appropriate information and makes it available to appropriate professionals [42 CFR 417.106(c)].

The plan maintains a record-keeping system through which pertinent information relating to the health care of the member is accumulated, readily available and shared among appropriate professionals [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 2, April 1992, 4006].

**MEDICAID**

Regulation: Contracts provide for the maintenance of an appropriate record system for services to enrolled recipients [42 CFR 434.6(a)(7)].

Guidelines: The plan has mechanisms for the maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review through: (1) medical record standards that include requirements for patient identification number; personal data; entry date; provider identification; legibility; allergies; past medical history; immunizations; diagnostic information; medication information; consultations, referrals and specialty reports; emergency care; hospital discharge summaries; and advance directives; and (2) patient visit data that document each encounter and provide evidence of history and physical examination; plan of treatment; diagnostic tests; therapies and other prescribed regimens; follow-up; referrals and the results thereof; and all other aspects of patient care, including ancillary services [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard XIII, pp. 28-31].

The plan has a system to assess the content of medical records for legibility, organization, completion and conformance to its standards [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard XII.C.1, p.31].

**BUREAU OF PRIMARY HEALTH CARE**

Policy: Medical records are periodically reviewed to determine quality, completeness and legibility [Primary Care Effectiveness Review, Clinical Protocol, III.A.2].

A clinical record is maintained for every patient receiving care at the health center [Primary Care Effectiveness Review, Clinical Protocol, III.A.3].
II.F. Medical records (cont'd.)

**Policy:** Portable immunization records are provided for mobile populations, such as migrant and seasonal farm workers and homeless [Primary Care Effectiveness Review, Clinical Protocol, III.A.4].

Record reviews show uniform format and logical flow of information, legible information, timely entry of data, appropriately dated information, problem-oriented record in SOAP format, patient and family ID, signed consents for treatment when required, evidence that provider has reviewed consult reports, provider signature, conspicuous listing of drug allergies, documentation of reason for every visit, past and present medical histories, findings of physical examinations, documentation of special studies ordered, documentation of clinical assessments or diagnoses, and disposition of patients [Primary Care Effectiveness Review, Clinical Protocol, III.A.5].

Additional information for perinatal patients is documented in the record with respect to: presence of LMP and EDC, HIV/AIDS education, blood pressure, weight, urinalysis, FHR for visits after 12 weeks, first post-partum visit, ongoing risk assessment and management, childbirth and parity information [Primary Care Effectiveness Review, Clinical Protocol, III.A.7].

**NAIC**

Medical records are available for each encounter and reflect all aspects of patient care, including ancillary services [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/94, Section 3.C(1)].

Records are available to health care practitioners at each encounter [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/94, Section 3.C(2)].

There are standards for systematic review of conformance and corrective action when records are found not to conform [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/94, Section 3.C(3)].

Providers are required to maintain and make available to the health plan medical records that are necessary to monitor and evaluate the quality of care, conduct medical evaluations and audits, and determine, on a concurrent and retrospective basis, the medical necessity and appropriateness of care provided to health plan enrollees [NAIC, Draft Standards, Health Care Provider Contracting Model Regulation, 7/29/94; Technical changes: 8/27/94, Section 6.H].

**JCAHO**

The completeness, accuracy and timely completion of information in medical records are periodically reviewed and actions taken as necessary to improve [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 3.2.1].

The network uses a member information system that routinely provides access to all divergently located record components as necessary during the course of treatment [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 6.1].

The record of health information contains sufficient information to identify the member, support the diagnosis, justify the treatment/services, document the course and results of treatment and facilitate continuity of care among components. All information must be entered into the health record as soon as possible after its occurrence. All entries must be dated and authenticated [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 6.3-6.5].
II.F. Medical records (cont’d.)

NCQA

Medical records are maintained in a manner that is current, detailed, organized and permits effective patient care and quality review [NCQA Accreditation Standards, Medical Records, 1994, MR 1.0].

Medical records reflect all aspects of patient care, including ancillary services [NCQA Accreditation Standards, Medical Records, 1994, MR 1.1].

Records are available to health care practitioners at each encounter and to NCQA reviewers [NCQA Accreditation Standards, Medical Records, 1994, MR 1.2].

The organization sets standards for medical records and systematically reviews records for conformance, and institutes corrective action when standards are not met [NCQA Accreditation Standards, Medical Records, 1994, MR 2.0].

MINNESOTA

All plans: The plan implements a system to assure that medical records are maintained with timely, legible, and accurate documentation of all patient interactions, including documentation regarding patient history, health status, diagnosis, treatment and referred service notes [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1100, Subp.13.A].

The plan maintains a medical record retrieval system that ensures that medical records, reports and other documents are readily accessible to the plan [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1100, Subp.13.B].

OHIO

All plans: The plan maintains a medical record system that provides for sharing of all pertinent information relating to the health care of each enrollee among the plan’s health professionals [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.5].

At a minimum, the medical record system is maintained in a manner consistent with professional standards and practices and has sufficient staff, facilities, and equipment to provide medical records which are readily available and systematically organized [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.5].

Clinical information is maintained in the medical record in a current, legible, detailed, organized and comprehensive manner and reflects all aspects of patient care in addition to demonstrating conformity with good professional medical practice that allows for effective quality assurance review [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.15].

Medicaid: The plan has a paper or electronic system for medical records which facilitates case management and includes, at a minimum, state-specified contents [Ohio Administrative Code, Chapter 5101:3-26-077(A)(1)].

The plan/provider site has a policy regarding the confidentiality of medical records which ensures that records are handled to preclude loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure of information [Ohio Administrative Code, Chapter 5101:3-26-077(A)(2)].
II.F. Medical records (cont’d.)

Information obtained about enrollees related to their examination, care, and treatment is held confidentially and not divulged without the enrollee’s authorization unless it is required by law, necessary to coordinate the patient’s care or necessary in compelling circumstances [Ohio Administrative Code, Chapter 5101:3-26-077(A)(3)].

PENNSYLVANIA

All plans: Medical records are maintained in a current, detailed and comprehensive manner and conform with good professional medical practice, permit effective quality assurance review and facilitate continuity of care [28 Pa. Code, Section 9.74(a)(1)].

Medical records must be well organized, legible and reflect all aspects of patient care; contain a current and complete medical history and physical; and include complete and current listing of allergies, medications and diagnoses [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, C.3.1].

For each patient encounter, there must be a dated and signed progress note that contains, at a minimum, the chief complaint or purpose of visit; objective findings, diagnosis or medical impression; and therapeutic action [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, C.3.2].

Records reflect all aspects of patient care, including ancillary services, and are available to health care practitioners at each encounter [Pennsylvania Department of Health, Standards for Medical Records, 1.0].

Medicaid: There are standards for medical record keeping requirements which equal or exceed the following standards: the record is legible throughout; the record identifies the patient on each page; entries are signed and dated by the responsible licensed provider; the record contains a preliminary working diagnosis as well as a final diagnosis and the elements of a history and physical examination upon which the diagnosis is based; treatments and treatment plan are in the record; the record indicates the progress at each visit, change in diagnosis, change in treatment, and response to treatment; the record contains summaries of hospitalizations and reports of operative procedures and excised tissues; the record contains results, including interpretations of diagnostic tests and reports of consultations; the disposition of the case is entered into the record; the record contains documentation of the medical necessity of a rendered, ordered or prescribed service [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, Attachment IV, P].
II.G. Continuity of care

Statute: Services are available and accessible in a manner that assures continuity [Section 1876(c)(4)(A) of the Social Security Act].

Regulation: The plan ensures that required services, additional services and any other supplemental services for which the Medicare enrollee has contracted are furnished in a manner that ensures continuity [42 CFR 417.416(a)].

Policy: The concept of continuity of care emphasizes:
- coordination of health care services among primary and specialty care physicians;
- coordination among specialists;
- appropriate combinations of prescribed medications;
- coordinated use of ancillary services, including social services and other community resources
- appropriate discharge planning; and
- timely placement at different levels of care, including hospital, SNF and home health [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 10, April 1992, 2304].

The system of continuity of care may include the development of a plan for the overall treatment of each patient [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 10, April 1992, 2304.1].

Continuity of care may be achieved by having a primary physician responsible for coordinating a member's overall health care and by maintaining record-keeping systems through which pertinent information relating to the health care of the member is accumulated and shared among appropriate professionals [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 10, April 1992, 2304].

The plan makes arrangements for the physician or other health professional coordinating the member's overall health care to be kept informed about referral services provided to the member [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 10, April 1992, 2304].

Statute: Services are available and accessible in a manner that assures continuity [Title XIII of the Public Health Service Act, Section 1301(b)(4)].

Regulation: There are arrangements for a health professional to be responsible for coordinating an enrollee's care; a system of medical records that accumulates appropriate information and makes it available to appropriate professionals; and arrangements to ensure that the coordinating health professional is kept informed about referral services [42 CFR 417.106(c)].

Policy: The concept of coordination of care emphasizes:
- coordination of health care services among primary and specialty care physicians;
- coordination among specialists;
- appropriate combinations of prescribed medications;
- coordinated use of ancillary services, including social services and other community resources
- appropriate discharge planning; and
- timely placement at different levels of care, including hospital, SNF and home health [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 2, April 1992, 4006].
II.G. Continuity of care (cont’d.)

FEDERAL QUALIFICATION (cont’d.)

The plan has a health professional who is primarily responsible for coordinating a member’s overall health care [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 2, April 1992, 4006].

Arrangements are made for the physician or other health professional coordinating a member’s overall health care to be kept informed about referral services provided to the member [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 2, April 1992, 4006].

The system of continuity of care may include the development of plan for the overall treatment of each patient [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 2, April 1992, 4006.1].

MEDICAID

Guidelines: The plan has a basic system in place which promotes continuity of care and care management [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard XIV, p. 32].

BUREAU OF PRIMARY HEALTH CARE

Policy: The medical records reflect adequate continuity of care (e.g., continuity of primary care provider, timely return after hospitalization or delivery) [Primary Care Effectiveness Review, Clinical Protocol, III.A.8].

Protocols allow for tracking patients who require follow-up (e.g., specialty referrals, hospitalizations, chronic disease care, abnormal pap smears, immunization, X-ray and lab results, “no shows”) [Primary Care Effectiveness Review, Clinical Protocol, III.B.2].

Primary care providers continue to be the primary care manager of referred clients [Primary Care Effectiveness Review, Clinical Protocol, III.B.3].

Mechanisms exist to ensure continuity of care for all patients in all health center programs [Primary Care Effectiveness Review, Clinical Protocol, III.B.4].

NAIC

No standards specified.
II.G. Continuity of care (cont'd.)

Transition from each component or level of care in the network is based on the member's assessed needs and the organization's capability to provide the care or treatment [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 2.5].

Information necessary to facilitate continuity of care is provided to subsequent care givers at the time the site of services changes [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 2.5.1].

The delivery of health care services is integrated throughout the network [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 4].

Health care services are appropriate to meet the breadth and depth of the needs of the population served and its socio-cultural characteristics; and adequate to fulfill the network's mission and its contractual obligations [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 3.4].

The network assures that information is communicated by providers in a timely manner to facilitate the provision of an appropriate continuum of services [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 6].

A member is informed of any specific health care needs that require follow-up [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 8].

The network's leaders individually and jointly develop and participate in systematic and effective mechanisms for ensuring smooth transition of member care across network components [1994 Joint Commission Standards or Health Care Networks, Leadership, LD 4.2.3].

The plan evaluates the continuity and coordination of care members receive [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.6.3].

MINNESOTA

All plans: The plan provides for the coordination and continuity of care for enrollees referred to specialty physicians and, where possible, provides this coordination through the enrollee's primary care provider [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.5.B].

Medicaid: An individual plan of care is developed, implemented, evaluated, monitored, revised, and coordinated with other health professionals as appropriate and necessary [Minnesota Department of Human Services Rules, 9500.1460 Subp.15].

There is participation by health plan or provider staff in coordination with county case management activities, including case conferences when requested by the county [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.A.11].
II.G. Continuity of care (cont’d.)

MINNESOTA (cont’d.)

A plan develops a care-management system designed to coordinate the provision of health care services to its enrollees [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.11].

OHIO

All plans: The plan demonstrates that health care services will be provided in a manner that assures continuity of care [Ohio Revised Code, 1742.04(1)].

Continuity of care is assured through:
- a system of medical management for coordinating the provision of health care services for each enrollee;
- protocols for patient care;
- a referral system, including out-of-plan referrals, as needed;
- a system of documentation of referrals and of monitoring follow-up on referrals;
- provisions for monitoring of enrollees with ongoing medical conditions; and
- the maintenance of a medical record system that provides for sharing of all pertinent information relating to the health care of each enrollee among the plan’s health professionals [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.5].

Medicaid: There is a written description of the plan’s case management process for promoting continuity of care and care coordination [Ohio Administrative Code, Chapter 5101:3-26-073(A)].

The plan has written evidence of the communication of patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the providers where ongoing referral arrangements are in place [Ohio Administrative Code, Chapter 5101:3-26-073(B)(2)(b)].

The plan and/or providers develop a policy/procedure regarding follow-up in the event of broken or missed appointments [Ohio Administrative Code, Chapter 5101:3-26-073(B)(3)].

The plan and/or primary care provider designates an entity to monitor enrollees with chronic conditions [Ohio Administrative Code, Chapter 5101:3-26-073(C)(1)].

PENNSYLVANIA

All plans: The plan provides for the coordination and continuity of care for enrollees referred to specialists [28 Pa. Code, Section 9.75(d)(4)].

Appropriate health management and continuity of care are clearly reflected in the medical records with evidence of follow-up to previous encounters, hospital discharge summaries, referrals and referral results, and documentation of emergency encounters and follow-up [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, C.3.3].

Medicaid: There are procedures to ensure adequate discharge planning [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, Attachment IV, J].
The plan develops, and submits to the state, a plan to ensure effective communication among the plan, primary care physicians and drug and alcohol and mental health providers, which integrates inpatient treatment programs with the existing system of publicly funded community mental health agency programs [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, 14.3].
II.H.1. Quality assurance program/Program description/Activities

Statute: There is a quality assurance program that stresses health outcomes and provides review by physicians and other health professionals of the process followed in the provision of such health care policy [Section 1876(c)(6) of the Social Security Act].

Regulation: There is an ongoing quality assurance program that (1) stresses health outcomes consistent with the state of the art; (2) provides review by physicians and other health professionals; (3) uses systematic data collection of performance and patient results, interpret data to practitioners and make needed change; and (4) provides for remedial action, as necessary [42 CFR 417.418].

Policy: The QA program provides for a review of health outcomes for the entire range of care provided, assuring that all demographic groups, care settings and types of services are included in the scope of the QA review [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.2.A].

Areas for review are selected on the basis of high volume, high-risk diagnosis or procedure, adverse outcomes, or other problem-focused method consistent with the state of the art [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.2.B].

The QA program has written guidelines delineating a systematic process for conducting quality assurance activities, including: (1) identifying areas for review; (2) determining if problems exist in those areas; (3) providing feedback to appropriate health professionals; (4) recommending and implementing corrective actions; and (5) monitoring and evaluating the implementation of corrective actions to assure that appropriate changes have been made [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.F].

The QA committee or its designee reviews sources of data on performance and patient results, such as: enrollee complaints, health professional, provider, and staff feedback; member survey results; clinical and non-clinical study results; referrals through the utilization review system; and potential problem areas identified through the information system [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.3.B].

FEDERAL QUALIFICATION

Statute: There is a quality assurance program that stresses health outcomes and provides review by physicians and other health professionals of the process followed in the provision of health services [Title XIII of the Public Health Service Act, Section 1301(c)(6)].

Regulation: There is an ongoing quality assurance program that (1) stresses health outcomes consistent with the state of the art; (2) provides review by physicians and other health professionals; (3) uses systematic data collection of performance and patient results, interpret data to practitioners and makes needed change; and (4) includes written procedures for appropriate remedial action [42 CFR 417.106(a)].

Policy: The QA program provides for a review of health outcomes for the entire range of care provided, assuring that all demographic groups, care settings and types of services are included in the scope of the QA review [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.2.A].
II.H.1. Quality assurance program/Program description/Activities (cont’d.)

**FEDERAL QUALIFICATION (cont’d.)**

Areas for review are selected on the basis of high volume, high-risk diagnosis or procedure, adverse outcomes, or other problem-focused method consistent with the state of the art [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.2.B].

The QA program has written guidelines delineating a systematic process for conducting quality assurance activities, including: (1) identifying areas for review; (2) determining if problems exist in those areas; (3) providing feedback to appropriate health professionals; (4) recommending and implementing corrective actions; and (5) monitoring and evaluating the implementation of corrective actions to assure that appropriate changes have been made [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.F].

The QA committee or its designee reviews sources of data on performance and patient results such as: enrollee complaints, health professional, provider, and staff feedback; member survey results; clinical and non-clinical study results; referrals through the utilization review system; and potential problem areas identified through the information system [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.3.B].

**MEDICAID**

**Regulation:** There is an internal quality assurance system that provides for (1) review by appropriate health professionals; (2) systematic data collection of performance and patient results; (3) interpretation of data to the practitioner; and (4) making needed changes [42 CFR 434.34].

**Guidelines:** The quality assurance program provides a systematic process of quality assessment and improvement, including (1) the specification of clinical or health services delivery areas to be monitored; (2) the use of clinical indicators; (3) the use of clinical care standards/practice guidelines; (4) the analysis of clinical care and related services; (5) the implementation of remedial/corrective actions; (6) the assessment of effectiveness of corrective actions; and (7) the evaluation of continuity and effectiveness of the quality assurance program [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II, p. 15-18].

The scope of the quality assurance program is comprehensive, addressing both the quality of clinical care and the availability, accessibility, coordination, and continuity of care [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard I.B, p. 14].

The quality assurance program monitors quality of care against clinical care or health service delivery standards or practice guidelines based on reasonable scientific evidence and are developed or reviewed by plan providers [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II.C.1-2, p. 16].
II.H.1. Quality assurance program/Program description/Activities (cont’d.)

**BUREAU OF PRIMARY HEALTH CARE**

Policy: There is a written quality management plan including a QM Committee which meets at least quarterly. Reports of the QM Committee are reported to Administration and used to modify policies and procedures and in the strategic planning process. The QM plan includes a procedure for the random selection of medical records [Primary Care Effectiveness Review, Clinical Protocol, III.C.1].

**NAIC**

The internal quality assessment and improvement system includes principles and processes to foster the continuous improvement of health care provided to covered persons, including the provision of information on health care treatment protocols to providers, developed with appropriate clinical input, the measurement of provider performance, and the continuous identification of practices that result in the best health outcomes [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.A(1)].

No less than an annual analysis of patterns of care related to processes and outcomes based on an evaluation of variations in practice patterns as determined by reference data sources, practice guidelines, enrollee and provider-specific utilization information, enrollee satisfaction and grievance information. Priorities are established considering issues related to high volume, high risk and under-utilization and over-utilization of services. An evaluation of health service accessibility is also conducted no less than annually [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.B].

**JCAHO**

The network has a planned, systematic, network-wide approach to designing, measuring, assessing, and improving its performance [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PL.1].

Network leaders adopt and effectively employ an approach to performance improvement that includes at least the following:
- planning the process of improvement;
- setting priorities for improvement;
- measuring and assessing performance systematically;
- implementing improvement activities based on assessment; and
- maintaining achieved improvements [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 5.2-LD 5.2.5].

The design of network improvement activities is based on: the network’s mission, vision and plans; the needs and expectations of members, staff, purchasers, payers and others; up-to-date sources of information about designing processes (such as practice guidelines); and the performance of the processes and their outcomes in other organizations and networks [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PL 2.1-PL 2.1.4].

Processes measured on an ongoing basis include those that: (1) affect a large percentage of members; place members at serious risk if not performed well, or performed when not indicated or not performed when indicated; and (2) have been or are likely to be problem prone [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PL 3.4.1-PL 3.4.1.3].

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II.H.1. Quality assurance program/Program description/Activities (cont’d.)

JCAHO (cont’d.)

Processes of special interest include: member entry, assessment and treatment; transition in care among network components; important clinical events; preventive measures and health promotion programs; and over-utilization, under-utilization and inefficient utilization [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PL 3.4.2-PI 3.4.2.5].

NCOA

The QI program is designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and service to members, and to pursue opportunities for improvement [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.5.0].

The scope of the QI program is comprehensive, including the quality of clinical care and quality of service [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.5.1].

The monitoring and evaluation of clinical issues reflects the population served (e.g., age groups, disease categories and special risk status), clinical settings (e.g., institutional and non-institutional) and services (primary care and major specialty services, including mental health care) [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.5.3, 5.4].

The monitoring and evaluation of important aspects of care and service includes high-volume and high-risk services, and the care of acute and chronic conditions [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.6.1].

The plan uses a variety of mechanisms to identify important areas for improvement and to set meaningful priorities [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI 6.0].

The plan is accountable for adopting and using practice guidelines or explicit criteria that are based on reasonable scientific evidence and reviewed by plan providers [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.6.2].

MINNESOTA

All plans: The plan has an arrangement for an ongoing evaluation of the quality of health care [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.04, Subd.1(b)].

The components of the ongoing quality evaluation include:

Clinical components: acute care hospital, ambulatory care, emergency, mental health, preventive health services, pharmacy, chemical dependency, other professional health care services, home health care, durable medical equipment and skilled nursing care.

Organizational components: referrals, case management, discharge planning, appointment scheduling, second opinions, prior authorization, provider reimbursement arrangements, other systems, procedures that affect the delivery of care.

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II.H.1. Quality assurance program/Program descriptions/Activities (cont’d.)

MINNESOTA (cont’d.)

Consumer components: enrollee surveys, enrollee complaints, enrollee written and verbal comments [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1115, Subp.1].

The plan conducts focused studies as part of its overall quality assurance activities which are directed at problems, potential problems or areas with potential for improvement and, as appropriate, implements corrective actions [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1125, Subp.1-5]. This provision does not pertain to community integrated service networks.

Medicaid: The quality assurance system includes a process by which appropriate health professionals (1) review the delivery of services to enrollees; (2) evaluate the utilization and quality assurance data that is collected to assess patient care and plan performance; (3) convey the results of performance evaluations to individual clinics and practitioners; (4) ensure that appropriate corrective action is taken in response to any problem areas; and (5) verify that the changes made have been incorporated as a permanent improvement [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, VII.A].

OHIO

All plans: Quality assurance activities include:
- the establishment of criteria for evaluating the appropriateness of the care provided;
- the review of the plan's written clinical policies and procedures;
- the establishment and annual review of written protocols for patient care;
- the evaluation of the availability, accessibility and adequacy of personnel, facilities and services at each plan site;
- the assessment of health care continuity;
- the review of persistent or significant grievances;
- the review of medical records to determine the adequacy of and compliance with plan written procedures and protocols for record keeping and patient care; and
- the performance of quality of care studies which are based upon health care processes and outcomes [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.11].

Medicaid: There is in place a quality assurance program that consists of objective and systematic activities used to monitor and evaluate the quality of care delivered to enrollees and to pursue opportunities to improve care and resolve identified problems [Ohio Administrative Code, Chapter 5101:3-26-071(A)].

The quality assurance program includes:
- detailed goals and objectives which are developed at least annually;
- a timetable for implementation and accomplishment;
- indicators for the quality of clinical care and nonclinical aspects of service, including appropriateness, availability, accessibility, coordination and continuity of care;
- the measurement and evaluation of high-volume/high-risk services; and
- the assessment of enrollee satisfaction [Ohio Administrative Code, Chapter 5101:3-26-071(A)(1)].
II.H.1. Quality assurance program/Program description/Activities (cont’d.)

**OHIO (cont’d.)**

The quality assurance program includes the entire range of care provided by the plan by assuring that all demographic groups, care settings and types of services are included in the scope of review [Ohio Administrative Code, Chapter 5101:3-26-071(A)(2)].

**PENNSYLVANIA**

All plans: The plan has arrangements for an ongoing quality assurance program [State of Pennsylvania, Health Maintenance Organization Act, Title 40, Section 1555.1(b)(1)(ii)].

The quality assurance program includes the following scope and content:
- evaluation of a representative sample of all services provided in institutional and non-institutional settings, including care provided in private practice offices;
- an appropriate methodology for identifying, evaluating and correcting clinical and quality of service problems;
- identification and application of uniform appropriate quality standards to evaluate the quality of care provided by all providers; and
- quality of clinical care and the quality of service elements, including availability, accessibility and continuity of care [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, B].

The review of quality of care is not limited to technical aspects of care but includes availability, accessibility and continuity of care provided to enrollees [28 Pa. Code, Section 9.74(b)].

**Medicaid:** The quality assurance system includes, at a minimum:
- routine medical audits of primary care physician sites at least once every 2 years;
- routine medical audits of each of the other participating provider types;
- standards of clinical care in the form of a written, professionally developed and accepted expression of desired performance of behavior by a provider under specific sets of circumstances;
- protocols that represent an accepted step-by-step set of instructions to achieve the standards of care;
- a quality assessment process that measures the clinical care provided to enrollees against formalized standards;
- focused medical care evaluations that are employed when indicators suggest that quality may need to be studied; and
- problem-oriented clinical studies of individual care [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, 14.3].

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II.H.2. Quality assurance program/Written plan

**MEDICARE**

Policy: Evidence of an ongoing quality assurance program includes a written plan which documents all requirements are met. It describes specific activities to be undertaken by the program over the coming year and indicates methodologies used and the personnel responsible for the activities. The program provides for keeping physicians and other providers informed of the written plan [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.A].

**FEDERAL QUALIFICATION**

Policy: Evidence of an ongoing quality assurance program includes a written plan which documents all requirements are met. It describes specific activities to be undertaken by the program over the coming year and indicates methodologies used and the personnel responsible for the activities. The program provides for keeping physicians and other providers informed of the written plan [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.A].

**MEDICAID**

Guidelines: There is a written description of a plan's quality assurance program which addresses (1) goals and objectives; (2) scope; (3) specific activities; (4) continuous activity; (5) provider review; and (6) focus on health outcomes [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard I, p. 14-15].


**BUREAU OF PRIMARY HEALTH CARE**

Policy: There is a written quality management plan approved by the Governing Body [Primary Care Effectiveness Review, Clinical Protocol, III.C.1].

**NAIC**

The plan maintains an internal quality assessment and improvement system that is clearly defined and documented in writing [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94; Section 4.A].

The internal quality assessment and improvement system includes a listing of objectives; an outline of the system structure including lines of authority and accountability; types of studies to be performed; methods of evaluation; performance improvement activities; and an annual effectiveness review [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.A(3)].
II.H.2. Quality assurance program/Written plan (cont’d.)

**JCAHO**

The responsibility for taking action on recommendations generated through performance improvement activities is assigned and defined in writing [1994 Joint Commission Standards for Health Care Networks, *Leadership*, LD 4.3.1.1].

**NCQA**

There is a written description of the QI program that outlines program structure and design [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI.1.1] that is reviewed annually and updated as necessary [NCQA Standards for Quality Management and Improvement, 1994, QI.1.2].

The role, structure and function, including frequency of meetings, of the QI committee are specified in the written plan [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI.1.6].

There is an annual QI work plan that includes: objectives, scope and planned projects for the year; planned monitoring of previously identified issues, including tracking of issues over time; and planned evaluation of the QI system [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI 1.10].

**MINNESOTA**

*All plans:* The plan has a written quality assurance plan that includes the following: (1) mission statement; (2) philosophy; (3) goals and objectives; (4) organizational structure; (5) staffing and contractual arrangements; (6) a system for communicating information regarding quality assurance activities; (7) the scope of the program; and (8) a description of peer review activities [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.1]. Community integrated service networks, while required to have a quality assurance program, do not have to file a written plan as a condition of licensure.

**OHIO**

*All plans:* There is a written plan to implement and maintain an ongoing program to assure that basic health services are provided in accordance with accepted standards of medical practice. This plan describes the goals and objectives, organizational arrangements and the methodology for ongoing monitoring and evaluation of health care services [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.10].

*Medicaid:* A written description of the quality assurance program specifies quality of care studies and other activities to be undertaken over a prescribed period of time, including methodologies, organizational arrangements, responsible individuals and other activities [Ohio Administrative Code, Chapter 5101:3-26-071(A)(3)].

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II.H.2. Quality assurance program/Written plan

**PENNSYLVANIA**

All plans: There is a written procedure to provide for ongoing review, analysis, assessment and subsequent actions for improvement of the quality of health care services delivered to enrollees [28 Pa. Code, Section 9.74(a)].

The Board of Directors adopts a written quality assurance program that delineates an identifiable structure responsible for performing quality assurance functions within the plan [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, A.1.1].

**Medicaid:** There is a written quality assurance plan, updated at least annually, which defines the organization and objectives of the quality assurance program [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, *Quality Assurance and Utilization Review*, Attachment IV, T].

There is an annual work plan of expected accomplishments which includes a schedule of clinical standards to be developed, medical care evaluations to be completed, and other key quality assurance activities to be completed [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, *Quality Assurance and Utilization Review*, Attachment IV, U].
II.H.3. Quality assurance program/Structure

MEDICARE

Policy: There is a QA committee which (1) meets on a regular basis and documents its activities and actions; (2) routinely reports to the governing body on its activities and actions; (3) is directed by an HMO physician. Participants in the QA program are HMO-affiliated health professionals who are representative of primary care and commonly used specialists [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.E].

FEDERAL QUALIFICATION

Policy: There is a QA committee which (1) meets on a regular basis and documents its activities and actions; (2) routinely reports to the governing body on its activities and actions; (3) is directed by an HMO physician. Participants in the QA program are HMO-affiliated health professionals who are representative of primary care and commonly used specialists [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.E].

MEDICAID

Guidelines: The quality assurance program has an identifiable structure responsible for performing QA functions and has (1) regular meetings; (2) established parameters for operating; (3) documentation of activities, findings, recommendations and actions; (4) accountability to the Governing Body or its designee; and (5) active participation from plan providers [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard IV, pp. 19-20].

There is a designated senior executive who is responsible for implementation of the quality assurance program [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard V, p. 20].

BUREAU OF PRIMARY HEALTH CARE

Policy: There is a clinical director who has responsibility for developing and implementing a clinical quality management program [Primary Care Effectiveness Review, Clinical Protocol, II.B.1].

There is a QM committee composed of appropriate clinical and administrative staff which meets regularly [Primary Care Effectiveness Review, Clinical Protocol, III.C.1].

NAIC

The internal quality assessment and improvement system includes an organizational structure for designing, measuring, assessing and improving the processes and outcomes of health care consistent with the provisions of a state’s Act and under the direction of the medical director or a designee of the director with the same or similar level of professional licensure or certification [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94; Section 4.A(2)].

The system structure includes lines of authority and accountability [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94; Section 4.A(3)].
II.H.3. Quality assurance program/Structure (cont’d.)

**JCAHO**

No standard specified.

**NCQA**

A designated senior executive is responsible for program implementation [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI.1.3] and the medical director has substantial involvement in QI activities [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI.1.3].

A committee oversees and is involved in QI activities [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI.1.5].

There are records reflecting actions of the committee [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI 1.9].

**MINNESOTA**

*All plans*: The governing body designates a quality assurance entity that may be a person or persons to be responsible for operation of the quality assurance program activities [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.3].

**OHIO**

*All plans*: There is a committee responsible for quality assurance activities, accountable to the governing body, which meets quarterly and maintains a formal record of its activities [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.10].

The quality assurance committee includes, but is not limited to, the medical director; representation of those health care services provided by the plan; representation from plan management; and representation from plan enrollment [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.11].

*Medicaid*: The quality assurance program outlines a structure, role and function of a quality assurance committee which meets at least quarterly and provides at least annual reports to the governing body [Ohio Administrative Code, Chapter 5101:3-26-071(C)].

Quality assurance committee members represent the geographic areas served by the plan and the provider network [Ohio Administrative Code, Chapter 5101:3-26-071(C)(5)].

A designated senior executive of the plan is responsible for quality assurance program implementation and the plan’s medical director has substantial involvement in quality assurance activities [Ohio Administrative Code, Chapter 5101:3-26-071(D)].

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II.H.3. Quality assurance program/Structure (cont’d.)

All plans: A medical director is responsible for implementation of the quality assurance program [28 Pa. Code, Section 9.76(b)].

The structure and operation of the plan’s quality assurance program involves physicians who are contracting with or employed by the plan [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, A.1.5].

The quality assurance program has an identifiable structure with the designation of a person responsible for quality assurance activities [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, A.1.1].

Medicaid: The plan establishes and maintains a Quality Assurance Committee representative of the service community and providers [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, 14.5].
II.H.4. Quality assurance program/Resources, people and material

**MEDICARE**

**Policy:** The QA program is appropriately structured, directed, evaluated and staffed to assure that activities are continuously performed and are effective [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.B].

The QA program is staffed by adequate and appropriate support personnel [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.E].

**FEDERAL QUALIFICATION**

**Policy:** The QA program is appropriately structured, directed, evaluated and staffed to assure that activities are continuously performed and are effective [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.B].

The QA program is staffed by adequate and appropriate support personnel [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.E].

**MEDICAID**

**Guidelines:** The quality assurance program has sufficient material resources and staff with the necessary education, experience or training to effectively carry out its specified activities [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard VI, p. 20].

**BUREAU OF PRIMARY HEALTH CARE**

**Policy:** There is a QM committee composed of appropriate clinical and administrative staff [Primary Care Effectiveness Review, Clinical Protocol, III.C.1].

**NAIC**

No standard specified.

**JCAHO**

The network allocates adequate resources for measuring, assessing and improving the network's management, clinical and support processes [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 5.3].

**NCQA**

Organizational arrangements and responsibilities for quality improvement processes are clearly defined and assigned to appropriate individuals [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.1.0].

Resources dedicated to the program are adequate to meet needs (e.g., personnel, analytic capabilities or data resources) [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.1.8].
II.H.4. Quality assurance program/Resources, people and material
(cont’d.)

MINNESOTA

All plans: There are sufficient administrative and clinical staff with knowledge and experience to assist in carrying out quality assurance activities, based on the number of enrollees, number of providers, the variety of health care services offered, the organizational structure and the quality assurance staffing levels used by other plans with similar functions [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.5].

Any plan staff or contractees conducting quality assurance activities are qualified by virtue of training and experience [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.12].

OHIO

All plans: There is sufficient administrative and clinical staff support to assist in executing the quality assurance functions of the plan [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.14].

Medicaid: Appropriate clinicians monitor and evaluate quality [Ohio Administrative Code, Chapter 5101:3-26-071(B)].

PENNSYLVANIA

All plans: The plan’s quality assurance program demonstrates the presence of adequate support staff to carry out its responsibilities [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, A.1.3].

Medicaid: There is adequate staffing of all quality assurance functions [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, Attachment IV].
II.H.5. Quality assurance program/Performance measurement

**MEDICARE**

The Medicare program has two initiatives underway to collect performance measurements. Under the Medicare Managed Care Quality Improvement Project, performance measures have been developed for diabetes, mammography, influenza vaccination, and access to care. This approach shifts the focus of PRO review from random case review to greater emphasis on patterns of care. In addition, there are plans to adapt HEDIS (Health Plan Data Information Set) to the Medicare population.

**Regulation:** The quality assurance program stresses health outcomes consistent with the state-of-the-art [42 CFR 417.418].

**FEDERAL QUALIFICATION**

**Regulation:** The quality assurance program stresses health outcomes consistent with the state-of-the-art [42 CFR 417.418].

**MEDICAID**

A project is near completion to adapt HEDIS (Health Plan Data Information Set) to the Medicaid population.

**Guidelines:** At a minimum, performance measurements for childhood immunization and prenatal care are collected by the plan or as a part of the external quality review process [A Health Care quality Improvement System for Medicaid Managed Care: A Guide to States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard 1.B].

In certain 1115 or 1915 waiver requests, HCFA may require the collection of program appropriate performance measurements (e.g., childhood immunization, pediatric asthma).

**BUREAU OF PRIMARY HEALTH CARE**

The health center uses quality of care indicators in improving services [Primary Care Effectiveness Review, Clinical Protocol, III.C.2].

**NAIC**

Plans have in place a system to collect clinical outcomes [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/95, Section 3.H.(1)].
II.H.5. Quality assurance program/Performance measurement (cont’d).

JCAHO

Plans collect data that include measures (indicators) of care processes and outcomes for assessing performance [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 7.1].

NCQA

The plan uses quality indicators that are objective, measurable and based on current knowledge and clinical experience to monitor and evaluate each important aspect of care and service [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.9.1].

MINNESOTA

Medicaid: Performance measurements are collected as part of the external quality review process which includes the collection of quality indicators in the areas of childhood immunization, prenatal care and other areas of special interest as defined by the Medicaid agency each year [Requests for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, VII.D.4].

OHIO

Medicaid: Performance measurements are collected as part of the annual external quality review process which includes the collection of quality indicators in the areas of special interest to the Medicaid agency [Ohio Administrative Code, Chapter 5101:3-26-07(C)(2)].

PENNSYLVANIA

All plans: Performance measurements are collected as part of the tri-annual external quality review process. During this process, the external review entity validates quality indicators used by the plan in conducting their own focused clinical care studies [Invitation to Qualify as an Approved HMO Quality Review Organization, Pennsylvania Department of Health, Appendix II. External Assessment Process, Responsibilities of Review Organizations].

Medicaid: The plan is required to submit semi-annual reports to the state, including performance measurements on prenatal care, immunizations, preventive care and hypertension [Pennsylvania Department of Public Welfare, Operating Agreement, Section 13.E.ix-x].
II.H.6. Quality assurance program/Systematic data collection

**MEDICARE**

**Regulation:** The plan uses a systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed change [42 CFR 417.418(b)].

**Policy:** The plan maintains data from multiple sources, such as: medical records; enrollee complaints; feedback from physicians, other health professionals and staff; member survey results; clinical and non-clinical study results; referrals through the utilization review system; and potential problem areas identified through the information system [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.4.B].

**FEDERAL QUALIFICATION**

**Statute:** There are effective procedures for developing, compiling, evaluating and reporting statistics and other information relating to cost; patterns of service utilization; availability, accessibility and acceptability of services; to the extent possible, the health status of members; and other information as required by the Secretary [Title XIII of the Public Health Service Act, Section 1301(c)(8)].

**Regulation:** The plan uses a systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed change [42 CFR 417.106(a)(3)].

There are effective procedures to develop, compile, evaluate and report the following information:

- patterns of utilization of services
- availability, accessibility and acceptability of services
- to the extent practical, developments in the health status of enrollees [42 CFR 417.126(a)].

**Policy:** The plan maintains data from multiple sources, such as: medical records; enrollee complaints; feedback from physicians, other health professionals and staff; member survey results; clinical and non-clinical study results; referrals through the utilization review system; and potential problem areas identified through the information system [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.4.B].

**MEDICAID**

**Regulation:** The internal quality assurance system provides for the systematic data collection of performance and patient results [42 CFR 434.33(c)].

Periodic medical audits of prepaid health plans identify and collect management data for use by medical audit personnel and provide that such data include reasons for enrollment and termination and use of services [42 CFR 434.53(b)(2)(3)].

**BUREAU OF PRIMARY HEALTH CARE**

**Policy:** Management information system data are used in the QM program [Primary Care Effectiveness Review, Clinical Protocol, III.C.1].

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II.H.6. Quality assurance program/Systematic data collection (cont’d.)

The health center uses the following data in improving the quality of services: demographic data, show/no show data, clinical measures data, chronic disease quality of care indicators, acute illness quality of care indicators, patient satisfaction, case management, ongoing community assessment data [Primary Care Effectiveness Review, Clinical Protocol, III.C.2].

The health center collects data that provides baselines for quality improvement on selected criteria [Primary Care Effectiveness Review, Clinical Protocol, III.C.1].

NAIC

Plans have in place a system to collect demographic, health status, risk factor and clinical data on patients being treated for specified conditions to permit case mix reporting of medical outcomes. The measures include, but are not limited to, clinical outcomes, patient functional status, patient satisfaction and risk management and reduction [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/95, Section 3.H(1)].

For each encounter, data are collected corresponding to the Uniform Ambulatory Care Data set (UACD) for outpatient encounters, or the Uniform Hospital Discharge Data set for inpatient stays. This data is available for all encounters, including referrals out of the traditional plan networks [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/94, Section 3.A(1)].

Minimum data elements include: birth date; gender; provider identification; diagnosis codes; procedure codes; dates of service; and source of expected payment [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/94, Section 3.A.(2)].

The plan assesses the quality of health care provided to enrollees through the systematic collection and analysis of relevant data in accordance with statutory and regulatory requirements [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.A].

The quality improvement system includes pattern analysis through the use of enrollee and provider-specific information from multiple sources, such as utilization management, claims processing, enrollee satisfaction and grievances [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.B(1)(0)].

JCAHO

Data are collected on an ongoing basis, aggregated and analyzed for patterns and trends to provide feedback to those providing services and to identify and respond to the learning needs of those providing service [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 2.3].

Data are collected in a timely, economical and efficient manner and with the degree of accuracy, completeness and discrimination necessary for intended use [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 3.1].

The format and methods for disseminating data and information and providing feedback to network components and participating practitioners are standardized, whenever possible [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 4.1].

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II.H.6. Quality assurance program/Systematic data collection (cont’d.)

JCAHO (cont.)

Data include at least the following: (1) instances of occurrence of measures (indicators) of care processes and outcomes used for assessing performance; (2) summaries of actions taken as the result of network-wide performance improvement activities, including risk management and utilization review; (3) practitioner-specific information [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 7.1].

The collected data include measures of processes and outcomes. Outcome measures should include at least the categories of prevention, physiological function, functional status, and physical and psychological comfort [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PL 3.1-PI 3.1.2].

The network collects data about the needs and expectations of members and others and the degree to which they have been met and its practitioners’ views regarding current performance and opportunities for improvement [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PL 3.3-PI 3.3.2].

NCQA

The plan uses quality indicators that are objective, measurable and based on current knowledge and clinical experience to monitor and evaluate each important aspect of care and service [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.9.1].

Appropriate methods and frequency of data collection are used for each indicator [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.9.2].

Data collected through monitoring and evaluation activities are analyzed by appropriate clinicians and multidisciplinary teams, where indicated [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.9.3].

MINNESOTA

All plans: The plan has a procedure to develop, compile, evaluate and report statistics relating to the cost of its operation, the pattern of utilization of its services, the quality, availability and accessibility of its services, and such other matters as may be reasonably required by the state [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.04, Subd.1(o)].

The quality assurance program has prompt access to necessary medical record data including data by diagnosis, procedure, patient and provider [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.7].

The plan establishes and maintains procedures to develop, compile, evaluate and report statistics which include the collection and maintenance of at least the following data: operational statistics, gross utilization aggregates, demographic characteristics, disease-specific and age-specific mortality rates; and enrollment statistics [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1200]. These requirements do not apply to community integrated service networks.
II.H.6. Quality assurance program/Systematic data collection (cont’d.)

MINNESOTA (cont’d.)

Medicaid: The plan provides a complete record of all diagnostic and treatment encounters, drugs, supplies and medical equipment items to individual enrollees [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, VI.A].

OHIO

All plans: There is a procedure to gather and report statistics relating to the cost and effectiveness of operations, pattern of utilization and the quality, availability and accessibility of services [Ohio Revised Code, 1742.04(S)].

Medicaid: The plan submits annual and quarterly financial and utilization reports, except as determined by the state that monthly reports are required due to concerns regarding the quality of care, delivery of services, fiscal operations or solvency of the plan [Ohio Administrative Code, Chapter 5101:3-26-06(C)(5)(6)].

PENNSYLVANIA

All Plans: Data on the utilization of health care services are collected and analyzed periodically to identify for further in-depth investigation potential over-utilization, under-utilization or misutilization of health services by enrollees or providers [28 Pa. Code, Section 9.74(e)].

Medicaid: The plan establishes and maintains a system to collect sufficient patient encounter data to identify the physician who delivers services [Pennsylvania Department of Public Welfare, Operating Agreement, Section 4, Medical Services, 4.3].

The plan collects and analyzes data to implement effective quality assurance, utilization review and peer review programs [Pennsylvania Department of Public Welfare, Operating Agreement, Section 13, Records and Reports, 13.7].

The plan gathers baseline data on the health status of targeted enrollees including a periodic assessment of health outcomes at specified intervals [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, Attachment IV, Y].
II.H.7. Quality assurance program/Peer review/Practitioner participation

**MEDICARE**

**Statute:** The quality assurance program provides for review by physicians and other health professionals [Section 1876(c)(6) of the Social Security Act].

**Regulation:** The plan provides for review by physicians and other health professionals in its quality assurance program and provides its practitioners with interpretation of data on performance and patient results [42 CFR 417.418(b)].

**Policy:** Physicians and other health professionals participating on the QA committee focus their review on the clinical process of care, systematically selecting and reviewing medical charts through a rational approach to identify and evaluate problems [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.3.A].

The review by physicians and other health professionals of the process of care includes a review of QA data (e.g., enrollee complaints, member surveys, feedback from professionals, providers and staff) and the selection and evaluation of performance of reviewers in accordance with written guidelines [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.3.C].

The QA program provides feedback to health professionals and HMO staff regarding performance and patient results [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.4.D].

**FEDERAL QUALIFICATION**

**Statute:** The quality assurance program provides for review by physicians and other health professionals [Title XIII of the Public Health Service Act, Section 1301(c)(6)].

**Regulation:** The plan provides for review by physicians and other health professionals in its quality assurance program [42 CFR 417.106(a)(2)] and provides its practitioners with interpretation of data on performance and patient results [42 CFR 417.106(a)(3)].

**Policy:** Physicians and other health professionals participating on the QA committee focus their review on the clinical process of care, systematically selecting and reviewing medical charts through a rational approach to identify and evaluate problems [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.3.A].

The review by physicians and other health professionals of the process of care includes a review of QA data (e.g., enrollee complaints, member surveys, feedback from professionals, providers and staff) and the selection and evaluation of permanence of reviewers in accordance with written guidelines [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.3.C].

The QA program provides feedback to health professionals and HMO staff regarding performance and patient results [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.4.D].
II.H.7. Quality assurance program/Peer review/Practitioner participation (cont’d.)

MEDICAID

Regulation: The internal quality assurance system provides for review by appropriate health professionals of the process followed in providing health services [42 CFR 434.34(b)] and the interpretation of performance data to the practitioner [42 CFR 434.34(d)].

Guidelines: Participating providers are kept informed about the written quality assurance plan and are required to cooperate with the program [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard VII, p. 15-18].

The quality assurance program provides for review by physicians and other health professionals of the process followed in the provision of health services and feedback to health professionals and plan staff regarding performance and patient results [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard I.E, p. 14-15].

Copies of the plan’s policies on members’ rights and responsibilities are provided to all participating providers [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard X.C., p. 24].

Appropriate clinicians monitor and evaluate quality, and multidisciplinary teams are used, where indicated [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II.D.1-2, p. 17].

The quality assurance committee includes active participation of health plan providers who are representative of the composition of the plan’s providers [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard IV.E, p. 20].

BUREAU OF PRIMARY HEALTH CARE

Policy: Minutes of regular staff meetings reflect problem resolution and an interdisciplinary coordinated approach to patient care [Primary Care Effectiveness Review, Clinical Protocol, II.B.12].

NAIC

There are assurances that contracting, employed and affiliated providers actively participate in developing, implementing and evaluating the quality improvement system [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.C].

Providers are required to cooperate with and participate in the plan’s quality improvement program, credentialing and recredentialing process, provider education programs and the enrollee grievance system [NAIC, Draft Standards, Health Care Provider Contracting Model Regulation, 7/29/94; Technical changes: 8/27/94, Section 6.F].

The clinical review criteria are developed with involvement from the appropriate actively practicing physicians and other appropriate actively practicing licensed health care providers [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 6.A(3)].
II.H.7. Quality assurance program/Peer review/Practitioner participation (cont’d.)

NAIC (cont’d.)

Qualified health care professionals administer the utilization review program and oversee review decisions. Board certified physicians are utilized when appropriate. A licensed, board-certified clinical practitioner evaluates the clinical appropriateness of adverse utilization review decisions [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 6.B].

JCAHO

The performance improvement activities are carried out collaboratively and include the appropriate components of the network and practitioners [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PI 1.1].

Information on relevant aspects of performance is regularly fed back by the network to each component and participating practitioner [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PI 4.3].

NCQA

The organization’s providers participate actively in the QI committee [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.1.7].

Appropriate clinicians are to be used to evaluate data on clinical performance of practitioners. Multidisciplinary teams are used, where indicated, to analyze and address systems issues [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI 9.3].

MINNESOTA

All plans: Provider agreements include provisions requiring the provider to cooperate with and participate in the plan’s quality assurance program, dispute resolution procedure, and utilization review program [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.123, Subd.2].

A physician or physicians designated by the governing body advises, oversees and actively participates in the implementation of quality assurance activities [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1110, Subp.4].

Medicaid: The plan conveys the results of its performance evaluation to individual clinics and practitioners [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, VII.A].
II.H.7. Quality assurance program/Peer review/Practitioner participation (cont’d.)

**OHIO**

All plans: Provider contracts include their responsibilities with regard to participation in the quality assurance/utilization review programs, credentialing process and grievance resolution process of the plan [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.4].

Participation by physicians and other health professionals in quality assurance and utilization activities is adequate to monitor clinical performance and resolve problems. An appropriate range of specialists are involved to assure that a broad spectrum of clinical performance is monitored and corrective action is taken when indicated [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.14].

There is a program of provider education informing providers of the quality assurance program and how services will be monitored [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.15].

**Medicaid:** Appropriate clinicians monitor and evaluate quality through review of individual cases where there are questions about care and through studies analyzing patterns of clinical care [Ohio Administrative Code, Chapter 5101:3-26-07/10(B)].

**PENNSYLVANIA**

All plans: The results of quality assurance activities are made known to participating providers in a manner designed to facilitate improvement in the quality of service delivered [28 Pa. Code, Section 9.74(c)].

The structure and operation of the plan's quality assurance program involves physicians who are contracting with or employed by the plan [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, A.1.5].

**Medicaid:** Physicians and other health care practitioners participate in quality assurance, utilization review and peer review programs [Pennsylvania Department of Public Welfare, Operating Agreement, Section 13, Records and Reports, 13.7].

There are procedures for informing providers of identified deficiencies [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, Attachment IV].

The plan establishes and maintains a Hospital Advisory Committee representative of participating hospital providers [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, 14.7].

The plan distributes standards, protocols, and guidelines to all providers [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, Attachment IV, O].

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II.H.8. Quality assurance program/Continuous improvement plan/Process

Regulation: There are written procedures for taking appropriate remedial action whenever it has been determined that there are inappropriate or substandard services provided or services that should have been furnished have not been provided [42 CFR 417.418(b)].

The plan has an ongoing quality assurance program for its health services provided or services which should have been furnished have not been provided [42 CFR 417.418(b)].

Policy: The quality assurance process includes methods for identifying areas for review; determining if problems exist in those areas and, where appropriate, intensifying the review of health professionals, providers or other areas to determine whether or not patterns exist; providing feedback to appropriate health professionals; recommending and implementing corrective actions; and monitoring and evaluating the implementation of corrective actions to assure that appropriate changes have been made [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.F].

The plan uses systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed changes [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201].

Regulation: The plan has an ongoing quality assurance program for its health services provided or services which should have been furnished have not been provided [42 CFR 417.106(a)].

There are written procedures for taking appropriate remedial action whenever it has been determined that there are inappropriate or substandard services provided or services which should have been furnished have not been provided [42 CFR 417.106(a)(4)].

Policy: The quality assurance process includes methods for identifying areas for review; determining if problems exist in those areas and, where appropriate, intensifying the review of health professionals, providers or other areas to determine whether or not patterns exist; providing feedback to appropriate health professionals; recommending and implementing corrective actions; and monitoring and evaluating the implementation of corrective actions to assure that appropriate changes have been made [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.F].

The plan uses systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed changes [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201].
II.H.8. Quality assurance program/Continuous improvement plan/Process (cont’d.)

**MEDICAID**

Regulation: The internal quality assurance system provides for making needed changes [42 CFR 434.34(e)].

Guidelines: The quality assurance program includes written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished, or whenever appropriate services are not furnished. Procedures address: types of problems and action to be taken; who makes final determinations; provision for feedback; accountability for actions, assessments and appropriate notification; and provider termination, if necessary [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II.E, pp. 17-18].

Methods are in place for continuously updating standards/guidelines [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II.C.4 p. 16].

**BUREAU OF PRIMARY HEALTH CARE**

Policy: For issues raised by the QM Committee, there is evidence that action was taken [Primary Care Effectiveness Review, Clinical Protocol, III.C.7].

**NAIC**

The plan uses various mechanisms to improve performance, including communication of quality improvement program findings to staff, providers and covered persons [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.C].

There are written procedures for taking action when information collected indicates areas for improvement relating to real or potential problems, including referral to enforcement agencies as required by law [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.E].

The plan documents efforts in improvement of quality and outcomes of health care by comparing progress with internal goals and external benchmarks adopted by the plan and approved by the regulatory authority [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.D].

**JCAHO**

The network systematically improves its performance by improving existing processes [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PI 5].

There is a systematic approach to improvement which includes: planning the change; testing it; studying its effects; and implementing changes that are worthwhile. When action is taken to improve a process, the network should assess the action’s effect and, when found not effective, plan and test a new action [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PI 5.2-PI 5.3.1.1].
II.H.8. Quality assurance program/Continuous improvement plan/Process (cont’d).

The network's leaders set expectations, develop plans, and manage processes to design, measure, assess, improve, and maintain the performance of the network's management, clinical and support activities [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 5].

Processes are designed to ensure that the competence of all practitioners is assessed, maintained, demonstrated, and improved on an ongoing basis [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 2].

Data and information is used to provide feedback on performance to network components and participating practitioners [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 7.1.5].

NCQA

There is evidence that results of evaluations are used to improve clinical care and service [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI 10.1].

There is a systematic method of tracking areas identified for improvement to assure that appropriate action is taken [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI 10.2].

MINNESOTA

All plans: The quality assurance entity monitors the effectiveness of corrective actions until problem resolution occurs. Results of implemented corrective action are documented and communicated to the governing body and involved providers [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1120, Subp.4].

Medicaid: Based on ongoing reviews under the quality assurance system, the plan develops an appropriate corrective action plan [Minnesota Department of Human Services Rules, 9500.1460 Subp.17].

OHIO

All plans: There is a clearly defined method of response to problems, which includes the development of appropriate recommendations for corrective action, as appropriate; the assignment of responsibility at the appropriate level for the implementation of recommendations; institution of action which is appropriate to the problem; and the institution of provider education and feedback when deficiencies relative to the delivery of health care services are found [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.13].

Medicaid: There are written procedures for implementing appropriate remedial action for problem identification; specification of the person or body responsible for correcting the problem; specific actions to be taken; corrective action plan implementation schedule; corrective action plan evaluation; modification of the plan if improvements do not occur; and reporting of significant noncompliance [Ohio Administrative Code, Chapter 5101:3-26-071(B)(3)].
II.H.8. Quality assurance program/Continuous improvement plan/process (cont’d.)

All plans: As part of the quality assurance program, there are regularly scheduled meetings demonstrating that quality assurance activities are performed on a continuous basis. Records of minutes reflecting activities and corrective actions are kept [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, A.1.6].

The quality assurance program identifies areas of deficiency and produces recommendations for corrective action, and the Board of Directors assures that appropriate corrective action is taken [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, A.1.8].

Evidence is provided that quality assurance activities have contributed to changes in the plan’s delivery system and appropriate follow-up to all problems identified has occurred [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, B.2.21].

Medicaid: There are procedures for informing providers of identified deficiencies, monitoring corrective action, instituting progressive sanctions, an appeal process, and reassessment to determine if corrective action has its intended results [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, Attachment IV, E].
II.H.9. Quality assurance program/Effectiveness assessment

**MEDICARE**

**Policy:** There are written guidelines for assessing the effectiveness of remedial action procedures as well as the effectiveness of the corrective actions themselves. This should be part of a plan’s annual review. [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.5.C].

The QA program has written guidelines delineating a systematic process for monitoring and evaluating the implementation of corrective actions to assure that appropriate changes have been made [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.F].

**FEDERAL QUALIFICATION**

**Policy:** There are written guidelines for assessing the effectiveness of remedial action procedures as well as the effectiveness of the corrective actions themselves. This should be part of a plan’s annual review [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.5.C].

The QA program has written guidelines delineating a systematic process for monitoring and evaluating the implementation of corrective actions to assure that appropriate changes have been made [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.F].

**MEDICAID**

**Guidelines:** As actions are taken to improve care, there is monitoring and evaluation of correction actions to assure that appropriate changes have been made [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II (F), p. 18].

Annually, a report is prepared indicating the activities completed, demonstrated improvements in quality, areas of deficiency and recommendations for corrective action and an evaluation of the overall effectiveness of the quality assurance program [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II.G, p. 18].

There is evidence that QA activities have contributed to significant improvement in the care delivered to members [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II.G.3, p. 18].
II.H.9. Quality assurance program/Effectiveness assessment (cont’d.)

**BUREAU OF PRIMARY HEALTH CARE**

No standard specified.

**NAIC**

Periodically, but no less than annually, the plan evaluates the strategies used to improve health care and to effect change in health care [NAIC, Draft Standards, *Quality Assurance Model Regulation*, 9/19/94; Section 4.C].

The plan documents efforts in improvement of quality and outcomes of health care by comparing progress with internal goals and external benchmarks adopted by the plan and approved by the regulatory agency [NAIC, Draft Standards, *Quality Assurance Model Regulation*, 9/19/94, Section 4.C].

**JCAHO**

Network leaders analyze and assess the effectiveness of their contributions to improving performance [1994 Joint Commission Standards for Health Care Networks, *Leadership*, LD 5.4].


**NCQA**

The plan assures follow-up on identified issues to ensure that actions for improvement have been effective [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI 10.3].

The plan evaluates the overall effectiveness of its QI program [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI 11.0].

There is an annual written report on quality, including a report of completed activities, trending of clinical and service indicators and other performance data, and demonstrated improvements in quality [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI 11.1].

There is evidence that QI activities have contributed to improvement in the care and services provided to members [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI 11.2].

**MINNESOTA**

*All plans:* An evaluation of the overall quality assurance program is conducted at least annually, with reports sent to the governing body and amendments made appropriately [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1110, Subp.8].

The quality assurance entity monitors the effectiveness of corrective actions until problem resolution occurs [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1120, Subp.4].

*Medicaid:* Based on ongoing reviews under the quality assurance system, the plan develops an appropriate corrective action plan and monitors the effectiveness of the corrective action or actions taken [Minnesota Department of Human Services Rules, 9500.1460 Subp.17].
II.H.9. Quality assurance program/Effectiveness assessment (cont’d.)

**OHIO**

All plans: There is a method for following up on recommendations to assure that corrective action has been implemented; results of such action are evaluated; revisions to recommendations are made; and ongoing monitoring occurs if necessary [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.13].

Medicaid: The plan conducts an annual review of the continuity and effectiveness of the quality assurance program, including a written report on studies and other activities outlining performance data, demonstrated quality improvements in areas of deficiency and recommendations for corrective action [Ohio Administrative Code, Chapter 5101:3-26-071(B)(4)].

**Pennsylvania**

All plans: At least once a year, the Board of Directors reviews a report on quality assurance activities, including studies undertaken, results, subsequent actions and aggregate data on utilization and quality of services rendered [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, A.1.7].

Medicaid: The quality assurance system includes a comprehensive, detailed, semi-annual report on all quality assurance activities, including studies undertaken, results, subsequent actions and aggregate data on utilization and clinical quality of medical care rendered [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, Attachment IV, V].
II.I. External review

**MEDICARE**

**Statute:** Each risk-based sharing contract maintains an agreement with a utilization and quality control peer review organization or with an entity selected by the Secretary [Section 1876(i)(7)(A) of the Social Security Act].

The agreement (between the Medicare risk-sharing HMO/CMP and the peer review organization) provides for the review of services (including both inpatient and outpatient services) for the purposes of determining whether the quality of services meets professionally recognized standards of health care, including whether appropriate health care services have been provided in inappropriate settings and whether individuals enrolled in the plan have adequate access to health care services provided by or through such plan [Section 1154(a)(4)(B) of the Social Security Act].

The review organization conducts an appropriate review of all written complaints about the quality of services not meeting professionally recognized standards of health care, if the complaint is filed with the review organization by an individual entitled to benefits for such services [Section 1154(a)(14) of the Social Security Act].

**Regulation:** The Plan agrees to comply with the requirements for PRO review of services provided to Medicare enrollees [42 CFR 417.478(a)].

**Policy:** Medicare risk-based contracting HMOs/CMPs maintain a written agreement with the PRO which provides for the review of services (including both inpatient and outpatient services) provided to Medicare enrollees to: (1) determine whether such services meet professionally recognized standards of health care, including whether appropriate services have not been provided or have been provided in inappropriate settings; (2) determine whether individuals enrolled with an eligible organization have adequate access to health care services; and (3) maintain a beneficiary outreach program designed to apprise individuals of the role of the peer review system, of the rights of the individual under such a system, and of the method and purposes for contacting the organization. Such review also includes a review of all written complaints filed by Medicare beneficiaries or their representatives about the quality of services [Contract Requirements, Part 3, Chapter 1, September 1992, 3001.1.A].

**FEDERAL QUALIFICATION**

No standard specified.

**MEDICAID**

**Statute:** The State contracts with a utilization and quality control peer review organization or a private accreditation body to conduct an annual, independent, external review of the quality of services furnished under each contract [Section 1902(a)(30)(C) of the Social Security Act].

**Guidelines:** External quality review includes three types of activities: (1) focused studies of patterns of care; (2) individual case review in specific situations; and (3) follow-up activities on previous pattern of care study findings and individual case review findings [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Chapter 4, pp. 47-67].

**BUREAU OF PRIMARY HEALTH CARE**

No standard specified.
II.I. External review (cont’d.)

**NAIC**

States may consider allowing plans to meet quality assurance and utilization review standards by receiving accreditation from or complying with the data reporting standards of recognized private accreditation or data reporting entities. The state may periodically affirm that the standards in use by the private entity are in excess of the standards established by the state. Plans holding accreditation by the private entities could be deemed as having met the desired standards [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/1994, Section 3, Drafting Note].

**JCAHO**

The JCAHO survey may itself be an external review when conducted at the request of state agencies or purchasers.

**NCQA**

No standard specified.

**MINNESOTA**

**Medicaid:** There is an annual independent review of Medicaid services provided by each contract with a utilization and quality assurance review organization or a private accreditation body to evaluate and improve the quality and appropriateness of care provided to enrollees [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, VII.D.4].

**OHIO**

**Medicaid:** A comprehensive quality assurance survey is conducted annually by an independent contractor selected by the Ohio Department of Human Services. The survey consists of three components:

- **Quality of care studies:** include a review of medical records by specific criteria which are selected by a stratified 2-stage cluster sampling methodology.

- **Provider facility and medical record survey:** consists of visits by the Ohio Department of Human Services or its designee to selected plan providers for the purpose of evaluating the physical facilities and medical records of the providers to determine whether the provider or site complies with applicable rules.

- **Plan administrative survey:** includes one or more on-site visits to the plan and a review of all aspects of a plan’s operation, including, but not limited to, components such as the internal quality assurance program, functioning of the governing body, the credentialing process and the plan’s ability to provide accurate and timely data to the external contractor.

Following the site surveys, a summation conference is held to discuss findings. A preliminary report is issued so that any inaccuracies can be corrected by the plan prior to issuance of the final report. Within 30 days of receipt of the final report, the plan submits any necessary corrective action plan to the state [Ohio Administrative Code, Chapter 5101:3-26-07(C)(2)].
II.I. External review (cont’d.)

All plans: Within one year of receipt of a certificate of authority and every three years thereafter, a plan must arrange to have an external quality assurance assessment performed to study the quality of care being provided to enrollees based on a review of a statistically significant sample of medical records. Plans have the flexibility to choose their Quality Review Organization from a series of prequalified organizations [28 Pa. Code, Section 9.93]. An external quality review includes:

- **Review of documents** including quality assurance plan; complaint and grievance file; minutes of Board of Directors’ meetings; minutes from meetings of committees and other entities responsible for quality assurance; utilization review/control reports; selected ambulatory medical records; reports of quality assurance studies and activities;

- **Meetings** with CEO, Medical Director, Chairperson or physician supervisor of the committee with quality assurance responsibilities, members of the quality assurance committee or responsible entity, patient care coordinator, at least one member of governing body, consumer liaison responsible for member service or grievance procedures, and other providers, board members as requested;

- **Validation of pre-selected focused clinical care studies** conducted by the plan during the past 24 months. This review includes review of the rationale for the plan selecting the topic; the validity of the study question; the appropriateness of guidelines or standards against which care was evaluated; sample selection; data sources used; the medical record abstraction instrument used to conduct the study; the data analysis; the written summary results; the plan for quality improvement; and the resurvey plan; and

- **Medical record review** to verify the plan’s monitoring of sentinel events and adverse outcomes as well as a general medical record review which randomly selects at least 50 records of primary care physicians [Invitation to Qualify as an Approved HMO Quality Review Organization, Pennsylvania Department of Health, Appendix II, External Assessment Process, Responsibilities of Review Organizations].

Following a summation meeting, the Quality Review Organization prepares a report for review by the plan, including recommendations for follow-up. The plan has 5 days to comment and make factual error corrections. The Department of Health issues a final report indicating areas of deficiencies and required follow-up actions. The plan submits annual progress reports covering activities, problems and recommendations to the state for monitoring purposes [Invitation to Qualify as an Approved HMO Quality Review Organization, Pennsylvania Department of Health, Appendix II, External Assessment Process, Responsibilities of Review Organizations].

**Medicaid:** The plan agrees to an annual external, independent assessment of its performance which includes, but is not necessarily limited to, the federally required reviews of (1) access to care, quality of care, cost effectiveness and the effect of case management; and (2) the plan’s quality assurance procedures, implementation of the procedures and the quality of care provided [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, 14.11].

The plan submits a corrective action plan to resolve any performance or quality of care deficiencies identified by the independent assessors as determined necessary by the state [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, 14.11].
II.J.1. Credentialing/Recredentialing/Frequency

**MEDICARE**

No standard specified.

**FEDERAL QUALIFICATION**

No standard specified.

**MEDICAID**

Guidelines: Recredentialing occurs at least every two years [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Chapter 4, pp. 47-67].

**BUREAU OF PRIMARY HEALTH CARE**

No standard specified.

**NAIC**

Initial credentialing is to be done prior to any health professional contract becoming effective [NAIC, Draft Standards, Health Professional Credentialing Model Regulation, 9/19/94, Section 2.A]. Recredentialing occurs at least every three years [NAIC, Draft Standards, Health Professional Credentialing Model Regulation, 9/19/94, Section 2.D].

**JCAHO**

Appointments and reappointments are made for time periods that do not exceed two years [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 3.4]

**NCQA**

Initial credentialing and verification is ongoing and up-to-date [NCQA Accreditation Standards, Credentialing, 1994, CR 5.0]. Re-credentialing is implemented at least every two years [NCQA Accreditation Standards, Credentialing, 1994, CR 10.1].

**MINNESOTA**

No standard specified.
II.J.1. Credentialing/Recredentialing/Frequency (cont’d.)

**OHIO**

*All plans: Providers are evaluated upon initial hiring and on a continuing basis thereafter [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.6].*

*Medicaid: There is written evidence that the recredentialing procedure is implemented, at a minimum, every 2 years [Ohio Administrative Code, Chapter 5101:3-26-072(C)(3)].*

**PENNSYLVANIA**

No standard specified.
II.J.2. Credentialing/Recredentialing/Verification

MEDICARE

Regulation: Under general authority, credentialing can be addressed under 42 CFR 417.412(b)(1) which requires that a plan has sufficient administrative capability to carry out the requirements of the contract.


FEDERAL QUALIFICATION

Regulation: Health professionals means physicians, dentists, nurses, podiatrists, optometrists, physicians' assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists, and other professionals engaged in the delivery of health services who are licensed, practice under the institutional authority of the plan, a medical group, individual practice association, or other authority consistent with state law [42 CFR 417.1].

Under general authority, credentialing can be addressed under 42 CFR 417.124 which requires that the plan has administrative and managerial arrangements satisfactory to HCFA, as demonstrated in part by personnel and systems sufficient for the plan to organize, plan, control, and evaluate the financial, marketing, health services, quality assurance program, administrative and management aspects of the plan [42 CFR 417.124(a)(2)].

MEDICAID

Guidelines: There are written policies for the credentialing process which are approved by the governing body or its designee and which, at a minimum, encompasses all physicians, dentists and other licensed independent practitioners.

Initial credentialing

- Collect and review verification of: current license; DEA or CDS certificate; graduation from medical school and completion of residency or other post-graduate training, as applicable; work history; professional liability claims history; clinical privileges; malpractice insurance; any revocation or suspension of state license or DEA/BNDD number; any curtailment or suspension of medical staff privileges; any sanctions imposed by Medicare or Medicaid; and any censure by the state or county Medical Association.

- Review statements by the applicant regarding any physical or mental health problems; history of chemical dependency/substance abuse; and history of loss or limitation of privileges or disciplinary activity.

- Visit each potential primary care practitioner's office, including documentation of a structured review of the site and medical record-keeping practices [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard IX, pp. 21-22].
II.J.2. Credentialing/Recredentialing/Verification (cont’d.)

Recredentialing

- Review current standing with respect to: current license; DEA or CDS certificate; graduation from medical school and completion of residency or other post-graduate training, as applicable; work history; professional liability claims history; clinical privileges; and malpractice insurance.

- Review statements by the applicant regarding any physical or mental health problems; history of chemical dependency/substance abuse; and history of loss or limitation of privileges or disciplinary activity.


BUREAU OF PRIMARY HEALTH CARE

Policy: Clinicians are licensed in the jurisdiction served by the health center [Primary Care Effectiveness Review, Clinical Protocol, II.B.2].

Documents are present and current in clinical staff personnel files reflecting: current license, DEA registration, references, life support training, continuing education, annual evaluation, malpractice insurance, National Practitioner Databank Inquiries, definition of privileges, current contract, supervision agreement [Primary Care Effectiveness Review, Clinical Protocol, II.B.5].

Initial credentialing: The initial credentialing process ensures that clinical staff possess the training, experience, and competence required in their job descriptions [Primary Care Effectiveness Review, Clinical Protocol, II.B.3].

Recredentialing: A system is in place for the ongoing recredentialing of clinical staff that evaluates performance and licensure and certifies capability to continue to serve on the health center staff [Primary Care Effectiveness Review, Clinical Protocol, II.B.4].

NAIC

Initial credentialing: Primary verification is conducted: on current license, certificate of authority or registration to practice medicine, nursing, physical therapy or other health field/profession, and history of licensure within 120 days of effective date of health professional's contract; current level of professional liability coverage (if applicable); status of hospital privileges; specialty board certification status; current Drug Enforcement Agency (DEA) registration certificate; graduation from medical, nursing, or other health professional school; and completion of post-graduate training [NAIC, Draft Standards, Health Professional Credentialing Model Regulation, 9/19/94, Section 2.B].

Primary or secondary verification is conducted on the health professional’s license history, malpractice history, and practice history [NAIC, Draft Standards, Health Professional Credentialing Model Regulation, 9/19/94, Section 2.C].

Recredentialing: Primary verification is conducted on current license or certificate of authority to practice, current level of professional liability coverage, status of hospital privileges, and current DEA registration certificate [NAIC, Draft Standards, Health Professional Credentialing Model Regulation, 9/19/94, Section 2.D].
II.J.2. Credentialing/Recredentialing/Verification (cont’d.)

Processes are designed to ensure that the competence of all practitioners is assessed, maintained, demonstrated, and improved on an ongoing basis [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 2].

There are written credentialing criteria that are uniformly applied to licensed independent practitioners requesting membership on the practitioner panel of the network [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 3.1].

Initial: At a minimum, information is reviewed on the following: pending challenges to any licensure or registration; voluntary or involuntary termination of professional or medical staff membership reduction or loss of clinical privileges; involvement in professional liability actions; statement pertaining to applicant’s ability to perform his or her professional activities; chronological work history covering last 10 years; signed statements consenting to the inspection of records and documents pertinent to application [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 3.5-HR 3.5.1.7].

The following information is verified from the primary source: current licensure; relevant education; relevant training; relevant experience; current competence; involvement in professional liability actions; DEA registration and amount and source of liability insurance, when required [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 3.6-HR 3.6.5].

The network conducts an assessment of the content of the clinical records and office practices of each site where primary or specialty care is rendered by the practitioner when such sites are not under the auspices of an organization accredited by JCAHO [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 3.8].

Recredentialing: The same primary source verification and clinical record review as described above is conducted at the time of reappointment, if there could have been any changes [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 3.10.1].

The network conducts assessments of the content of clinical records and office practices of a subset of sites where care is being rendered by practitioners being considered for reappointment [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 3.10.2].

Provider-specific information from the performance improvement function is considered in comparison to aggregate information for the network’s providers when making reappointment decisions [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 3.10.3].

Licensed independent practitioners who practice in a network are privileged by the component [1994 Joint Commission Standards for Health Care Networks, Management of Human Resources, HR 4].
II.J.2. Credentialing/Recredentialing/Verification (cont’d.)

The plan has written policies and procedures for the credentialing process that include original credentialing, recredentialing, recertification, and/or reappointment of physicians and other licensed independent practitioners [NCQA Accreditation Standards, Credentialing, 1994, CR 1.0].

Initial credentialing
- The plan obtains and reviews verification from primary sources of the following: current valid license to practice; clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility; a valid DEA or CDS certificate, as applicable; graduation from medical school and completion of a residency, or Board certification, as applicable; work history; current, adequate malpractice insurance; and professional liability claims history [NCQA Accreditation Standards, Credentialing Standards, 1994, CR 5.0].

- The applicant completes an application which includes a statement regarding physical and mental health status, lack of impairment due to chemical dependency/substance abuse, history of loss of license and/or felony convictions and history or limitation of privileges or disciplinary activity [NCQA Accreditation Standards, Credentialing, 1994, CR 6.0, 6.1, 6.2].

- The organization requests information on the practitioner from recognized monitoring organizations which include the National Practitioner Data Banks, State Board of Medical Examiners, Medicare, Medicaid [NCQA Accreditation Standards, Credentialing, 1994, CR 7.0].

- There is an initial visit to each potential primary care practitioner’s office and to the offices of obstetricians/gynecologists and other high-volume specialists, which results in a structured review of the site and of medical record-keeping practices [NCQA Accreditation Standards, Credentialing, 1994, CR 8.0-8.1].

Recredentialing
- The plan obtains and reviews verification from primary sources of the following: current valid license to practice; clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility; a valid DEA or CDS certificate, as applicable; Board certification, as applicable; work history; current, adequate malpractice insurance; and professional liability claims history [NCQA Accreditation Standards, Credentialing, 1994, CR 10.2].

- The applicant makes a statement regarding physical and mental health status, and lack of impairment due to chemical dependency/substance abuse [NCQA Accreditation Standards, Credentialing, 1994, CR 10.3].

- The organization requests information on the practitioner from recognized monitoring organizations, including the National Practitioner Data Banks, State Board of Medical Examiners, Medicare, Medicaid [NCQA Accreditation Standards, Credentialing 1994, CR 11.0].

- The recredentialing process includes review of data from member complaints; results of quality reviews; utilization management; and member satisfaction surveys [NCQA Accreditation Standards, Credentialing 1994, CR 12.0].

- An on-site visit to provider offices (primary care providers, obstetricians/gynecologists, and high-volume specialists) that includes a structured review of the site and of medical record-keeping practices [NCQA Accreditation Standards, Credentialing, 1994, CR 13.0].

- The plan has policies and procedures for reducing, suspending, or terminating practitioner privileges [NCQA Accreditation Standards, Credentialing, 1994, CR 14.0].
II.J.2. Credentialing/Recredentialing/Verification (cont’d.)

MINNESOTA

All plans: The plan has policies and procedures for provider selection and qualifications [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1110, Subp.11].

OHIO

All plans: The plan has a credentialing process for verifying upon initial hiring, and on a continuing basis thereafter, that providers are qualified to provide the planned services [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.6].

Initial credentialing includes, but is not limited to, the following criteria:

- current licensure, certification or registration with the State;
- written references;
- prior or pending malpractice litigation;
- adequate malpractice insurance;
- complaints received and any disciplinary action initiated against the provider by the Medical Board;
- criminal convictions;
- revocation or suspension of DEA/BNDD number;
- curtailing, suspension or termination of hospital medical staff privileges; and
- any documented history of high complication rates, morbidity and mortality rates or engaging in unproven medical practices [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.7].

Recredentialing: No standard specified.

Medicaid: The plan has written procedures for the initial credentialing process for physicians and other licensed independent practitioners [Ohio Administrative Code, Chapter 5101:3-26-072(B)(1)].

Initial credentialing includes:

- The collection and verification of: valid license to practice; valid DEA certificate, as applicable; graduation from medical school and completion of residency, or other training, as applicable; work history; professional liability claims history; good standing of clinical privileges at the designated hospital; current and adequate malpractice insurance; any revocation or suspension of a state license or DEA number; any curtailment or suspension of medical staff privileges; any sanctions imposed by Medicare or Medicaid; any censure by the state or county Medical Association; and any information maintained by the National Practitioner Data Bank and the State Board of Medical Examiners.

- A practitioner statement regarding any physical or mental health problems that may affect ability to provide health care; any history of chemical dependency/substance abuse; history of loss of license and/or felony convictions; history of loss or limitation of privileges or disciplinary activity; and an attestation to corrections/completeness of the application.

- A site visit to each potential primary care practitioner’s office to ensure conformance to HMO standards [Ohio Administrative Code, Chapter 5101:3-26-072(B)(3)].
II. J. 2. Credentialing/Recredentialing/Verification (cont’d.)

Ohio (cont’d.)

Recredentialing includes:
• The verification of state licensure; valid DEA as applicable; graduation from medical school and completion of residency or other post-graduate training, as applicable; work history; professional liability claims history, good standing of hospital clinical privileges; liability insurance.
• An attestation from the practitioner regarding physical or mental problems which may affect service provision.
• A review of data from member complaints; results from quality reviews; utilization management; and member satisfaction surveys [Ohio Administrative Code, Chapter 5101:3-26-072(B)(3)].

Pennsylvania

All plans: The plan establishes credentialing and recredentialing standards [HMO Certification of Authority Application Materials, HMO Applications, Technical Advice and Assistance, p.1].

Initial credentialing: All primary care physicians are site-visited as a part of the credentialing process to assess availability and accessibility of services for new enrollees. There is evidence, through review of the appointment book, of average number of patients seen per hour, availability of emergency appointments, etc. [HMO Certification of Authority Application Materials, HMO Applications, Technical Advice and Assistance, p.1-2].

At the time of credentialing, there is documentation of at least a preliminary assessment of the primary care provider’s medical records for compliance with plan medical record keeping standards using the NCQA medical record assessment tool [HMO Certification of Authority Application Materials, HMO Applications, Technical Advice and Assistance, p.2].

The Medical Director reviews a minimum of 3 medical records in order to verify the clinical competence of the applicant [HMO Certification of Authority Application Materials, HMO Applications, Technical Advice and Assistance, p.3].

Medicaid: There are specific provider credentialing and recredentialing requirements [Pennsylvania Department of Public Welfare, Operating Agreement, Section 11, Quality Assurance and Utilization Review, Attachment IV, X].

Minimum credentialing criteria include:
• maintain a current Pennsylvania medical license;
• conform to the Principles of Ethics of the American Medical Association or the American Osteopathic Association;
• personally perform or directly supervise the ambulatory primary care services of the enrollee;
• be a member of the medical staff with admitting privileges to at least one accredited general hospital in the service area;
• earn continuing medical education credits;
• attend at least one session on case management policies and procedures per year; and
• have a current provider agreement with the department [Pennsylvania Department of Public Welfare, Operating Agreement, Section 9, Provider Enrollment and Handbooks, 9.3].

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II.K. Utilization management/Underutilization

**MEDICARE**

**Statute:** The plan does not operate any physician incentive plan which reduces or limits medically necessary services or places a physician or physician group at substantial financial risk [Section 1876(i)(8)(A)(i)(ii) of the Social Security Act].

**Policy:** The information system has the capability to aggregate data to identify patterns of suspected aberrant care, such as underutilization, inappropriate utilization, adverse outcomes, or substandard care [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.4.A].

**FEDERAL QUALIFICATION**

**Regulation:** There are effective procedures to monitor utilization, control costs and achieve utilization goals [42 CFR 417.103(b)].

**Policy:** The information system has the capability to aggregate data to identify patterns of suspected aberrant care, such as underutilization, inappropriate utilization, adverse outcomes, or substandard care [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.4.A].

Plans consider the effect on patient care and health outcomes of physician compensation arrangements that encourage physicians to control use of services [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.2.C].

**MEDICAID**

**Guidelines:** The plan has a utilization management program which includes, at a minimum, procedures to evaluate medical necessity, underutilization as well as overutilization of service; criteria used; information sources; and the process used to review and approve the provision of medical services [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard XIII, p. 31].

The plan has mechanisms to detect underutilization as well as overutilization [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard XIII, p. 31]

**BUREAU OF PRIMARY HEALTH CARE**

**Policy:** Providers participate in utilization review for areas of potential risk (e.g., outpatient primary care, subspecialty referral, hospital care, pharmacy, laboratory) [Primary Care Effectiveness Review, Clinical Protocol, III.D.1].
II.K. Utilization/Underutilization (cont’d.)

NAIC

A written utilization review program is approved by the corporate board of the plan and includes at a minimum: procedures to evaluate clinical necessity, appropriateness and efficiency of health services, and processes to detect under- as well as over-utilization of services; data sources and clinical review criteria used in decision making; the process for conducting appeals of adverse utilization review decisions; any data collection processes and analytical methods that may be used in assessing utilization of health care services; provisions for assuring confidentiality of clinical information; the organizational structure that periodically assesses utilization review activities and reports to the governing body, or its designee; and the staff position functionally responsible for day-to-day program management [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 4.5.A].

An annual summary report of utilization review activities is filed with the appropriate regulatory agency [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 5.B].

The plan establishes priority areas to conduct patterns of care analyses based, in part, on information identifying underutilization or overutilization of health services [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.B(1)(d)].

The plan’s utilization review program uses documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 6.A].

JCAHO

Processes that are measured on an ongoing basis include those that: affect a large percentage of members; and/or place members at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or are likely to be problem prone [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PI 3.4.1-PI 3.4.1.3].

Processes measured encompass at least those related to member entry, assessment and treatment; transition in care among components of the network; important adverse clinical events; preventive measures and health promotion programs; and overutilization, underutilization, and inefficient utilization of clinical resources [1994 Joint Commission Standards for Health Care Networks, Improving Network Performance, PI 3.4.2-PI 3.4.2.5].

NCQA

The plan has a documented utilization management program description that describes both delegated and nondelegated activities, and which includes, at a minimum, policies and procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services [NCQA Accreditation Standards, Utilization Management, 1994, UM 1.0, 1.1].

There is a mechanism for updating the UM program description on a periodic basis [NCQA Accreditation Standards, Utilization Management, 1994, UM 1.2].

Where procedures are used for preauthorization and concurrent review, qualified medical professionals supervise review decisions [NCQA Accreditation Standards, Utilization Management, 1994, UM 2.0].
II.K. Utilization/Underutilization (cont’d.)

A physician conducts a review for medical appropriateness on any denial [NCQA Accreditation Standards, Utilization Management, 1994, UM 2.1].

Decisions are made in a timely manner, depending on the urgency of the situation [NCQA Accreditation Standards, Utilization Management, 1994, UM 5.0].

There is a set of written utilization review decision protocols that is based on reasonable medical evidence [NCQA Accreditation Standards, Utilization Management, 1994, UM 3.0].

Criteria for the appropriateness of medical services are clearly documented and available, upon request, to participating physicians [NCQA Accreditation Standards, Utilization Management, 1994, UM 3.1].

There is a mechanism for updating review criteria periodically [NCQA Accreditation Standards, Utilization Management, 1994, UM 3.3].

The plan has mechanisms to detect underutilization and overutilization [NCQA Standards for Quality Management and Improvement, 1994, QI.6.4].

The plan has policies and procedures to evaluate the appropriate use of new medical technologies, or new applications of established technologies, including medical procedures, drugs and devices [NCQA Accreditation Standards, Utilization Management, 1994, UM 7.0].

There are mechanisms to evaluate the effects of the UM program using member satisfaction data, provider satisfaction data and/or other appropriate means [NCQA Accreditation Standards, Utilization Management, 1994, UM 8.0].

MINNESOTA

All plans: Data from the plan’s utilization review activities are reported to the quality assurance program for analysis at least quarterly [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1110, Subp.10]. Community integrated service networks are exempt from having to report this data on a quarterly basis.

Medicaid: The plan considers the following variables in performing its utilization monitoring function:
- capacity of its provider network;
- geographic accessibility of its provider network;
- waiting times for appointments;
- no-shows for appointments;
- availability of culturally competent care/interpreters;
- clinic hours;
- 24-hour access for emergency situations;
- provider profiling;
- tracking of referrals;
- written protocols and established time frames for prior approval, second medical opinion, concurrent review and discharge planning;
- production of regular utilization review management reports; and
- appropriate management of high-risk cases [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, VII.B].
II.K. Utilization/Underutilization (cont’d.)

**OHIO**

All plans: There is a procedure to gather and report statistics relating to the cost and effectiveness of operations, pattern of utilization and the quality, availability and accessibility of services [Ohio Revised Code, 1742.04(5)].

A utilization review committee is established whose activities include the analysis of in-plan/out-of-plan utilization, analysis of referral trends, analysis of ambulatory treatment patterns, and analysis of inpatient hospital utilization [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, pp. 11-12].

Medicaid: There is a written description of the plan’s utilization review program which includes:
- policies and procedures to evaluate medical necessity;
- criteria used;
- information sources; and
- a process to review and approve the provision of medical services [Ohio Administrative Code, Chapter 5101:3-26-078(A)(B)].

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**PENNSYLVANIA**

All Plans: There is a procedure to assure that only those services which represent proper utilization of health care facilities and conform to contractual provisions are provided [28 Pa. Code, Section 9.74(a)(2)].

The quality assurance program examines the use of specialists to detect inappropriate, underutilization, and overutilization [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, B.2.5].

Medicaid: The plan analyzes quarterly utilization profiles and follow-up on underutilization and overutilization, based on established standards [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, Attachment IV].

There are procedures for monitoring the quality and adequacy of medical care, including assessing the use of distributed guidelines and possible under-treatment/underutilization of services [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, Attachment IV].
II.L. QA integration into operations

MEDICARE

Policy: The QA committee or its designee reviews sources of data on performance and patient results, such as: enrollee complaints; health professional, provider, and staff feedback; member survey results; clinical and non-clinical study results; referrals through the utilization review system; and potential problem areas identified through the information system [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.3.B].

The Chief Executive Officer provides leadership in the area of QA by integrating accountability for QA into the management of the HMO [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.A].

FEDERAL QUALIFICATION

Policy: The QA committee or its designee reviews sources of data on performance and patient results, such as: enrollee complaints; health professional, provider, and staff feedback; member survey results; clinical and non-clinical study results; referrals through the utilization review system; and potential problem areas identified through the information system [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.3.B].

The Chief Executive Officer provides leadership in the area of QA by integrating accountability for QA into the management of the HMO [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.A].

MEDICAID

Guidelines: QA information is used in recredentialing, recontracting and/or annual performance evaluations; activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances; and there is a linkage between QA and other management functions of the plan, such as network changes, benefits redesign, medical management systems, practice feedback, patient education and member services [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard XVI, pp. 32-33].

BUREAU OF PRIMARY HEALTH CARE

Policy: QM findings are used to modify policies and procedures and in the strategic planning process [Primary Care Effectiveness Review, Clinical Protocol, III.C.1].

NAIC

The plan’s quality improvement activities are integrated with other plan functions, such as provider credentialing, provider contracting, development of provider panels, utilization management, enrollee grievances, risk management, data reporting and enrollee satisfaction activities [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 1].
II.L. QA integration into operations (cont'd.)

NAIC (cont'd.)

Utilization review program activities are coordinated with other medical management activity, including quality assurance, credentialing, provider contracting, data reporting, member satisfaction assessment processes and risk management [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 6.G].

JCAHO

Leaders and all staff assigned clinical and/or managerial responsibility participate in cross-component activities to improve network performance [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 4.3].

NCQA

The findings, conclusions, recommendations, and actions taken, and results of the actions taken as a result of QI activity, are documented and reported to appropriate individuals within the organization. The QI information is used in recredentialing, recontracting, and/or annual performance evaluations [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.3.1].

QI activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.3.2].

There is evidence of linkages between QI and other functions, such as network changes, benefits redesign, medical management systems, practice feedback to providers, and patient education [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.3.3].

MINNESOTA

No standard specified.

OHIO

All plans: The quality assurance program encompasses all aspects of the plan's health service delivery functions [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.10].

Medicaid: Documentation and reporting of the findings, conclusions, recommendations, actions taken and results of the quality assurance activity are made to appropriate plan staff [Ohio Administrative Code, Chapter 5101:3-26-071(E)(1)].

There are written procedures for establishing interaction between quality assurance and other plan departments to disseminate information such as: changes in provider network; changes in benefit package; changes in preauthorization procedures; provision of feedback to physicians; changes in patient education efforts; and changes in the member services department [Ohio Administrative Code, Chapter 5101:3-26-071(E)(3)].
II.L. QA integration into operations (cont’d.)

No standard specified.
II.M. Complaint resolution

Statute: There are meaningful procedures for hearing and resolving member grievances [Section 1876(c)(5)(A) of the Social Security Act].

The (external) review organization conducts an appropriate review of all written complaints about the quality of services not meeting professionally recognized standards of health care, if the complaint is filed with the review organization by an individual entitled to benefits for such services [Section 1154(a)(14) of the Social Security Act].

Regulation: The plan maintains written rules that deal with grievances and appeals procedures [42 CFR 417.436(a)(7)].

The plan provides members with a copy of its written grievance and appeals procedures [42 CFR 417.436(b)].

The plan provides to its enrollees the steps to follow in completing the appeals process and the time limits imposed on each step of the procedures [42 CFR 417.600].

An appeals process is available to Medicare beneficiaries which includes a five-part process:

*Initial determination:* decisions made by the HMO or CMP relating to:
  - reimbursement for emergency or urgently needed services;
  - services furnished by the organization that the enrollee believes are Medicare covered and should have been furnished and/or reimbursed; and
  - services that the HMO or CMP refuses to provide and/or reimburse, which the enrollee believes Medicare is obligated to cover and which the enrollee has not received elsewhere [42 CFR 417.606(a)].

Enrollees must be informed in writing of the appeals procedures available to them in the event that they are dissatisfied with an initial determination made by the HMO or CMP [42 CFR 417.604(c)].

*Reconsideration:* Any party dissatisfied with the initial determination may request a reconsideration in writing [42 CFR 417.614].

Generally, the plan that made the initial determination also reconsider it [42 CFR 417.620], except that the reconsideration must be made by a person or persons who were not involved in making the initial determination. The reconsideration is based on a review of the initial determination, the evidence and findings upon which it was based, and any other evidence submitted by the parties [42 CFR 417.622].

Notice of the reconsideration determination must be given the requesting party stating the reasons for the reconsidered determination. A reconsideration determination is final and binding unless a request for a hearing is filed within 60 days (exceptions apply) [42 CFR 417.626,632].

*Hearing by an Administrative Law Judge* in cases where the amount in controversy is $100 more [42 CFR 417.624]. HCFA designates a hearing officer to conduct the hearing [42 CFR 417.666], which is open to the parties and to the public [42 CFR 417.676].

*Appeals Council Review:* any party to the hearing may request an Appeals Council Review [42 CFR 417.634].
II.M. Complaint resolution (cont’d.)

MEDICARE (cont’d.)

Court review: the amount in controversy must be $1,000 or more [42 CFR 417.636].

The PRO determines whether the quality of services provided by an HMO or CMP meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings [42 CFR 466.72(a)(1)].

Policy: The grievance and appeal procedures are mutually exclusive. Complaints concerning the quality of services a member received are treated as a grievance except when associated with a denial of service. Complaints concerning timely receipt of services are treated as grievances except when an enrollee complains that he or she had to use out-of-plan services because of excessive waiting times [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 6, March 1991, 2400].

Generally, the following items are not subject to the appeals procedures but are processed under the grievance procedures of the organization: determinations of items or services included in an optional supplemental plan; complaints about waiting times, physician demeanor and behavior, adequacy of facilities; involuntary disenrollment issues; disputes about items or services that have been furnished for which the enrollee has no further liability for payment [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 6, March 1991, 2400.4].

All enrollees are provided a written explanation of grievance procedures which includes at least the following information:
- how to file a grievance;
- differences between the appeals and grievance procedures;
- time limits for filing a grievance; and

The agreement with the PRO provides for review by the PRO of all written complaints filed by Medicare beneficiaries or their representatives about the quality of services [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Part 3, Chapter 1, Contract Requirements, p. 3-1-4, Rev. 12].

FEDERAL QUALIFICATION

Statute: There are meaningful procedures for hearing and resolving member grievances [Title XIII of the Public Health Service Act, Section 1301(c)(5)].

Regulation: The plan has and uses meaningful procedures for hearing and resolving enrollee grievances which ensure that grievances and complaints are transmitted in a timely manner to appropriate decision-makers who have the authority to take corrective action; appropriate and prompt action is taken; and notification is given to all concerned parties as to the results of any investigation [42 CFR 417.124(g)].

MEDICAID

Regulation: There are written internal grievance procedures that provide for prompt resolution and assure the participation of individuals with authority to require corrective action [42 CFR 434.32].

The state has procedures to ensure the proper implementation of a plan’s grievance procedure [42 CFR 434.63].
II.M. Complaint resolution (cont’d.)

Guidelines: The plan has a system for resolving members’ complaints and formal grievances that includes:
- procedures for registering and responding to complaints and grievances in a timely fashion
- documentation of the substance of complaints and actions taken
- procedures to ensure a resolution of a complaint or grievance
- aggregation and analysis of complaint and grievance data and use of the data for quality improvement

BUREAU OF PRIMARY HEALTH CARE

Policy: Patient complaints are reviewed for patterns and appropriate corrective action is taken. There is a protocol to handle patient complaints in languages other than English [Primary Care Effectiveness Review, Clinical Protocol, III.C.2].

NAIC

The plan has written procedures for hearing and resolving enrollee complaints [NAIC, Draft Standards, Complaint Procedure Model Regulation, 12/6/94, Section 4].

The complaint procedure includes a statement of the enrollee’s right to file a complaint at any time with the Commissioner (of Insurance), the telephone number and complete address of the Commissioner [NAIC, Draft Standards, Complaint Procedure Model Regulation, 12/6/94, Section 4.C].

The plan has a two-level complaint review process that includes:

First level: A first-level complaint review committee (composed of one or more employees of the plan) reviews a complaint within 10 working days of submission and issues a decision to the individual filing the complaint which includes: names of persons participating in the decision, description of the complaint, the committee’s decision, evidence or documentation used as the basis for the decision, a statement describing the appeal process to the second level [NAIC, Draft Standards, Complaint Procedure Model Regulation, 12/6/94, Section 5].

Second level: A second-level complaint review committee, one-third of whose members are enrollees, is appointed by the board of directors (or its representative). Written procedures are established for investigating and conducting the hearing which require:
- such hearings to be held within 45 days of receipt of the appeal;
- that the enrollee is informed of his or her rights to have a personal representative assist in preparing for the grievance procedure;
- the decision from a second-level complaint hearing to be rendered within 5 working days following the committee meeting; and
- a written notice of the outcome of the review which includes the nature of the complaint, the committee decision and rationale, evidence or documentation considered in the decision, and a statement of an enrollee’s right to appeal to the Commissioner of Insurance [NAIC, Draft Standards, Complaint Procedure Model Regulation, 12/6/94, Section 6].

The plan may not use the time frame or procedures of the plan’s complaint process to discourage or prevent the enrollee from receiving medically pressing care in a timely manner [NAIC, Draft Standards, Complaint Procedure Model Regulation, 12/6/94, Section 7].
II.M.  Complaint resolution (cont’d.)

The plan establishes an appeals process exclusively for utilization review adverse determinations, distinct from the complaint procedure, for enrollee complaints regarding health care benefits, operating procedures, quality of care, access, claims or services. Enrollees dissatisfied with the outcome of an appeal may seek additional remedies under The plan’s complaint procedures [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 3.C].

Written notice of an adverse determination includes a description of the appeal procedures, and instructions for initiating an appeal [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 3.C].

The plan has written procedures for standards and expedited appeals of decisions not to certify an admission, continued stay, procedure or service. For emergency appeals, the plan makes every reasonable effort to process the request within 72 hours and to issue a decision no later than 1 business day following receipt of all necessary information [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 9].

The plan maintains a systematic telephone log of complaints that includes name of caller, time of call, type of complaint, and resolution [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/95, Section 3.J(1)].

The plan maintains records of grievances that include the name of the covered person, category, date received, date of each hearing, resolution at each level, date of resolution at each level, contract or certificate number and identity of providers involved [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/95, Section 3.J(2)].

JCAHO

All settings in the network have an effective mechanism for receiving and resolving complaints and grievances including assurance that all members are informed of these policies [1994 Joint Commission Standards for Health Care Networks, Rights, Responsibilities and Ethics, R1 4].

NCQA

There is a timely and organized system for resolving members’ complaints that includes:

- procedures for registering and responding to complaints and grievances in a timely fashion;
- documentation of the substance of complaints, grievances and actions taken;
- procedures to ensure a resolution of the complaint or grievance;
- aggregation and analysis of complaint and grievance data and use of the data for QI;
- an appeals process for grievances that includes a member’s right to a review by a grievance panel; a right to a second review with different individuals; at least one of the levels of review wherein the member may appear before the panel; and expedited procedure for emergency cases [NCQA Accreditation Standards, Members’ Rights and Responsibilities, 1994, RR 4.1].

Notification of denial includes appeal process information [NCQA Accreditation Standards, Utilization Management, 1994, UM 6.0].
II.M. Complaint resolution (cont’d.)

All plans: A plan's internal complaint system is considered reasonable and acceptable if the following procedures are followed:

- The complainant promptly receives a complaint form from the plan when wishing to register a complaint.
- The plan provides for informal discussion or consultations to resolve or recommend the resolution of the complaint.
- The plan notifies the complainant within 30 days after receiving the written complaint of its decision and the reasons for it. Where an adverse decision is rendered, the complainant is notified of the right to appeal.
- If the complainant appeals, the plan offers an option of a hearing or a written reconsideration, with the person or persons not solely the same person who made the initial decision.
- The plan provides the opportunity for alternative dispute resolution of any complaint which is unresolved by the above mechanisms.
- If the complaint involves a dispute about an immediately and urgently needed service, the plan uses an expedited dispute resolution process appropriate to the particular situation with notification to the Commissioner of Health within 1 day of the complaint and its determination.
- A complainant may at any time submit a complaint to the Commissioner of Health, who may either independently investigate the complaint or refer it to the plan for further review.

The plan maintains a record of each written complaint filed with it for 5 years [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.11].

When a complaint involves a plan's coverage of service, the Department of Health may review the complaint and any information necessary to make a determination and order the appropriate remedy [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.11].

Data on complaints related to quality of care are reported to the appointed quality assurance entity at least quarterly [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1100, Subp.9].

Medicaid: There are written procedures for reviewing enrollee complaints which include:

- a plan for notifying enrollees how to file a complaint or grievance;
- an informal complaint system with a resolution required in 10 days;
- a formal grievance system in which determination is made within 30 calendar days and which contains the following elements: (1) person with authority to resolve the case is designated to hear the complaint; (2) the enrollee has the right to be represented at the hearing by a representative of his or her choice, including legal counsel; (3) the enrollee and the plan may call witnesses to provide relevant testimony; (4) a determination is made and written notice given within 30 days with indication given of the right to appeal to the state; and (5) the plan notifies the ombudsperson within 3 working days after any written complaint is filed by an enrollee [Minnesota Department of Human Services Rules, 9500.1463 Subp.3].

Complaints related to the appropriateness, quality or necessity of medical services are reviewed by the plan quality assurance coordinator or medical director for quality assurance implications [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, VII.D.2].

The plan maintains a record of all written complaints from enrollees, actions taken in response to complaints and the final disposition of the complaints and reports this information to the state on a semiannual basis [Minnesota Department of Human Services Rules, 9500.1463 Subp.8].
II.M. Complaint resolution (cont’d.)

All plans: The plan has procedures for responding to all written complaints which inform the enrollee of all rights to appeal a decision to a Peer Review Organization or a Peer Review Committee within the plan. Copies of these complaints and responses are kept for 3 years and made available to the Department of Insurance and Health [Ohio Revised Code, 1742.14(B)].

Enrollees are informed annually about the complaint procedure [Ohio Revised Code, 1742.20(A)].

The plan has a grievance resolution process which addresses all potential areas of enrollee dissatisfaction and includes the following elements:

- at least one level of appeal;
- reasonable time frames for each step in the process, not to exceed 60 days, to ensure prompt and thorough consideration;
- all grievances, including verbal grievances, are recorded in writing;
- confidentiality of the grievance;
- an enrollee has up to one year to register a grievance;
- the appointment of a grievance officer to facilitate and coordinate the enrollee’s use of the grievance process;
- participation of individuals appropriate to the nature of the complaint;
- grievances related to clinical policies or practices are forwarded to the medical director for prompt review;
- establishment of a grievance committee with authority to require corrective action;
- annual assessments of the grievance process; and
- minutes of grievance committee meetings are available to the state [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, pp.16-17].

Medicaid: The plan has written grievance and complaint procedures which address both medical and nonmedical areas of enrollee dissatisfaction and which include the following elements:

- a grievance committee with a specific individual designated as the coordinator;
- the grievance and complaint processes contain at least one level of appeal;
- access-related complaints are resolved within 3 working days;
- all other complaints are resolved within 10 working days;
- all grievances are resolved within 20 working days;
- all medically-related grievances are forwarded to the medical director for review prior to committee resolution;
- the quality assurance committee receives periodic reports regarding the number and types of grievances and complaints; and
- the plan ensures that confidentiality is maintained throughout the grievance process [Ohio Administrative Code, Chapter 5101:3-26-074(A)].
II.M. Complaint resolution (cont’d.)

All plans: A plan establishes and maintains a grievance resolution system whereby the complaints of enrollees are acted upon promptly and satisfactorily [State of Pennsylvania, Health Maintenance Organization Act, Title 40, Section 1560(e)].

The grievance procedure includes the following elements:
- There is an initial level of investigation and review of any grievance, conducted by a committee consisting of one or more individuals who may be employees of the plan, wherein the enrollee presents written data pertinent to the grievance.
- An enrollee has the right to appeal a decision of the initial review committee to a second level of review conducted by a committee established by the Board of Directors that includes at least one-third members who are subscribers to the plan.
- The second level of review decision is binding unless the enrollee appeals to the Secretary of the Health Department;
- The plan specifies reasonable time limits for disposition of grievances at each level.
- A description of the grievance system is distributed to enrollees at enrollment and annually thereafter.
- Enrollees have a right to have a staff member of the plan appointed to assist them.
- The enrollee has the right to appeal a negative decision to the Department of Health, which, upon receipt of the request and a review of all relevant information (including independent opinions from medical consultants as necessary) makes a final determination.
- The plan maintains records of all grievances in its annual report to the state [28 Pa. Code, Section 9.73].

Medicaid: Grievance procedures must, at a minimum:
- Define a grievance;
- Delineate between a complaint and grievance;
- Include the time frames to ensure prompt review and processing of complaints and grievances;
- Be the same for all enrollees;
- Ensure that enrollees have access to all documentation pertaining to resolution of a grievance; and
- Ensure that staff appropriately report and handle enrollee complaints and grievances [Pennsylvania Department of Public Welfare, Operating Agreement, Section 7, Recipient Complaint and Grievance System, 7.2].

The plan has an independent complaint and grievance committee which reviews and assesses the appropriateness of the plan’s identification and resolution of complaints and grievances [Pennsylvania Department of Public Welfare, Operating Agreement, Section 7, Recipient Complaint and Grievance System, 7.5].
II.N. Rights and responsibilities—Plan

**Statute:** The plan provides each enrollee with an explanation of:
- right to benefits from the organization;
- any restrictions on payments for services outside of the organization
- out-of-area coverage;
- coverage for emergency and urgent care; and
- appeal rights of enrollees [Section 1876(c)(3)(E) of the Social Security Act].

The plan maintains written policies and procedures respecting advance directives [42 U.S.C., Section 1876(c)(8)].

**Regulation:** The plan furnishes a copy of the rules to each Medicare enrollee at the time of enrollment and at least annually thereafter with respect to:
- benefits;
- how and where to obtain services;
- restrictions on coverage;
- obligations of the plan to assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services as required;
- services, other than emergency or urgently needed services, that the plan chooses to provide outside of the HMO or CMP;
- premium information;
- grievance and appeals procedures;
- disenrollment rights;
- obligation of the enrollee to notify plan if leaving the service area for more than 90 days;
- expiration date of the contract; and
- advance directives [42 CFR 417.436(a)(b)].

**Policy:** Membership rules are provided at the time of enrollment and annually thereafter and should include:
- description of benefits;
- how and where to obtain services;
- restrictions on coverage;
- plan’s obligation to assume financial responsibility for emergency and urgently needed services;
- services provided from outside sources;
- premium information;
- internal grievances and Medicare appeals procedures;
- disenrollment rights and procedures; and

The plan provides written information to all adult enrollees at the time of enrollment concerning their rights under state law to accept or refuse medical or surgical treatment and to execute and formulate advance directives, such as living wills or durable powers of attorney for health care [Medicare HMO/CMP Manual, Part 3, Chapter 1, Contract Requirements, 3001.1.E].
II.N. Rights and responsibilities--Plan (cont’d.)

**FEDERAL QUALIFICATION**

**Regulation:** The plan provides instructions to its enrollees on procedures to be followed to obtain medically necessary emergency health services in and out of the service area [42 CFR 417.101(a)(3)] and how to access basic health services [42 CFR 417.101(e)(3)].

The plan provides a written description, easily understood by the average enrollee, of the following, to its enrollees:
- benefits;
- coverage, including statement on eligibility for benefits;
- procedures for obtaining benefits and description of the circumstances under which benefits may be denied
- rates;
- grievance procedures;
- service area;
- participating providers; and
- financial information, including the most recent audited information [42 CFR 417.124(b)].

**MEDICAID**

**Regulation:** Members are informed, at the time of enrollment, of their rights to terminate enrollment [42 CFR 434.27(c)].

The plan informs and distributes written information to adult individuals concerning policies on advance directives, including a description of applicable state laws [42 CFR 434.28].

**Guidelines:** Upon enrollment, members are provided with a written statement that includes information on:
- rights and responsibilities of members;
- benefits and services;
- provision for after-hours and emergency coverage;
- the plan’s policy on referrals for specialty care;
- charges to members, if applicable;
- procedures for notifying members of termination or change in benefits, services or service delivery sites;
- procedures for appealing decisions;
- procedures for changing practitioners;
- procedures for disenrollment; and

Standards and guidelines used in the quality assurance program are included in provider manuals [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II.C.5, p. 16].

Member information is written in prose that is readable and easily understood and in the languages of the major population groups served [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard X.H, p. 26].
II.N. Rights and responsibilities--Plan (cont’d.)

No standard specified.

The plan includes a description of its quality assurance and quality improvement procedures and a statement of patient rights and responsibilities with respect to those procedures in a handbook provided to new enrollees [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 6, A(2)].

The plan annually provides information to enrollees on its quality assurance system’s activities and progress in meeting internal goals and established benchmarks [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 6.A(3)].

Grievance procedures are a part of a plan’s certificate, member booklet or outline of coverage [NAIC, Draft Standards, Grievance Procedure Model Regulation, 8/22/94, Section 4.B].

The plan includes a summary of its utilization review procedures and a statement of patient rights and responsibilities with respect to these procedures in the certificate of coverage or member handbook [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 11.A].

Providers are required to comply with advance directives programs for Medicare and Medicaid enrollees, if applicable [NAIC, Draft Standards, Health Care Provider Contracting Model Regulation, 7/29/94, Technical changes: 8/27/94, Section 6.R].

All settings in the network have an effective mechanism for informing members of their rights and responsibilities, including complaint and grievance procedures [1994 Joint Commission Standards for Health Care Networks, Rights, Responsibilities and Ethics, R1 4.1].

All clinical settings have effective mechanisms to assist and encourage each member in providing information needed by practitioners [1994 Joint Commission Standards for Health Care Networks, Rights, Responsibilities and Ethics, R1 5.1].

Members are informed of any potential consequences of not complying with a recommended treatment [1994 Joint Commission Standards for Health Care Networks, Rights, Responsibilities and Ethics, R1 5.2].

A member is informed of any specific health care needs that require follow-up [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 8].
II.N. Rights and responsibilities—Plan (cont’d.)

Network components are responsible for providing information to members that enable them to access health care services and/or benefits, including at least the following:

- general information about the network, services provided, organizations, and practitioners;
- how to access services in the network;
- how to access emergency services;
- scope of services included in the benefit package;
- charges, copayments, and fees for which member is responsible;
- how to obtain services outside the network’s geographical service area;
- how to obtain services not covered by the benefit package;
- changes in network benefits, charges, services and/or practitioners;
- how to change providers within the network; and
- how to disenroll from the network [1994 Joint Commission Standards for Health Care Networks, Education and Communication, ED 1-ED 1.4.8].

The plan provides a copy of policies on members’ rights and responsibilities to all participating providers and directly to members [NCQA Accreditation Standards, Members’ Rights and Responsibilities, RR 3.0].

Members are provided a written statement that includes information on:

- the organization’s policy on referrals for specialty care;
- provisions for after-hours and emergency coverage;
- benefits and services included and excluded from membership and how to obtain them (special benefit provisions that apply to services obtained outside the system, procedures for obtaining out-of-area coverage, charges to members, procedures for notifying members affected by termination or change in benefit or service or service delivery site);
- procedures for appealing adverse decisions concerning coverage, benefits or relationship to the organization;
- procedures for changing practitioners;
- procedures for disenrollment of nongroup subscribers; and
- procedures for voicing complaints and/or grievances, and for recommending changes in policies and services [NCQA Accreditation Standards, Members’ Rights and Responsibilities, RR 5.1].

Members are provided information about practice guidelines for the use of preventive health services [NCQA Accreditation Standards, Preventive Health Services, PH 3.0].

Member information is written in language that is readable, easily understood and consumer-tested and is available, as needed in the language(s) of the major population groups served [NCQA Accreditation Standards, Members’ Rights and Responsibilities, RR 6.1-6.2].
II.N. Rights and responsibilities--Plan (cont’d.)

All plans: Evidence of coverage must include statement of:
- the health care services and other benefits;
- exclusions or limitations on services;
- where and how to obtain health care services, including emergency and out-of-area services;
- total amount of payment and copayment;
- description of the plan’s method for resolving enrollee complaints; and
- enrollee rights and responsibilities [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.07].

The plan provides an annual report to its enrollees which includes: (1) summary of its most recent annual financial statement; (2) description of the plan, its facilities and personnel; (3) current evidence of coverage or contract; (4) statement of consumer information and rights [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.07].

Medicaid: A description of the plan’s complaint and grievance procedure and the state’s appeal procedure is provided to enrollees at the time of enrollment [Minnesota Department of Human Services Rules, 9500.1463, Subp.3].

The plan describes the circumstances under which a referral may be made to primary care physician specialists if it does not provide direct access to all of these primary care physician practitioners [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.2].

The certificate of coverage must contain a clear and concise statement of:
- health care services the enrollee is entitled to receive;
- exclusions or limitations on services;
- proper use of the membership card;
- how transportation services can be accessed;
- how services may be obtained, including emergency, urgent care and out-of-plan services;
- fact that services are provided at no cost to the enrollee, except for certain out-of-plan services;
- plan’s method for addressing and resolving enrollee complaints and a complete description of the state appeal procedures, including the role of the state ombudsperson;
- enrollee rights;
- the plan’s medical and remedial care program, including care management;
- plan services for which enrollee must obtain plan approval;
- telephone number and name of plan employee whom the enrollee may contact regarding coverage or in case of emergency;
- plan’s Child and Teen checkup program;
- how enrollees who are non-English speaking and/or hearing impaired can access interpreter services;
- coordination of benefits; and
- conversion rights of enrollees [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, III.E.5].
II.N. Rights and responsibilities—Plan (cont’d.)

All plans: The enrollee handbook includes information on:
- covered health care services and benefits and any exclusions or limitations;
- where and in what manner information is available for the enrollee on how to access health services;
- provisions for the enrollee to obtain services on a 24-hour, 7-day-a-week basis;
- procedures for obtaining health services outside the service area;
- information on how to change physicians and any limitations;
- policy on the rights and responsibilities of enrollees;
- method for resolving enrollee grievances;
- terms and conditions under which coverage may be terminated;
- plan eligibility requirements;
- arrangements to ensure continued provision of services in the event of plan insolvency or loss of provider sites; and
- number, type, qualifications, availability and location of health care professionals and facilities [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, pp.2-3].

Medicaid: Enrollees are advised of their ability to self-refer to mental health services offered through community mental health centers, family planning services provided by qualified providers and substance abuse services offered through programs certified by ODADAS [Ohio Administrative Code, Chapter 5101:3-26-03(H)(3)(4)(5)].

The plan provides enrollees with a member handbook including:
- rights and responsibilities of enrollees;
- a statement of covered and excluded services and benefits;
- provisions made for urgent and emergency care coverage in and out of the service area;
- procedures for enrollees to express their grievances, complaints or recommendations for change;
- a listing of all aid categories eligible for plan coverage;
- information stating how to use the plan ID in lieu of the Medicaid card;
- a statement regarding the need to use plan facilities and providers with the exception of mental health services, family planning and substance abuse services;
- information on how to obtain and change primary care provider;
- a description of the EPSDT program;
- information on how to arrange transportation;
- an explanation of and procedures for receiving medical services in and out of the enrollee’s county of residence;
- in the voluntary program, information on the right to and the procedure for an enrollee to request disenrollment;
- in the mandatory program, information on the right to and procedure for voluntarily disenrolling from a current plan and changing to another;
- an explanation of automatic disenrollment;
- information on loss of Medicaid eligibility;
- information on coverage cancellation;
- the right to refuse to participate in experimental research;
- an explanation of subrogation and coordination of benefits;
- a clear identification of corporate or parent identity of the plan;
- information on enrollee’s right to self-refer to community health centers, qualified family planning providers and ODADAS programs;
- policies on enrollee’s right to formulate advance directives; and
- information stating that the plan provides covered services to enrollees through a provider agreement with the Ohio Department of Human Services and how members can contact the Department if they so desire [Ohio Administrative Code, Chapter 5101:3-26-08(J)(3)(a-w)].
II.N. Rights and responsibilities--Plan (cont'd.)

Medicaid: The plan maintains a 24-hour, 7-day-a-week toll free hotline to respond to enrollees' inquiries, complaints, and problems [Pennsylvania Department of Public Welfare, Operating Agreement, Section 6, Recipient Services, 6.2].

The plan provides the following materials to enrollees:

- names and locations of participating primary care case managers and their hospital affiliations;
- identification of primary care sites accessible to handicapped enrollees;
- identification of languages spoken at the primary care sites;
- explanation of the procedures for obtaining benefits, including self-referred services;
- explanation of where and how emergency medical care is available, including an explanation of out-of-area coverage;
- description of the grievance procedures;
- information regarding pregnancies which conveys the importance of prenatal care;
- information about family planning services;
- notification that the selection of certain primary care physicians may result in residents providing care to enrollees;
- information stressing preventive care and periodic visits to primary care physicians;
- information regarding the availability of second surgical opinions;
- information on the availability and process for accessing Medicaid services which are not the responsibility of the plan; and
- information on the availability and access to EPSDT services for members under 21 [Pennsylvania Department of Public Welfare, Operating Agreement, Section 6, Recipient Services, 6.4].
II.O. Rights and responsibilities--Member

**MEDICARE**

**Regulation:** There are written policies and procedures concerning advance directives including an enrollee's right to make decisions about medical care, and the right to accept or refuse medical treatment. Documentation is in the medical record as to whether or not an individual has executed advance directives [42 CFR 417.436(d)].

**Policy:** The enrollee agrees to abide by the plan's rules after they are disclosed during the enrollment process [42 CFR 417.422(a)(5)].

**FEDERAL QUALIFICATION**

No standard specified.

**MEDICAID**

**Regulation:** Enrolled recipients are allowed to choose their health professional in the plan to the extent possible and appropriate [42 CFR 434.29].

**Guidelines:** The plan has a written policy that addresses members' responsibility to provide, to the extent possible, information needed by professional staff in caring for the member and to follow instructions and guidelines given by those providing services [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard X, p. 24].

There is a written policy on enrollee rights that addresses an enrollee's right:
- to be treated with respect, dignity and need for privacy;
- to be provided with information about the plan, its services, practitioners and member rights and responsibilities;
- to be able to choose primary care practitioners, within the limits of the plan network;
- to participate in decision-making regarding health care;
- to voice grievances about the plan or care;
- to formulate advance directives; and
- to have access to the medical record [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard X, p. 24].

**BUREAU OF PRIMARY HEALTH CARE**

No standard specified.

**NAIC**

An enrollee has the right to file a complaint at any time with the Commissioner (of Insurance) [NAIC, Draft Standards, Complaint Procedure Model Regulation, 12/6/94, Section 4.C].

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II.O. Rights and responsibilities--Member (cont'd.)

All direct care settings have an effective mechanism for member involvement in all aspects of treatment, care, and service, including, as appropriate: use of family, significant other and/or surrogate decision makers to facilitate appropriate care or treatment decisions; resolution of disagreements in care or treatment decisions; decisions to withhold resuscitative services; decisions to forgo or withdraw life-sustaining treatment; decisions to participate in investigational and/or clinical studies [1994 Joint Commission Standards for Health Care Networks, Rights, Responsibilities and Ethics, RI 2-RI 2.5].

All direct care settings have an effective mechanism for consideration of the member's needs regarding confidentiality of information, communications and privacy [1994 Joint Commission Standards for Health Care Networks, Rights, Responsibilities and Ethics, RI 3-RI 3.3].

Members are informed of their responsibility for providing necessary information to facilitate effective treatment and for cooperating with those providing services; members are informed of any potential consequences of not complying with a recommended treatment [1994 Joint Commission Standards for Health Care Networks, Rights, Responsibilities and Ethics, RI 5-RI 5.2].

A member is informed of any specific health care needs that require follow-up care [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 8].

There is a written policy recognizing rights of members to:
• voice grievances about the organization or care provided;
• be provided with information about the organization, its services, the practitioners providing care, and members' rights and responsibilities;
• participate in decision-making about their care; and
• be treated with respect and recognition of their dignity and need for privacy [NCQA Accreditation Standards, Members' Rights and Responsibilities, RR 1.1].

There is written policy that addresses members' responsibility for cooperating with those providing health care services, including providing needed information to professional staff, and following instructions [NCQA Accreditation Standards, Members' Rights and Responsibilities, RR 2.0-2.1.2].

All plans: The enrollee bill of rights includes:
• right to available and accessible services;
• right to be informed of health problems and to receive information regarding treatment alternatives and risks sufficient to assure informed choice;
• right to refuse treatment and right to privacy of medical and financial records;
• right to file a grievance and the right to initiate a legal proceeding when experiencing a problem with the plan or its providers;
• right to a grace period of 31 days for the payment of premium;
• Medicare enrollees have the right to voluntarily disenroll and the right not to be requested to disenroll except in circumstances specified in federal law; and
• Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the plan [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.07].
II.O. Rights and responsibilities--Member (cont’d.)

**MINNESOTA (cont’d.)**

**Medicaid:** Enrollee rights include:
- right to file an appeal with the plan or state;
- right to request an expedited hearing from the state; and
- right to obtain a second medical opinion from a plan provider [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, III.E.5h].

**OHIO**

All plans: The plan has a policy on the rights and responsibilities of enrollees [Ohio Administrative Code, Chapter 5101:3-26-08(J)(3)].

**Medicaid:** The plan and/or providers have a policy regarding enrollee responsibility and participation in their own care [Ohio Administrative Code, Chapter 5101:3-26-073(B)(4)].

The plan has written policies on the rights of enrollees which include:
- enrollees are treated with respect, consideration and dignity;
- enrollees are ensured confidential handling of information concerning their diagnosis, treatments, prognosis and medical and social history;
- information is conveyed to the individual’s legally authorized representative when concern for an enrollee’s health makes it inadvisable to give him/her information;
- enrollees are given the opportunity to participate in decisions involving their health care unless contraindicated;
- enrollees are assured of auditory and visual privacy during examinations;
- enrollees are afforded the opportunity to approve or refuse release of information except when release is required by law;
- enrollees are given the opportunity to refuse treatment or therapy and to be counselled regarding the consequences;
- enrollees are given the opportunity to express grievances;
- enrollees are assured that all plan-enrollee information is available as needed in the language of major population groups served;
- enrollees are informed of student practitioner roles and their right to refuse student care; and
- enrollees are informed of their right to refuse to participate in experimental research [Ohio Administrative Code, Chapter 5101:3-26-078(J)(4)].

**PENNSYLVANIA**

All plans: The plan has written procedures for informing subscribers of at least the following enrollee rights:
- timely and effective redress of grievances;
- right to complete and easily understood written information;
- right to receive from PCP information on diagnosis, treatment and prognosis;
- right to name, professional status and function of personnel providing health services to him/her;
- informed consent before start of any procedure or treatment;
- whether any provider or facility engages in experimentation or research affecting his/her care or treatment;
- right to refuse treatment to the extent permitted by law;
- right to have records pertaining to care treated confidentially;
- right to medical record unless restricted for medical reasons; and
- right to emergency care [28 Pa. Code, Section 9.77].
II.P. Member satisfaction

**MEDICARE**

**Statute:** The plan conducts periodic surveys of current and past enrollees to determine the degree of access to services and satisfaction with the quality of services [Section 1876(i)(8)(A)(ii)(I) of the Social Security Act].

**Policy:** The plan maintains data on enrollee complaints [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.4.B] and has the information reviewed by the QA committee [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.3.B].

**FEDERAL QUALIFICATION**

**Policy:** Plans maintain data on enrollee complaints [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.4.B] and have the information reviewed by the QA committee [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.3.B].

**MEDICAID**

**Guidelines:** Opportunities are provided for members to offer suggestions for changes in policies and procedures [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard X.F, p. 26].

The plan conducts periodic surveys of current, changing and disenrolled members to assess member satisfaction with respect to perceived problems in the quality, availability and accessibility of care. Survey results are used to identify and investigate sources of dissatisfaction, outline steps for follow-up action and inform practitioners and providers [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard X.K, pp. 27-28].

**BUREAU OF PRIMARY HEALTH CARE**

**Policy:** Patient satisfaction data is used in improving quality of services [Primary Care Effectiveness Review, Clinical Protocol, III.C.2].

**NAIC**

Plans complete periodic satisfaction surveys covering general satisfaction with the plan and the health care provided [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/94, Section 3.I(3)].

**JCAHO**

The network regularly gathers and takes appropriate action on information that relates to member satisfaction with the services provided [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 2.4.3.1].

Network leaders regularly assess and use information about member needs and satisfaction [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 5.5].
II.P. Member satisfaction (cont’d.)

NCQA

Members may offer suggestions for quality improvement [NCQA Accreditation Standards, Quality Management and Improvement, 1994, Q1.5.2].

The plan assesses and enhances member satisfaction with its services by:
- periodically assessing at least a sample of patient complaints, requests to change practitioners and/or facilities, and disenrollments of its members;
- conducting periodic surveys of satisfaction with the plan’s services;
- identifying and addressing sources of dissatisfaction; and
- informing practitioners and providers of assessment results [NCQA Accreditation Standards, Members’ Rights and Responsibilities, RR 8.0].

MINNESOTA

All plans: The Commissioner of Health or each plan may conduct enrollee surveys to ascertain enrollee satisfaction as part of the overall quality evaluation program [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1100].

Medicaid: There is an ongoing review of enrollee satisfaction as monitored through an annual survey [Minnesota Department of Human Services Rules, 9500.1460 Subp.17].

OHIO

All plans: The quality assurance program encompasses surveys of enrollee and provider satisfaction [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.10].

Medicaid: The plan provides enrollees with the opportunity to offer suggestions for quality improvement [Ohio Administrative Code, Chapter 5101:3-26-071(F)(1)].

At a minimum, the plan conducts an annual enrollee satisfaction survey to assess perceived programs regarding the quality, availability and accessibility of health care based on a sample of current Medicaid enrollees, former enrollees and enrollees who have requested to change practitioners and/or facilities [Ohio Administrative Code, Chapter 5101:3-26-071(F)(2)].

As a result of the survey, the plan identifies and investigates sources of dissatisfaction; outlines steps of action to follow-up on findings; informs practitioners, providers and enrollees of survey findings; and reevaluates the effects of the survey activity [Ohio Administrative Code, Chapter 5101:3-26-071(D)(2)(c)].

PENNSYLVANIA

All plans: Plans are required to have one-third of their Board [28 Pa. Code, Section 9.96] and Grievance Committee [28 Pa. Code, Section 9.73] composed of subscribers to the plan

Medicaid: The plan shall establish and maintain a Community Advisory Committee representative of the community served [Pennsylvania Department of Public Welfare, Operating Agreement, Section 14, Quality Assurance and Utilization Review, Attachment IV, 14.6].

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II.Q. Accountability

**MEDICARE**

**Policy:** The policymaking body (or designee reporting to such body) annually reviews the continuity and effectiveness of the QA program and adapts it in accordance with the findings of its review [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.C].

The Chief Executive Officer provides leadership in the area of QA by integrating accountability for QA into the management of the HMO [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.A].

**FEDERAL QUALIFICATION**

**Statute:** The plan has administrative and managerial arrangements satisfactory to the Secretary [Title XIII of the Public Health Service Act, Section 1301(c)(1)(B)].

**Regulation:** There is a policymaking body that exercises oversight and control over the HMO's policies and personnel to ensure that decisions are in the best interest of enrollees [42 CFR 417.124(a)(1)].

**Policy:** The policymaking body (or designee reporting to such body) annually reviews the continuity and effectiveness of the QA program and adapts it in accordance with the findings of their review [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.C].

The Chief Executive Officer provides leadership in the area of QA by integrating accountability for QA into the management of the HMO [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.A].

**MEDICAID**

**Guidelines:** Responsibilities of the governing body for monitoring, evaluating and making improvements to care include: oversight of the quality assurance program; designation of an oversight entity if such oversight is not provided directly by the governing body; review of progress reports on quality assurance activities; at least an annual review of the quality assurance program; and delineation of program modifications, where appropriate [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard III, p. 18].

**BUREAU OF PRIMARY HEALTH CARE**

**Policy:** QM Committee reports are communicated to the administration and to the board [Primary Care Effectiveness Review, Clinical Protocol, III.C.1].

There is a written quality management plan approved by the governing body [Primary Care Effectiveness Review, Clinical Protocol, III.C.1].
II.Q. Accountability (cont’d.)

The corporate board of a plan or a committee or designated executive staff specifically appointed by the board is responsible for the quality assurance activities and periodically reviews and revises the program document to assure ongoing appropriateness [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 5].

Network leaders develop and implement effective mechanisms to assure consistent performance of patient care processes throughout the network [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 1.1.4].

The QI committee is accountable to the governing body of the organization. There is evidence of accountability at the highest levels of the organization and ongoing and/or continuous oversight of the QI process [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.2.0].

The governing body formally designates a subcommittee to provide oversight of QI or formally decides to provide such oversight as a committee of the whole [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.2.1].

There is documentation that the governing body has approved the overall QI program and annual QI plan [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.2.2-2.3] and received regular written reports from the QI program [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QI.2.4].

The governing body, or the group or individual to whom the governing body has formally delegated the credentialing function, reviews and approves credentialing policies and procedures [NCQA Accreditation Standards, Credentialing, 1994, CR 2.0].

The plan designates a credentialing committee or other peer review body that makes recommendations regarding credentialing decisions [NCQA Accreditation Standards, Credentialing, 1994, CR 3.0].

All plans: The plan assumes ultimate responsibility for the evaluation of quality of care provided to enrollees and the governing body periodically reviews and approves the quality assurance program activities [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1100, Subp.2].

The governing body designates a quality assurance entity that may be a person or persons responsible for operation of the quality assurance program activities. This entity meets with the governing body at least quarterly [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1100, Subp.3].

Medicaid: The process of continuous quality improvement takes place with the full acknowledgment and approval of the governing body of the plan and the governing body is routinely informed of and approves any changes in the system [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, VII.A].

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II.Q. Accountability (cont’d.)

Ohio

All plans: There is a committee responsible for quality assurance activities, accountable to the governing body, which meets quarterly and maintains a formal record of its activities [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.10].

There is recognition in the plan bylaws that the governing body is ultimately accountable for the quality of health care provided to enrollees. The governing body oversees the activities of the quality assurance program and the committee responsible for quality assurance reports to plan management and the governing body not less than quarterly [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.15].

Medicaid: There is documentation that the governing body approves the overall quality assurance program [Ohio Administrative Code, Chapter 5101:3-26-072(A)(2)].

The governing body may formally designate and provide documented evidence that a committee has been established for the oversight of quality assurance [Ohio Administrative Code, Chapter 5101:3-26-072(A)(1)].

Pennsylvania

All plans: At least once a year, a report is presented to the board of directors on quality assurance activities, including studies undertaken, results, subsequent actions and aggregate data on utilization and quality of services rendered to enrollees [28 Pa. Code, Section 9.74(d)].

The plan implements a program for accountability which determines the QA responsibilities and provides an organizational structure so that the accountable person and any associated committees or entities are ultimately accountable to the Board of the plan [Appendix I, Pennsylvania Department of Health, HMO Quality Assurance Standards, A.1.2].
II.R. Delegation

MEDICARE

Policy: If certain quality assurance functions are delegated, the governing body remains accountable for all QA activities and must demonstrate that all basic requirements of the QA program are met [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.D].

FEDERAL QUALIFICATION

Policy: If certain quality assurance functions are delegated, the governing body remains accountable for all QA activities and demonstrates that all basic requirements of the QA program are met [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.1.D].

MEDICAID

Guidelines: Where the governing body's participation with quality improvement issues is not direct, a designated committee of the senior management of the managed care organization is responsible [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard III, p. 18].

The plan remains accountable for all quality assurance functions, even if certain functions are delegated to other entities. When the plan delegates any QA activities to contractors, there is a written description of the activities, procedures for monitoring and evaluating the implementation of these functions and evidence of continuous and ongoing evaluation of delegated activities [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard VIII, p. 20].

BUREAU OF PRIMARY HEALTH CARE

No standard specified.

NAIC

The plan has the statutory responsibility to monitor and oversee the offering of covered services to enrollees. That responsibility cannot be delegated or assigned to an intermediary organization [NAIC, Draft Standards, Health Care Provider Contracting Model Regulation, 7/29/94; Technical changes: 8/27/94, Section 7.B].

JCAHO

When the network delegates any function, it uses clear criteria and performance expectations to guide the delegation process; retains the prerogative to make key decisions; actively oversees the delegated activity; periodically collaborates with the delegate to coordinate activities; and maintains evidence that the delegates comply with all standards that would apply if the activity had not been delegated [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 3-LD 3.5].
If the plan delegates any QI activities to contractors, there is evidence of oversight, including a written description of delegated activities, the delegate’s accountability for these activities, the frequency of reporting to the plan, and the process by which delegation will be evaluated [NCQA Accreditation Standards, *Quality Management and Improvement*, 1994, QI 12.0-12.4].

If the plan delegates any UM activities to contractors, there is evidence of oversight of the contracted activity, including a written description of delegated activities, the delegate’s accountability for these activities, the frequency of reporting to the plan, and the process by which delegation will be evaluated [NCQA Accreditation Standards, *Utilization Management*, 1994, UM 9.0-9.1.4].

If the plan delegates any credentialing activities to contractors, there is evidence of oversight of the contracted activity, including a written description of delegated activities and the delegate’s accountability for these activities [NCQA Accreditation Standards, *Credentialing*, 1994, CR 15.0-15.1.2].

The plan monitors the effectiveness of the delegate’s credentialing and reappointment or recertification processes at least annually [NCQA Accreditation Standards, *Credentialing*, 1994, CR 15.3].

If the plan delegates any member service activities to contractors, there is evidence of oversight of the contracted activity, including a written description of the delegated activities, the delegate’s accountability for these activities, the frequency of reporting complaints and grievances and member survey data to the plan, and the process by which the delegated activity will be evaluated [NCQA Accreditation Standards, *Members' Rights and Responsibilities*, 1994, RR 9.0-9.1.4].

**MINNESOTA**

All plans: If the plan contracts with another entity to conduct quality assurance activities, the plan has review and reporting requirements developed and implemented to ensure that the organization contracting with the plan is fulfilling all delegated quality assurance responsibilities [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1100, Subp.6].

**OHIO**

All plans: If the plan delegates certain functions of the quality assurance program to other organizations, the governing body retains ultimate responsibility for the quality of medical care rendered to its enrollees and assesses that such care is subject to ongoing quality assurance review [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.16].

The plan’s governing body receives regular reports on activities undertaken, findings, recommendations and results of actions taken by the delegated entity. A representative of the plan participates in the delegated entity’s quality assurance activities [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.16].

Medicaid: The plan is accountable for all quality assurance program activities, including those delegated to other entities [Ohio Administrative Code, Chapter 5101:3-26-071(G)].
II.R. Delegation (cont’d.)

Ohio (cont’d.)

In cases where quality assurance activities are delegated, there is evidence including: a written description of the delegated activity; the delegate’s accountability for the activities, the frequency of reporting to the plan, the plan’s procedures for monitoring the delegated activities, and evidence of continuous evaluation of the delegated activities by the plan [Ohio Administrative Code, Chapter 5101:3-26-071(G)(2)(3)(4)].

In cases where credentialing activities are delegated, there is a written description of the delegated activities and the delegate’s accountability for these activities. The plan monitors the effectiveness of the credentialing and recredentialing process and retains the right to approve new providers and to terminate or suspend individual providers [Ohio Administrative Code, Chapter 5101:3-26-0721(D)].

Pennsylvania

All plans: The plan is fully responsible for the clinical quality of care and quality of services and, when delegating functions, the plan remains responsible for providing clear evidence that services are of high quality and at all times meet the standards of the plan, as well as the standards of the state. The plan must be able to demonstrate that the activity remains under the oversight of its quality assurance program and that performance is regularly reported to the plan’s board of directors [Commonwealth of Pennsylvania, Department of Health, HMO Technical Assistance Advisory 94-1, HMO Oversight of Delegated Activities].
II.S. Provider contracts

MEDICARE

Regulation: The HMO or CMP retains responsibility whenever it arranges for another entity to furnish specified services to Medicare enrollees of the HMO or CMP [42 CFR 417.401].

There are written agreements executed between the plan and another entity in which the other entity agrees to furnish specified services to Medicare enrollees of the plan, but the plan retains responsibility for those services [42 CFR 417.401].

The plan does not have any agents or management staff or persons with ownership or control interests who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social service programs [42 CFR 412(b)(2)].

FEDERAL QUALIFICATION

Statute: Contracts between the plan and health professionals for the provision of basic and supplemental services shall include provisions established as the Secretary requires to ensure the delivery of quality health care services and sound fiscal management [Title XIII of the Public Health Service Act, Section 1301(b)(3)(C)&(D)].

MEDICAID

Regulation: No subcontract terminates the legal responsibility of the plan to carry out its required activities [42 CFR 434.6(c)].

Guidelines: Contracts specify that hospitals and other contractors will allow the plan access to the medical records of its members [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard VII.A, p. 20].

The plan includes in all its provider contracts, for both physician and non-physician providers, a requirement securing cooperation with the quality assurance program [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard VII.B, p. 20].

BUREAU OF PRIMARY HEALTH CARE

Policy: Special provisions pertain to contract services for pharmacy, laboratory, and radiology, including: documentation of proper licensure and compliance with federal, state and local regulations; licensed and certified personnel, as appropriate; listing of services and related fees; maintenance of files for a reasonable time period; sliding fee discounts; and satisfaction with timeliness and quality of services and posting of results in medical records [Primary Care Effectiveness Review, Clinical Protocol, III.M.2, IV.K.3., IV.L.2].
II.S. Provider contracts (cont’d.)

Provider contracts include a provision requiring the provider to maintain and make medical records available to the plan that are necessary to monitor and evaluate quality of care, conducting medical evaluations and audits, and determining, on a concurrent and retrospective basis, the medical necessity and appropriateness of care provided to enrollees, and to make such medical records available to appropriate state and federal authorities and their agents involved in assessing the quality of care or investigating enrollee grievances or complaints and to comply with the applicable state and federal laws related to privacy and confidentiality of medical records [NAIC, Draft Standards, Health Care Provider Contracting Model Regulation, 7/29/94; Technical changes: 8/27/94, Section 6.I].

The plan assures that contracting, employed and affiliated providers, including those who provide health care services to covered persons, actively participate in developing, implementing and evaluating the quality improvement system [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.C].

A subcontract between an intermediary organization (e.g., individual practice association, hospital or medical staff partnerships, medical groups, etc) and participating providers contain all the same provisions as required in the contract between the plan and the intermediary organization [NAIC, Draft Standards, Health Care Provider Contracting Model Regulation, 7/29/94; Technical changes: 8/27/94, Section 7.A].

When the network subcontracts any function, it uses clear criteria and performance expectations to guide the contractor; retain the prerogative to make key decisions; actively oversee the contracted activity; periodically collaborate with the subcontractor to coordinate activities; and maintain evidence that the subcontractor complies with all standards that would apply if the activity had not been subcontracted [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 3-LD 3.5].

Requirements for participation in QI activities are incorporated into all provider contracts and employment agreements. Contracts specify that the plan has access to the medical records of its members [NCQA Accreditation Standards, Quality Management and Improvement, 1994, QL.4.0].

Medicaid: Subcontracts include provisions for the Department of Human Services to evaluate through inspection or other means the quality, appropriateness and timeliness of services performed by the subcontractor and the plan has similar assurances to monitor the performance of its subcontractors [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.9].

All plans: Provider contracts include provisions for provider responsibilities to participate in quality assurance, utilization review, credentialing and the grievance resolution processes [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.4].
II.S. Provider contracts (cont’d.)

**OHIO (cont’d.)**

Medicaid: The execution of a subcontract does not terminate the plan’s legal responsibility to assure that all of the plan’s activities and obligations are carried out in accordance with applicable requirements and the plan’s provider agreement [Ohio Administrative Code, Chapter 5101:3-26-05(A)(4)].

All subcontractors agree to comply with the provisions for record keeping and auditing and fulfill the requirements of all laws, regulations and contractual obligations of the plan [Ohio Administrative Code, Chapter 5101:3-26-05(D)(1)(4)].

There is a requirement securing cooperation with the plan’s quality assurance program in all its provider subcontracts for physician and nonphysician providers [Ohio Administrative Code, Chapter 5101:3-26-05(D)(18)].

**PENNSYLVANIA**

All plans: All provider contracts are reviewed by the Department of Health.

Medicaid: Contracts and subcontracts entered into by the plan do not terminate the plan’s obligations under the agreement [Pennsylvania Department of Public Welfare, Operating Agreement, Section 12, Contracts and Subcontracts, 12.1].
II.T. Information systems adequacy

**MEDICARE**

**Regulation:** The plan maintains a health (including medical) record keeping system through which pertinent information relating to the health care of its Medicare enrollees is accumulated and is readily available to appropriate individuals [42 CFR 417.416(c)(2)].

**Policy:** The information system is able to collect individual patient care data related to health professional, member, diagnosis, procedure, date and location of service. The system has the capability to aggregate data to identify patterns of care [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.4.A].

**FEDERAL QUALIFICATION**

**Regulation:** The plan has effective procedures to develop, compile, evaluate and report to HCFA, to its enrollees, and to the general public, at the time and in the manner that HCFA requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information with respect to: the cost of operation; the patterns of utilization of its services; the availability, accessibility, and acceptability of its services; developments in the health status of its enrollees; information demonstrating that the plan has a fiscally sound operation; and other matters that HCFA may require [42 CFR 417.126(a)].

The plan has administrative and managerial arrangements satisfactory to HCFA, as demonstrated in part by personnel and systems sufficient for the plan to organize, plan, control, and evaluate the financial, marketing, health services, quality assurance program, administrative and management aspects of the plan [42 CFR 417.124(a)(2)].

**Policy:** The information system is able to collect individual patient care data related to health professional, member, diagnosis, procedure, date and location of service. The system has the capability to aggregate data to identify individual instances and patterns of suspected aberrant care [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.4.A].

The plan maintains data from multiple sources such as medical records; enrollee complaints; feedback from physicians, other health professionals, providers and staff; clinical and non-clinical study results; referrals through the utilization review system; and potential problem areas identified through the information system [Manual for Federally Qualified Health Maintenance Organizations (Title 13, Public Health Service Act), Transmittal No. 1, November 1989, 4201.4.B].

**MEDICAID**

**Guidelines:** Methods and frequency of data collection are appropriate and sufficient to detect need for program change [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard II.B.3, p. 16].

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II.T. Information systems adequacy (cont’d.)

Policy: Clinical staff has access to computer-based literature search services such as Grateful Med or Lonesome Doc [Primary Care Effectiveness Review, Clinical Protocol, II.B.15].

The management information system must be adequate to provide the information needed at given points in time and over time, including utilization data by patient and program characteristics and provider [Primary Care Effectiveness Review, Management Information Systems, pp. 2-32].

NAIC

Claims and encounter information are stored electronically for at least (a defined) number of years [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/94, Section 3.B].


The plan’s data system is sufficient to support utilization review program activities and to generate management reports to enable the plan to effectively monitor and manage health care services [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 6.E].

In addition to age and gender of each enrollee, the plan has a centrally accessible enrollment database that identifies the race, census tract and educational level of each enrollee [NAIC, Draft Standards, Data Reporting Model Regulation, 12/6/94, Section 3.F].

The plan has the capacity to identify exemplary and problematic patterns of health care in the aggregate and for individual providers [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94, Section 4.E].

JCAHO

Information management processes within the network are appropriate for the network’s size and complexity [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 1.1].

Based on the network’s information needs, appropriate staff participate in assessing, selecting, and integrating health care information technology and, as appropriate, the use of efficient interactive information management systems [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 1.1.1].

The information management function enables the combination of data and information; make information from one system (clinical and/or organizational) available to others; provides reports; clarifies and interprets data and information; and enables linkages of member care data and nonmember care data and information over time among the network’s components [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 5].

The network ensures that information is communicated to practitioners in a timely manner to facilitate the provision of an appropriate continuum of services [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 6].
II.T. Information systems adequacy (cont'd.)

NCQA

No standard specified.

MINNESOTA

All plans: The data collection and reporting system supports the information needs of the quality assurance program activities [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1100, Subp.7].

The plan establishes and maintains procedures to develop, compile, evaluate, and report statistics which include the collection and maintenance of at least the following data:
- operational statistics sufficient to meet state requirements relating to annual financial reports;
- gross utilization aggregates, including hospital discharges, surgical hospital discharges, hospital bed days, outpatient visits, laboratory tests and x-rays;
- demographic characteristics, including the age and sex of enrollees;
- disease-specific and age-specific mortality rates; and
- enrollment statistics [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1200].

OHIO

All plans: An appropriate management information system is developed and implemented which is capable of providing clinical and administrative information necessary to evaluate the quality, availability, and accessibility of services provided in addition to the overall cost and effectiveness of the plan's operations [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.13].

The management information system should provide, at a minimum:
- specification of the data collected to evaluate the accessibility and availability of services and how data can be used to make a valid assessment;
- specification of the data collected regarding cost and effectiveness of services;
- assurances that the data needed by quality assurance and utilization review committees are collected, valid and available; and
- demonstration that the system is capable of generating enrollment and utilization data required by the state [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.13].

Medicaid: The plan maintains a management information system that supports utilization and quality assurance programs and complies with state data collection requirements [Request for Proposals for Health Maintenance Organizations to Provide Medicaid Covered Services to the Aid to Dependent Children and Healthy Start Eligible Populations in Ohio, State of Ohio Department of Human Services, May 19, 1994, V.4, p. 22-23].

Pennsylvania

Medicaid: The plan maintains a system that satisfies HCFA Medicaid Management Information System (MMIS) certification standards and System Performance Review (SPR) requirements [Pennsylvania Department of Public Welfare, Operating Agreement, Section 10, Payment of Providers, 10.2].

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II.U. Confidentiality

MEDICARE

*Regulation:* The plan agrees to comply with the requirements of the Privacy Act [42 CFR 417.486(c)] and to meet the confidentiality requirements for medical records [42 CFR 417.486(d)].


FEDERAL QUALIFICATION

*Statute:* There are safeguards concerning the confidentiality of the doctor-patient relationship [Title XIII of the Public Health Service Act, Section 1301(c)(8)].

*Regulation:* Confidentiality of the health and medical records of enrollees is ensured [42 CFR 417.106(d)].

MEDICAID

*Regulation:* Contractors safeguard information about recipients [42 CFR 434.6(a)(8)].

*Guidelines:* The plan acts to ensure that the confidentiality of specified patient information and records is protected, including: (1) written policies on confidentiality; (2) assurances that patient care offices have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information; (3) the plan holds confidential all information obtained by its personnel about enrollees related to their care and treatment; (4) any release of information in response to a court order is reported to the patient in a timely manner; and (5) enrollee records may be disclosed to qualified personnel for the purpose of conducting scientific research, but such reports cannot disclose participant identity in any manner [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard X.I, p. 26-27].

BUREAU OF PRIMARY HEALTH CARE

*Policy:* There are policies in place that provide for confidential access to medical records by adolescent patients [Primary Care Effectiveness Review, Clinical Protocol, III.A.12].

NAIC

The plan has written policies and procedures to assure that patient-specific clinical information and provider-specific performance data are maintained in a confidential manner, including provisions for: safeguards against unauthorized use or disclosure; guidelines for reporting and release of data; mechanisms to ensure that data reports related to utilization and quality of care have as their primary purpose to educate and inform users of the data; opportunities for affected parties to review and respond to data reports; guidelines to prevent unauthorized release of patient-specific data to the public; and provisions that any party making reports available to the public is held accountable for failure to comply with a standard of due care and confidentiality [NAIC, Draft Standards, Utilization Review Model Regulation, 6/13/94, Section 10].
II.U. Confidentiality (cont’d.)

The network determines the need for and appropriate levels of security and confidentiality of data and information [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 2.1].

The network has an effective mechanism designed to safeguard records and information against loss, destruction, tampering and unauthorized access or use [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 2.3].

The network determines how data can be easily retrieved on a timely basis without compromising the security and confidentiality of the data [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 2.2].

The information management function provides for confidentiality, integrity and the security of information [1994 Joint Commission Standards for Health Care Networks, Management of Information, IM 2].

All direct care settings have an effective mechanism for consideration of the member’s needs regarding confidentiality of information, communications and privacy [1994 Joint Commission Standards for Health Care Networks, Rights, Responsibilities and Ethics, RI 3-R1 3.3].

All settings in the network that provide care have effective mechanisms that provide for consideration of the member’s needs regarding confidentiality of information [1994 Joint Commission Standards for Health Care Networks, Rights, Responsibilities and Ethics, RI 3].

The plan acts to ensure that confidentiality of specified patient information and records is protected [NCQA Accreditation Standards, Members’ Rights and Responsibilities, RR 7.0].

The plan has written confidentiality policies and procedures [NCQA Accreditation Standards, Members’ Rights and Responsibilities, 1994, RR 7.1].

The plan ensures that patient care offices have implemented mechanisms that guard against unauthorized or inadvertent disclosure of confidential information to persons inside and outside the plan who should not have access to such information [NCQA Accreditation Standards, Members’ Rights and Responsibilities, 1994, RR 7.2].

Patients are afforded the opportunity to approve or refuse the release of identifiable personal information by the plan, except when such release is required by law [NCQA Accreditation Standards, Members’ Rights and Responsibilities, 1994, RR 7.3].
II.U. Confidentiality (cont’d.)

MINNESOTA

All plans: Any information pertaining to the diagnosis, treatment, or health of any enrollee is private and is not disclosed to any person except as required to carry out state requirements [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.14, Subd.4].

Medicaid: The plan is in full compliance with the Minnesota Government Data Practices Act [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.15].

Pursuant to state statutes, under certain circumstances the plan protects the minor from disclosure of certain information to parents if affirmatively requested by the minor and it is in the best interest of the minor [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.16].

The plan devises a method in which a provider can designate on the claim form those services (e.g., family planning services for children and adults) which must be treated as confidential and should not appear on the Explanation of Medical Benefits [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.16].

OHIO

All plans: The plan maintains a medical record system which ensures patient confidentiality [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.5].

The confidentiality of all grievances is retained [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, pp.16-17].

Medicaid: As a condition of enrollment, an eligible individual waives any privilege of confidentiality that may exist as a result of the provider-patient relationship for the limited purpose of authorizing and directing the plan to receive and release all medical records necessary to provide continuity of medical care or to administer the plan [Ohio Administrative Code, Chapter 5101:3-26-02(B)(1)(d)].

The plan/provider site has a policy regarding the confidentiality of medical records which ensures that records are handled to preclude loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure of information [Ohio Administrative Code, Chapter 5101:3-26-077(A)(3)].

Information obtained about enrollees related to their examination, care, and treatment is held confidentially and not divulged without the enrollee’s authorization unless it is required by law, necessary to coordinate the patient’s care or necessary in compelling circumstances [Ohio Administrative Code, Chapter 5101:3-26-077(A)(3)].

PENNSYLVANIA

All plans: All information reviewed during the external quality review survey are held confidentially except for such information which might be required to be disclosed to appropriate regulatory officials [Invitation to Qualify as an Approved HMO Quality Review Organization, Pennsylvania Department of Health, Appendix II, External Assessment Process, Responsibilities of Review Organizations].

130 Summary, Quality Improvement Standards and Processes
II.U. Confidentiality (cont’d.)

Medicaid: The plan agrees to make appropriate provisions to physically secure and safeguard all sensitive listings, documents, and files related to the state [Pennsylvania Department of Public Welfare, Operating Agreement, Section 13, Records and Reports, 13.8].

The plan maintains the highest standards of integrity in the performance of its agreement with the state and takes no action in violation of state and federal laws, regulations, or other requirements that govern contracting with the state [Pennsylvania Department of Public Welfare, Operating Agreement, Contractor Integrity Provisions, 2].
II.V. Cultural sensitivity

**MEDICARE**

**Regulation:** Enrollment is substantially representative of the general population [42 CFR 417.424(b)].


**Policy:** Marketing materials are available in all languages in which verbal marketing activities are conducted [Medicare Health Maintenance Organization/Competitive Medical Plan Manual, Transmittal No. 8, January 1992, 2208.1].

**FEDERAL QUALIFICATION**

**Statute:** The plan enrolls persons who are broadly representative of the various age, social, and income groups within the area it serves [Title XIII of the Public Health Service Act, Section 330(c)(3)(A)].

**Regulation:** Enrollment is offered to persons who are broadly representative of the various age, social, and income groups within the service area [42 CFR 417.124(c)].

**MEDICAID**

**Regulation:** The plan does not discriminate against individuals eligible to be covered under contract, on the basis of health status or need for health services [42 CFR 434.25(b)].

**Guidelines:** Member information is written in prose that is readable and easily understood and is available, as needed in the languages of the major population groups served (those representing at least 10% of a plan's membership) [A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, Health Care Financing Administration, July 6, 1993, Standard X.H, p. 26].

**BUREAU OF PRIMARY HEALTH CARE**

**Policy:** There are providers who are competent in languages spoken by health center clientele [Primary Care Effectiveness Review, Clinical Protocol, II.B.8].

There is a protocol to handle patient complaints in languages other than English [Primary Care Effectiveness Review, Clinical Protocol, III.C.2].

Health education materials are available in languages representing the community [Primary Care Effectiveness Review, Clinical Protocol, IV.A.1].

Interpreter services are provided in the following circumstances, as appropriate: in the health center, in the hospital, after hours, and for referred patients [Primary Care Effectiveness Review, Clinical Protocol, IV.A.3].

**NAIC**

Providers provide health services without discrimination against an enrollee on the basis of age, sex, ethnicity, religion, sexual preference, health status or disability [NAIC, Draft Standards, Health Care Provider Contracting Model Regulation, 7/29/94, Technical changes: 8/27/94, Section 6.M].

132 Summary, Quality Improvement Standards and Processes
II.V. Cultural sensitivity (cont’d.)

JCAHO

Health care services take into account the socio-cultural characteristics of the population served [1994 Joint Commission Standards for Health Care Networks, Continuum of Care, CC 3.2].

NCQA

No standard specified.

MINNESOTA

All plans: Enrollment cannot discriminate on the basis of age, sex, race, health or economic status [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.10].

A plan does not discriminate in enrollment policy against any person solely by virtue of status as a recipient of medical assistance or Medicare [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.12, Subd.8].

The plan, either directly or through its contracted mental health or chemical dependency provider, makes available services that are culturally specific or appropriate to a specific age, gender or sexual preference, to the extent reasonably possible [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1010, Subp.2.E.(4)].

Medicaid: The plan develops a strategy for addressing the needs of the minority populations it serves which incorporates the following elements:
- provision of culturally appropriate services;
- bilingual staff and/or interpreters; and
- coordination with community resources [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.6].

A plan provides high quality, comprehensive patient care that is culturally and linguistically appropriate and is provided in accordance with current professional standards [Request for Proposals, Medical Assistance/General Assistance Medical Care, Managed Care Health Plan Contracts, State of Minnesota, Section 2, II.C.11].

OHIO

Medicaid: Enrollment occurs without regard to an eligible individual’s race, color, religion, sex, sexual preference, age, disability, national origin, Vietnam-era veteran’s status, ancestry, health status or need for health services [Ohio Administrative Code, Chapter 5101:3-26-02(B)(1)].

The plan provides the services of an interpreter, during normal business hours, proficient in the primary language of any population group that constitutes 10% or more of its enrollees [Ohio Administrative Code, Chapter 5101:3-26-08(I)(2)].

The subcontractsor agrees not to discriminate in the delivery of services based on the enrollee’s race, color, religion, sex, sexual preference, age, disability, national origin, Vietnam-era veteran’s status, ancestry, health status or need for health services [Ohio Administrative Code, Chapter 5101:3-26-05(D)(9)].
II.V. Cultural sensitivity (cont'd.)

Medicaid: The plan provides for necessary translation assistance on its 24-hour, 7-day-a-week toll-free hotline to respond to enrollees' inquiries, complaints, and problems [Pennsylvania Department of Public Welfare, Operating Agreement, Section 6, Recipient Services, 4.2].
II.W.  Consumer participation

MEDICARE

No standard specified.

FEDERAL QUALIFICATION

Statute: The application shows satisfactory specification of the role for members in the planning and policymaking of the organization [Title XIII of the Public Health Service Act, Section 1306(b)(3)(J)]

MEDICAID

No standard specified.

BUREAU OF PRIMARY HEALTH CARE

Policy: A majority of the members of the Board of Directors represent users of the services of the center [Primary Care Effectiveness Review, Governance Protocol, I, Exhibit D].

NAIC

Enrollees have the opportunity for meaningful input into the quality improvement process [NAIC, Draft Standards, Quality Assurance Model Regulation, 9/19/94; Section 4.C].

JCAHO

Educational programs are designed to facilitate a member’s active participation in his or her health care and in decision making about health care options and the consequences of the options selected [1994 Joint Commission Standards for Health Care Networks, Education and Communication, ED 4.1].

Where appropriate, members collaborate to design services [1994 Joint Commission Standards for Health Care Networks, Leadership, LD 2.4.1]

NCQA

No standard specified.

MINNESOTA

All plans: If a plan is a nonprofit corporation, at least 40% of the governing body is composed of consumers elected by the enrollees from among the enrollees [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.06]. In addition to the 40% consumer representatives, 51% of the community integrated service network’s governing body is composed of residents of the plan’s service area.
II.W. Consumer participation (cont’d.)

MINNESOTA (cont’d.)

If a plan is a local governmental unit, an enrollee advisory body is established, elected by the enrollees from among the enrollees [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.06].

The governing body establishes mechanisms to afford the enrollees an opportunity to express their opinions in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of mechanisms prescribed by the state [Minnesota Statutes, Chapter 62D, Health Maintenance Organizations, 62D.06].

Consumer representatives on the governing body are enrollees at the time of their election and during their term of office [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1400, Subp.3].

The Commissioner of Health may consider alternatives to the above governing body composition, such as:
- permitting enrollees to attend and express their opinions at certain regular meetings of the governing body or special meeting called for the express purpose of affording enrollees an opportunity to express their opinion;
- creating a special committee of the governing body which holds meetings at least quarterly and which are open to all enrollees to express their opinions;
- designating a special administrative office within the plan, responsible directly to the governing body, which will be open to enrollees to express their opinions on a regular basis;
- creating enrollee councils which will be afforded a reasonable opportunity to meet with the governing body or its designee to express enrollee opinions; and
- such other mechanisms as the Commissioner may authorize [Chapter 4685, Department of Health, Health Maintenance Organizations, 4685.1500].

OHIO

All plans: The quality assurance committee includes representation from plan management, and representation from plan enrollment [Health Maintenance Organization Standards and Filing Requirements, Ohio Department of Health, Office of Health Policy and Analysis, p.111].

PENNSYLVANIA

No standard specified.