Quality Improvement Primer for Medicaid Managed Care

Final Report

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The authors have tried to synthesize a complex project and translate that experience for others. It has not always been possible to capture the depth and scope of work within each of the sites nor to fully recognize the efforts of state policymakers, plan representatives, review entities and consultants in the demonstration process. We would, however, like to call special attention to project staff, past and present, who shaped this project within each of their states and helped make implementation of the QARI guidelines a reality.

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This project has been a multi-year effort spanning two administrations. We would not be where we are today without the early help of Tina Nye, former director of HCFA’s Medicaid Bureau, and Mary Dewane and Ann Page of HCFA’s Office of Coordinated Care.
CHAPTER I
Introduction

This Quality Improvement (QI) Primer is a compilation of insights and tools gathered over a two year period as three states implemented a new approach for monitoring the quality of services under Medicaid managed care arrangements. Through funds made available from The Henry J. Kaiser Family Foundation, Minnesota, Ohio and Washington worked with the National Academy for State Health Policy to test the effectiveness and feasibility of quality improvement guidelines published by the Health Care Financing Administration (HCFA).

A formal assessment of the project and the merits of the guidelines is being conducted by Mathematica Policy Research (MPR) and will be available in 1996. Two interim reports have been prepared by MPR and are available on request.¹ The importance of sharing early lessons from the demonstration is prompted by a survey conducted by the National Academy indicating that 17 states are using the QARI guidelines². Earlier surveys conducted by HCFA showed many states had adapted the guidelines to their states or planned to do so in the future. By synthesizing the experience of the project to date, we hope to both caution and encourage states in their efforts and, in the process, ensure that the insights from the demonstration are put to good use as soon as possible.

A draft edition of the QI Primer was prepared for preview at a conference on March 13, 1995, Making Quality Improvement Work in Medicaid Managed Care. This meeting provided an opportunity for state and Federal policymakers to learn firsthand about the demonstration with special emphasis on the factors which impede and enhance the development of an effective monitoring program. This final edition of the QI Primer incorporates the discussion generated at this meeting.

HCFA's Quality Assurance Reform Initiative

In early 1991, HCFA's Medicaid Managed Care Office initiated the Quality Assurance Reform Initiative (QARI) to design a more credible approach to monitoring and improving the quality of managed care services. Three groups were particularly instrumental in advising HCFA during this process:

* The National Task Force on Medicaid Managed Care, convened by the National Academy, set out to examine barriers to growth of effective, quality


² Survey of State Managed Care Initiatives, National Academy for State Health Policy, September, 1994.
Medicaid managed care and to advise HCFA in the development of proposals for federal legislative and regulatory reform in this area. Representing HCFA, state officials, managed care plans, Congressional staff and consumer and provider advocacy groups, the Task Force concluded that a more coherent federal policy was needed for assisting states in their quality oversight responsibilities which would shift the orientation of review from a process to an outcome focus.\(^3\)

- A *Medical Directors' Group*\(^4\), composed of physicians and state officials, evaluated a compilation of existing quality improvement standards\(^5\) for managed care organizations and proposed to HCFA a single, uniform set of guidelines for managed care organizations contracting with the Medicaid program.

- Practical advice and consultation from the states was assured by a *State Medicaid Agency Technical Advisory Group* convened by HCFA. Its role was to help assess the viability of these reforms and the system capacity issues they may imply for state agencies.

Phase I of the Quality Assurance Reform Initiative was completed in July, 1993 with the publication of the document entitled, *A Health Care Quality Improvement System for Medicaid Managed Care - A Guide for States* (commonly referred to as the “QARI guidelines”). In addition to proposing new working relationships among the managed care plans, the state agencies with which they contract and the independent external quality review entity, this document lays out specific criteria for managed care plans to use in designing their internal quality assurance programs. Copies of these guidelines were distributed to all state Medicaid agencies to assist them in meeting their regulatory responsibilities for monitoring care delivered to Medicaid recipients under managed care arrangements.

Since the guidelines were not issued as standards, their adoption and use by states are expected to vary. The guidelines, however, provide an opportunity for states to review their present mechanisms for monitoring service delivery and to examine whether these efforts are fully integrated into an effective system of quality

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3 A final report of the National Task Force, *Improving Access and Quality of Care Under Medicaid Managed Care: Proposals for Reform* (January, 1993) is available through the National Academy for State Health Policy (202/874-6524).

4 Convened by the National Academy for State Health Policy, the Medical Directors' Group is composed of medical directors of participating plans nominated by the Group Health Association of America (GHAA) and the American Managed Care and Review Association (AMCRA) and representatives of state Medicaid agencies.

5 Some of the more well-known quality improvement standards considered included those developed by the National Committee for Quality Assurance (NCQA); the National Association of HMO Regulators (now the National Association of Managed Care Regulators); and standards pertaining to Health Maintenance Organizations and Competitive Medical Plans (CMP) contracting with the Medicare program.
improvement within state government and within a state's participating plans. Specifically, states can benefit in several important ways from QARI:

- The guidelines provide greater specificity on how states can fulfill current statutory and regulatory requirements;
- Implementation of QARI will result in greater uniformity in quality improvement among states and plans;
- Because the proposed guidelines are based in large part on existing standards used by the Medicare program and private review entities, redundant requirements placed on plans should be reduced;
- The guidelines can assist start-up states as they consider the scope of activities, staff expertise and cost necessary to properly monitor and improve quality of care.

Despite the obvious advantages to the QARI guidelines, their implementation represents a significant commitment of resources on the part of state agencies and the managed care plans with which they contract. For most states, full implementation of the guidelines requires an expanded level of effort with respect to staffing, coordination and systems capacity.

**Three state demonstration project**

A three-state demonstration has been completed to test the effectiveness of the QARI guidelines and to examine the issues faced by states in implementing their provisions. Four principal objectives were identified for the project:

1. To test federal reforms in Medicaid managed care quality assurance and to determine their effectiveness in monitoring quality of care;
2. To increase state capacity to implement and manage Medicaid managed care quality assurance reforms;
3. To provide HCFA and Congress with information to refine proposed quality assurance standards based upon the experience of demonstration states; and
4. To encourage the growth of Medicaid managed care by providing a cost effective and credible system of quality assurance.

Eleven states responded to a Request for Proposals issued by the National Academy in October, 1992. Selection criteria emphasized a state's demonstrated capacity and commitment to implement the complex requirements of the guidelines, including strong Medicaid agency leadership and support by a state's participating managed care plans. In choosing Minnesota, Ohio and Washington, the Kaiser Family
Foundation also sought diverse environments within which to examine the feasibility and effectiveness of the quality assurance guidelines.

Each state was awarded grants up to $250,000, not including in-kind contributions and federal financial participation. Funds from the project were used to support staff recruitment, convene meetings and work groups, hire consultants to customize the program to the specific needs of the state, re-design data systems, design and test new reporting forms, and provide staff and provider training. The National Academy for State Health Policy directed the project and, together with HCFA staff, provided ongoing program guidance to the sites.

Although HCFA released QARI as guidance, each of the demonstration states agreed to implement the guidelines as if their provisions were standards. This approach was essential to assuring that all sites were testing the same system requirements and that the demonstration not become a moving target. At the same time, however, QARI was never perceived as a static document and was intended to evolve based on the input and insights of states working collaboratively with their managed care plans. While the demonstration states may have been restricted in their application of the guidelines, we are hopeful that their experience will enhance the knowledge base of non-participating states as they consider the application of the guidelines to their own settings.

The demonstration began February 1, 1993 and came to a close in April, 1995.

Profile of participating states

The choice of states to participate in the demonstration obviously influences the outcome of the project and, more pertinent, the experiences reflected in this QI Primer. While the issues surfacing in the demonstration may not be universal or even representative, we believe that together they illustrate the range of challenges associated with developing performance measures and monitoring the care provided to Medicaid enrollees of managed care arrangements. To assist the reader in placing the findings of this QI Primer within context, however, a brief summary of each of the demonstration states is provided below. These profiles attempt to capture the status of each state at the time of project start-up with particular emphasis on their specific project focus and objectives.

Minnesota

The Minnesota Medicaid program has provided risk-based managed care since 1986 for AFDC, AFDC-related, elderly living in the community and elderly living in nursing homes. At the time of project start-up, the state had eight HMO contracts, serving twenty percent of the Medicaid population, and was expanding to achieve 30 percent penetration. There were two IPA models, one staff model and five clinic model health plans.
A full-time staff member was responsible for overseeing quality assurance for all prepaid programs in the state. This person initially became the Project Director for the QARI demonstration. State guidelines for health plans' internal QA programs were believed to be in substantial compliance with the QARI guidelines.

The state's contract for external review was terminated prior to project start-up due to conflicts of interest arising from the entity's acquisition by a company which owns and operates health plans. Consequently, the state entered into a new contract with the National Committee for Quality Assurance (NCQA) to conduct the required independent reviews, and to also provide technical assistance in the design of clinical audits of special study areas. The demonstration aimed to enhance plan participation in the development and implementation of these studies and to create forums for the active exchange of knowledge and expertise residing within the plans themselves. All plans agreed to participate in the project and saw benefit to standard data collection for issues of common concern to Medicaid.

The Minnesota Medicaid program had an historically collaborative relationship with the Department of Health, such as through joint administrative reviews of managed care plans which reduced duplication of their potentially overlapping activities. This relationship was enhanced through a separate 3-year project including the Medicaid agency, the Department of Health and plans to improve the quality, comparability, and reliability of data supplied to the two departments. A new state Management Information System has improved capacity for the collection and analysis of encounter data submitted to the Medicaid agency by health plans.

Minnesota represents an advanced managed care environment, one which is not easily replicable in other states. However, their contributions in the area of focused studies offer useful tools and approaches that have relevance to all states.

Ohio

Ohio was one of the earliest states to implement Medicaid managed care in 1978. At the start of the demonstration, 15 percent of Ohio's AFDC population and pregnant women and children under the expanded Medicaid program were enrolled in risk-based managed care in 12 of the state's 88 counties. Enrollment was mandatory in only one of those counties. There was an organized Managed Health Care Section within the Department of Human Services with responsibility for contracts, fiscal oversight, technical assistance, and quarterly site visits to review data and identify problems. The managed health care section had 14 staff persons, including clinical, planning and fiscal staff. Three additional staff were funded under the project and housed within the existing unit.

The 12 HMOs participating in the project at start-up represented 11 IPA models and one group model plan. Although the state had standards requiring plans to develop QA programs, provisions were not as extensive as those found in the QARI guidelines. An annual independent QA survey and quarterly site visits to contracting plans were conducted by the managed care staff in addition to tri-annual
reviews performed by the Department of Health as a condition of state licensure. Information was shared between the two departments every three years when reviews overlapped. The Ohio Department of Insurance licenses HMOs, monitors fiscal solvency and receives enrollee grievances.

Clinical practice guidelines had been developed under a 1985 contract with the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) for data abstraction and medical protocols for use by the external review entity. These had undergone continuous revision and expansion over the years. Prenatal and immunization indicators already existed, but the clinical indicators included in QARI were not in current use.

The management information systems of the state and plans are not compatible and the HMO network does not use common claims forms. Plans submit quarterly utilization data on enrollment, encounters by physician, specialist visits, hospitalizations, births, and a number of other areas. One of the initiatives of the demonstration was to enter into a contract to improve the state’s electronic systems, including the ability to monitor across plans through the development of software programs to facilitate the collection and analysis of data for focused study areas.

Although there was an existing external review entity at the start of the project, an RFP was issued during the demonstration further specifying the scope of work required under the external review function. Peer Review Systems, Inc. of Ohio was selected as the review entity to review study designs and to conduct focused studies. Other aspects of the demonstration included the development of tools to monitor member satisfaction, the review and incorporation of QARI standards for plans' internal quality assurance programs into state administrative code, and the examination of alternative approaches for enhancing consumer participation in the quality improvement process.

Ohio probably mirrors the status of many states with respect to the level of their QA activities, although their staffing and organization are those of an experienced program.

Washington

Washington State offers an opportunity to examine the impact of the QARI guidelines on a state with little history in managed care and an accelerated movement to create a managed care administrative and delivery system. Although risk-based contracting has been employed since 1981, only 8 percent of Washington’s Medicaid recipients were enrolled at project start-up. In 1986 enrollment grew to about 16,000 in response to a state legislative mandate to expand enrollment. The state Medicaid agency increased its commitment to expanding managed care early in 1992 by establishing the Primary Care Options Program, now called Healthy Options. Under this program a variety of coordinated care models were developed with the goal of mandatory enrollment of all AFDC Medicaid clients.
During the early implementation period it was widely recognized that a comprehensive managed care quality improvement system was badly needed. Like most other Medicaid programs, Washington's quality monitoring system was originally designed for the fee-for-service sector. The demonstration project provided the opportunity to implement and test a system specifically designed for a managed care delivery system. Prior to the demonstration, no staff were specifically assigned to quality assurance activities. One physician was designated to serve as QA coordinator for the Medicaid agency on a half-time basis.

Of the six health plans participating at the time of project start-up, three were IPA models and three were staff models. Up until the time of the demonstration, plans were required to comply with general program requirements, but there were no state standards for internal QA programs with the exception of grievance procedures. Three of the plans were using practice guidelines, and the state was performing well baby and maternity care case reviews through the mandated external quality review contract.

The PRO of Washington had been doing the independent reviews since 1988. Seven generic screens were used in addition to two state-defined screens in the areas of well baby and maternity services. Plans were reviewed quarterly by the PRO although these reviews were seen as mechanical with little direct value to the plans. The state required the submission of encounter data but, with limited staff capacity to resolve incongruities and definitional problems, this effort was met with limited compliance and failed to integrate the data into an overall QI strategy.

Washington was in the midst of health care system reforms at the time the proposal was submitted. They had received a Robert Wood Johnson Foundation grant to assist with implementing recommendations of the Washington Health Care Commission for comprehensive reform. The state Medicaid agency, including the QARI project, was to be a significant participant in the RWJ project. There was also a Health Policy Group convened by the Governor, including the directors of state agencies that purchase health care. These efforts formed the nucleus for collaboration among state agencies where limited coordination existed previously in the areas of oversight and regulation of health plans.

Washington was selected for the demonstration as an excellent laboratory for considering all system interactions under QARI. The state did not meet the QARI guidelines for any of the QA activities. Their experience provides a useful assessment of both process and structural shifts which were required under the QARI demonstration and their impact on health reform.

Purpose and Use of the QI Primer

For over two years, the demonstration states have been applying the provisions of the QARI guidelines to their own managed care environments. Each state has had its unique challenges and opportunities but has also experienced the benefits of collaborating with two other states on a similar mission. Through monthly
conference calls, quarterly technical assistance workshops and ongoing communication, a forum emerged for translating individual experiences into a collective examination of the guidelines. The project was also "shadowed" by the independent evaluation team at MPR who, in their interim reports, have identified important early lessons. This QI Primer attempts to capture the discussions, advice and reflections of project participants and to convey them to other states who are considering the design and refinement of their own quality improvement programs.

This QI Primer is not a substitute for the guidelines. The guidelines include an extensive treatment of the major tasks states and plans must undertake in developing their quality improvement programs in addition to detailed explanatory notes. Our text assumes that the reader is versed on the guidelines and provides only a brief synopsis of the guidelines' key provisions. Together, the guidelines and Primer create a practical guide on how a state may conceptualize their quality improvement system and go about the task of implementing that vision.

Chapters of the Primer are defined according to the activities which must be assumed by the major participants in the process - the state Medicaid agency, managed care plans, consumers, and federal oversight agencies. Each section is introduced by a brief synopsis of the relevant sections of the guidelines.

The QI Primer is divided into seven chapters:

Chapter I  Introduction
Chapter II  System Design
Chapter III  State Leadership Role
Chapter IV  Managed Care Plans - Building Capacity
Chapter V  Consumer Participation
Chapter VI  The Federal Role
Chapter VII  Monitoring and Evaluating the HCQIS

Copies of instruments, tools, policies and reports prepared under the demonstration are included in the appendices of this QI Primer. These are for illustrative purposes only and to serve as working models for other states to adapt to their own particular program needs.

It is obviously beyond the scope of this Primer to comment on every aspect of the guidelines. Rather we have focused on the principal responsibilities of the various parties and the issues around which most of the demonstration has centered. Where applicable, suggestions are made for facilitating the implementation process. In other cases, readers are cautioned on potential problems and are given the hindsight of project staff on ways to avoid similar pitfalls. Our goal is to present an honest and insightful account of the demonstration, complete with its flaws and foibles, so that others can learn from the experience. While we believe that the demonstration has enhanced the capacity of each of the participating states in their quality oversight functions, our greatest success must come from extending those lessons to the broader audience of state and federal policymakers.
CHAPTER II
System Design

In the development of the QARI guidelines, HCFA was faced with two related but potentially conflicting challenges. First, with states rapidly moving to managed care as a delivery system for their Medicaid recipients, there was increased pressure from Congress and consumer advocacy groups to strengthen oversight of these initiatives. Concurrently, there was a push among state policymakers and the managed care industry to eliminate restrictive federal policies which, while intended to serve as proxies for quality, were seen as inhibiting the expansion of Medicaid managed care. These competing demands offered an opportunity for HCFA to rethink its approach to quality monitoring. Taking its cues from the private sector, emphasis was placed on defining factors directly related to the delivery of quality of care at the plan level and simultaneously developing oversight systems based on valid and rigorous quality indicators.

It is worth noting that this was more than a subtle shift in perspective. Historically, both the Medicare and Medicaid programs have relied extensively, almost exclusively, on a regulatory approach to quality monitoring. The imposition and compliance review of structural and process standards for managed care plans were the principal vehicles for evaluating quality. Routine data submissions required of plans were often poorly specified and subsequently inaccurate or inconsistent and thus of limited use to policymakers. Mandated external reviews, as well, provided no consistent standards for measuring or comparing the quality of care delivered to Medicaid recipients.

At least conceptually, the QARI guidelines break from those traditions and offer a new approach to quality management. Accountability for performance shifts from reliance on externally imposed standards to a plan's own internal quality assurance program. Surveillance becomes rooted in standardized performance measurement based on reasonable scientific evidence, more indepth investigations of aspects of care most relevant to Medicaid populations and a collaborative rather than punitive orientation. By building capacity at the plan level and developing new tools for accurately monitoring performance with valid data, QARI strengthens the roles of both providers and states in achieving continuous quality improvement.

There are four principal sections to the QARI guidelines, each of which is described below:

System Framework: This section establishes the assumptions and key elements of a health care quality improvement system for Medicaid managed care:

- There should be an ongoing system, internal to the managed care plan, for effectively monitoring, evaluating and improving the care delivered by its

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6 The two most commonly cited restrictions included an enrollee's right to disenroll on demand from a plan and the "75/25 rule" requiring at least 25 percent of the enrollment of a managed care plan contracting with Medicaid to be composed of the privately insured.
providers. Standards are necessary for determining what constitutes "an acceptable internal quality assurance program."

- States must have effective mechanisms in place to monitor compliance with standards for internal quality assurance programs including an annual independent review of the effectiveness of a plan's quality improvement program.

- The federal government has the responsibility for overseeing that states adequately monitor their participating plans.

- The Medicaid recipient should have "a stronger voice" in affecting the "availability, accessibility and acceptability of the health care services they receive," including the ability to address their concerns directly to the state.

- Quality improvement is "an evolving science." Periodic review and appropriate revision of the system is necessary to assure that it keeps pace with state-of-the-art developments.

*Guidelines for internal quality assurance programs (IQAP):* With the advice of the Medical Directors' Group, HCFA developed a set of guidelines for use by state Medicaid agencies in setting up their own standards and review processes for internal quality assurance programs. During a year-long process, the Medical Directors' Group evaluated a compilation of existing quality improvement standards in current use by the public and private sector and proposed the following 16 standards, along with extensive specifications, as representing the principal components of an internal quality assurance program:

I. A written description of the goals, objectives, scope and activities of the program, including provisions for provider review and focus on health outcomes.

II. The presence of a systematic process of quality assessment and improvement that incorporates defined areas of focus, the use of quality indicators and practice guidelines and the implementation of effective remedial/corrective action.

III. Accountability of the Governing Body for monitoring, evaluating and making improvements to care through: the designation of an oversight entity; the review of quality assurance activities and reports; and the modification of the program as necessary.

IV. The identification of an active QA committee which meets regularly, operates under established parameters, documents its activities and is accountable to the Governing Body.
V. The designation of a senior executive who is responsible for program implementation.

VI. The IQAP has sufficient resources and staff with the necessary education, experience or training, to carry outs its specified activities.

VII. Providers are kept fully informed about the QA program, agree to cooperate, and allow access to the medical records of their members.

VIII. When QA activities are delegated, there is a written description of the delegated activities, and the plan has a method for evaluating the performance of those activities.

IX. There is a process for determining whether physicians and other health care professionals are qualified to participate in the plan which includes provisions for recredentialing at least every 2 years.

X. The organization demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

XI. The plan has standards for access (e.g. to routine, urgent and emergency care, telephone appointments, advice and member service lines) and performance is assessed against these standards.

XII. The plan takes steps to promote the proper maintenance, accessibility, availability and review of its medical records in a manner that permits effective patient care and quality review.

XIII. The plan has a written utilization management program which includes procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

XIV. The plan has a system in place which promotes continuity of care and case management.

XV. The plan maintains and makes available documentation of its QA activities.

XVI. The plan coordinates its QA activities with other management functions.

The State is "encouraged to work with plans during both the contract negotiation process and ongoing monitoring and evaluation of plan performance, to encourage and support full compliance (or phased-in compliance, if necessary) with the guidelines which the state chooses to adopt" (see QARI guidelines, Chapter 2, Page 13).
Focused studies: QARI recommends that select clinical conditions or aspects of health care delivery (e.g. access, coordination of care) be identified for indepth investigation by the plans and state. These focus areas should be based on issues of high prevalence or concern to the Medicaid population including those for which there are objective criteria for assessing care and for which there is likely to be an opportunity to improve care. A list of 33 clinical areas and six health service delivery areas are defined in the guidelines. States are encouraged to conduct studies in the areas of prenatal care and childhood immunization on a continuous basis and choose at least one additional area for periodic review.

Studies begin with a defined question that can be addressed through the identification of one or more objective, measurable indicators. These indicators are based on clinical care standards/practice guidelines or clinical experience and provide a means of objectively evaluating care. Performance is evaluated against indicators based on information obtained from medical records, claims, or administrative data. States should work closely with their plans to determine study areas of greatest interest and to coordinate data collection with other sources wherever possible.

External quality review: Federal statute requires that a state contract with an independent entity to assess the quality of services furnished under each managed care contract. QARI goes beyond the minimum specifications of federal law and outlines three optional approaches for conducting these reviews, each with varying levels of involvement by a plan: (1) the external review entity validates studies designed and conducted by the plan; (2) the external review entity and the plan jointly design and conduct a study; and (3) the studies are designed and implemented solely by the external review entity with minimal involvement of the plan.

When the QARI guidelines were developed in 1993, they represented a major advancement to how most states thought about their quality monitoring activities for risk-based managed care. QARI was never intended as a static document but rather forms the foundation for incorporating, on a continuous basis, other new and expanding tools for quality improvement. Later in the Primer, we discuss the implications of recent developments in the area of performance measurement and accreditation and their place within a state's quality improvement program.
CHAPTER III
State Leadership Role

The state Medicaid agency formed the hub of the demonstration and was instrumental in convening the key players, including other state agencies involved in regulating and monitoring managed care, the plans, consumers and external review entities. While other state agencies may assume major functions in the design and implementation of a quality improvement system for risk-based Medicaid managed care, the Medicaid agency alone has the federal statutory responsibility for monitoring the quality of care to Medicaid recipients. Thus, it is the Medicaid agency which must take on a leadership role in assuring that a system is in place for properly detecting and correcting quality problems in a timely and efficient manner. Shifting sands in the Medicaid program and state health reform movements may create new arrangements in the future with respect to quality oversight but they are unlikely to yield on the basic accountability of Medicaid or any successor agency for monitoring the quality of services provided to recipients under risk-based managed care.

This chapter lays out the steps and decision points a state is likely to go through in designing a quality improvement system such as is defined in the QARI guidelines. We have tried to address many of the generic questions and issues which are apt to surface whether or not a state intends to adopt the QARI guidelines. While states with long experience in managed care contracting may have already resolved many of the issues identified during this demonstration, this chapter may trigger other ideas and/or approaches that have not been addressed to date.

This chapter describes the following state-related activities in the process of developing and implementing a quality improvement system:

- Designing the infrastructure;
- Establishing system specifications;
- Implementation strategies;
- Monitoring performance; and
- The external review function.

This chapter, as with those that follow, discusses the experience of the demonstration states in the context of the QARI guidelines. Since the guidelines themselves allow for considerable flexibility in how the system is organized and the roles and responsibilities of participants, the discussion may not be exhaustive of the approaches a state may use in adapting the guidelines to their own unique situations and needs.

What's Required: The QARI guidelines specify that the Medicaid agency "which makes (health care) providers available to certain vulnerable populations has an obligation to set standards, and monitor and evaluate the provision of health care by the actual providers of the care or the organized systems of care through which these providers deliver care" [QARI Guidelines, Chapter 1 Section II.B].
Section III B of Chapter 1 cites federal law requiring states to annually assess the quality of health care delivered by the managed care organization and to contract for an annual, independent, external review of the quality of services delivered. Further rationale in this section indicates that states should have in place effective mechanisms to monitor a health plan’s compliance with the internal quality assurance program standards. The states responsibility for selection of areas for indepth study, contracting with an external review organization and other responsibilities are interspersed in Chapters 2, 3 and 4 of the guidelines and will be referenced more specifically in other sections of the Primer.

A. Designing the infrastructure

1. Philosophy and Scope - A state’s quality improvement program for managed care is not an isolated activity but grows out of a history and experience that shapes its development. It is unlikely, for example, that a state with a strong background in working collaboratively with its providers will abandon that approach when instituting its quality improvement program under managed care. Other states, with strong regulatory histories, may codify their QI requirements with very limited involvement of the plans. The QARI guidelines encourage states to work cooperatively with the plans and other interested players (advocacy organizations, state agencies) in determining the focus and approach of their QI program. However, in doing so, the state retains a leadership role in assuring that the interest of the state and its recipients is met and that the quality improvement program not simply be a self-serving instrument of the managed care plans with which the state contracts.

Aside from the overall philosophy a state brings to its quality improvement initiative, there is also the question of scope. Will the QI system for risk-based managed care be discrete from one the state has in place under its fee-for-service system or will the current monitoring system be expanded to address managed care? The experience of the demonstration states showed a strong preference for focusing their quality improvement program exclusively on managed care recognizing the differences inherent in risk-based capitated systems which required distinct emphases in a quality improvement program. As managed care becomes majority care within a state or, as discussed in the next section, there is a mandate to move in that direction, there may be incentives to combine QI staff resources with those of a residual fee-for-service system. Limiting scope, however, does not mean that one limits the beneficial interaction among various units of a state Medicaid agency, such as contract officers, fiscal staff, legal staff and MIS staff, as well as with other state agencies. Although not specifically addressed in the guidelines, these functions, as well as marketing, education and enrollment contract monitoring all have a place in an overall quality improvement system.

2. Relationship to health care reform - As both the public and private sectors face the increasing costs of our health care delivery system and related access problems, states are developing multiple strategies to reduce costs and enhance access. These range from market reform, Medicaid expansion programs, subsidies and cost
controls to initiatives which create greater leverage and economies within the system by merging the purchasing power of both the private and public sectors. Many of these reforms alter the traditional role of state Medicaid agencies and place authority in other and/or new state agencies.

The state of Washington passed legislation during the demonstration to expand access to health care giving the Department of Health the lead responsibility for a project to examine "policy framework and applications for practice indicators" as part of the state's health care reform initiatives. The QARI project staff met with representatives from other state regulatory and health purchasing agencies to discuss their respective future roles under Washington State health care reform. Ohio is also expanding access to health care for its low income population, building on the Medicaid managed care program and incorporating the QARI system into its long range plans. Minnesota has several initiatives underway to promote improved access to health care for its citizens all of which build on managed care. To adequately address the myriad of delivery arrangements under the proposed system, Minnesota is planning to establish a performance measurement unit which will consolidate all monitoring activities for managed care and a small residual fee-for-service system. The nature of quality assurance/improvement may well evolve beyond what is presently contemplated as health care reform moves forward.

3. Where to house the quality improvement function - Since the Medicaid agency has the statutory responsibility for overseeing the quality of services to its Medicaid recipients, decisions on where to house its quality improvement function should be determined by this agency or its umbrella entity. States vary considerably in structure, with some Medicaid programs having cabinet level status, while others are but one unit within a larger department. States do have the option of delegating Medicaid functions to other state agencies, with written agreements. Wherever located, the support of leadership at the Cabinet and management levels is critical to the development of an effective quality improvement program. It should also be clear that there is a "lead agency" to be accountable for the system and to retain control.

    Several alternatives are available to states. First, states may turn to Health Departments which oftentimes have oversight responsibilities for the quality of care provided by commercial managed care plans. Others may look to Surveillance and Utilization Review units which have traditionally performed these functions under fee-for-service. SURS staff have experience in analyzing data, identifying "outliers" and conducting studies based on claims data but do not necessarily bring the "system" perspective for quality assurance, nor have they engaged in detailed focused studies suggested in the guidelines. If the SURS unit is designated to carry out quality review activities for Medicaid managed care, they should be provided opportunities for enhancing their expertise in this area.

    Each of the demonstration states opted to locate the QARI initiative within a "managed care" unit of the Medicaid agency. While the decision to place the QARI initiative within the Medicaid agency centralized the locus of quality monitoring for Medicaid, it initially isolated the program from close interaction with other
departments with oversight responsibilities. For the most part, the need for ongoing coordination with other state agencies was realized late in the project and should be avoided by others through early and frequent communication.

Regardless of where the quality improvement function is located, links with other state agencies and state Medicaid agency staff are critical to the process. These include, but are not necessarily limited to:

- MIS staff whose data and/or expertise are often essential in effectively evaluating the performance of managed care plans;

- State agency staff responsible for marketing and enrollment provide upfront avenues for assuring that enrollees are properly informed of how to access the delivery system and their rights and responsibilities under managed care, essential prerequisites to quality of care; and

- Medicaid contract managers must understand the requirements placed on plans by a quality improvement system and thus should be participants in its development.

Proximity helps to reinforce the integration of these functions into the quality improvement activity by facilitating communication on a frequent, informal basis.

Appendix A shows where the QARI project was housed within each of the demonstration states. These are provided for illustrative purposes only and serve to demonstrate the many varied approaches to organizing this function.

4. **Staffing** - The experience of the demonstration suggests the value of having at least one full-time professional person in charge of a state’s quality improvement program for Medicaid managed care contracts. Staffing requirements will vary depending on the intended use of outside contractors and/or the external quality review entity. Given the time constraints and limited nature of the demonstration, each of the sites staffed their program using different approaches. Developing and implementing a quality improvement system is a long term process, and turnover of staff can set the program back. For an effective program states must devote the appropriate level of resources, whether using SURS staff, reassigning existing staff or hiring new staff.

Minnesota’s project team included staff experienced in quality assurance both from within state government and the private sector. This facilitated a prompt start to the project and built-in familiarity with current quality improvement systems and the managed care community. The temporary nature of the Project Director position made a line-position less feasible in Ohio and they opted to fill that position on a contractual basis. The nurse and administrative assistant positions were created as temporary state positions. Any potential divisiveness that this may have caused was relieved by placing these positions within the existing quality assurance unit to assure that, while offering a fresh approach to their task, the project team was closely linked with those who would be responsible for carrying
out the function long term. Washington established two line positions, recruiting one nurse from the SURS unit and a second nurse with former managed care experience. Initially, project staff included a full time program manager, nurse consultant advisor, and a half time computer programmer/analyst. Project staff was later revised to two project co-directors and a part-time computer programmer/analyst. These positions formed the core of the Medicaid agency's quality assurance effort. Near the end of the project one of the co-directors left and additional SURS staff was re-assigned to this unit. These positions are likely to continue in their roles once the project terminates. A sample job description for a nurse specialist supervisor and nurse specialist in Ohio's managed care unit are included in Appendix B.

The experience of the demonstration may not mirror that of other states where resources are likely to be limited for establishing new positions. In these cases, it may be necessary to consider alternatives, such as:

- To re-assign fee-for-service staff and invest in ample training programs to fully orient them to managed care and its implications for quality monitoring.

- Nurses who have served as ombudsmen or advocates may be oriented to quality improvement although they may lack management and technical skills.

- If recruitment is possible, the intricacies of managed care suggest some strong advantages to hiring persons with background and experience in this area.

Moreover, the demonstration has highlighted the need for strong leadership capability among staff and others who are placed in positions of chairing committees and workgroups. These qualities are particularly important given the diversity of people involved in the process and the cooperation and coordination required to make the system work.

Each demonstration state continues to develop plans for sustaining their quality improvement initiative long term. Advanced managed care states, such as Ohio and Minnesota, have an existing infrastructure within which the newly designed system can function. Minnesota's performance measurement unit will be dedicated to quality improvement functions for both fee-for-service and managed care. Washington is reviewing alternatives for creating a quality assurance unit which may span fee-for-service and managed care as well as incorporate the monitoring of care for non-Medicaid, public programs (e.g. Workers' Compensation, State employees, etc.).

5. Interagency coordination - One of the issues raised in the QARI guidelines is that of avoiding duplicative monitoring. States with managed care presence, such as HMOs, have established some form of regulatory oversight. The state agency regulating health insurance products and the State Health Department are the two agencies most likely to have some oversight responsibility for managed care plans.
States are advised to establish relationships with these agencies and seek their early support and participation on committees and workgroups. With limited state resources, state agencies can create efficiencies by coordinating on-site visits, using findings of other state agencies to supplement their own and developing complimentary policies and definitions to the extent feasible. Coordination does not mean abdication and cannot replace the reasonable additional requirements which a Medicaid agency must impose to protect the special and unique interests of its Medicaid recipients.

Understanding and building off the requirements of other state agencies not only benefits state agencies but can substantially reduce the burden on health plans. Plans are more receptive if it is apparent that state agencies are coordinating their activities. As the system is implemented, it is also important that the state not allow plans to play one agency against another as may happen if agencies are not talking to each other. In states where plan participation in Medicaid managed care is voluntary, it is important to recognize that plans may choose not to participate if the cost and burden to the plan is more than the plan is willing to bear.

It is critical to have the right people "at the table" when establishing relationships with other state agencies. To the extent possible, states should advocate for consistent representation from these agencies by at least one person who is in a position to speak up on the issues and work actively to address conflicting standards in a timely and effective manner. Agency representatives should understand the relationship of the QARI guidelines to their own mission and be in a position to suggest opportunities for collaboration. Intergovernmental management meetings might be indicated to resolve differences in approach.

While participation on committees and workgroups may be helpful, it is also important to maintain informal and frequent communication on a person-to-person basis. The greatest problems with respect to coordination occurring under the demonstration happened when one agency felt left out of the process and/or ill-informed about the potential impact of the QARI guidelines on their own roles and responsibilities.

6. **Committees and workgroups** - In designing a quality monitoring system, it is strongly recommended that the state involve the affected stakeholders: other state agencies, local or county health departments, health plans and consumers. It is important to clarify the roles of each of the participants from the beginning, and what will be expected of them as they engage in this process. Committees and workgroups are key to the development of a system, and they, too, must have a clear understanding of their mission, responsibilities and scope of work. Strong leadership of these committees and workgroups is important to accomplish the tasks set out and to build consensus and to keep the process on track.

The demonstration found two distinct levels of committee or workgroup involvement. First, an advisory committee was formed in each of the states to provide overall guidance on the direction of the project and alternative approaches for designing a quality improvement program. In Ohio this committee consisted of
representatives of state agencies with oversight responsibility (e.g. Medicaid, Health Department and Insurance), administrative staff of participating plans and consumers and their advocates. In Minnesota the committee consisted of representatives of the Medicaid agency and the Health Department, administrative staff of participating plans and county representatives. Washington initially convened an inter-departmental committee of only state agency representatives. Later, they included plans and consumers on the advisory committee.

The second level included technical workgroups, which were established to focus on methodological issues of the quality improvement system, such as MIS and focused studies, and typically included medical directors, clinicians and systems representatives from the plans, as well as some of the same committee members from the advisory committee. It is recommended that the external quality review agency also participate in these workgroups. Charts showing the organization of committees in the three demonstration states are included in Appendix C. As the project progressed, the workgroups’ importance heightened, oftentimes overshadowing the involvement of the advisory committees. This situation can create unintended tensions if the advisory committee is not kept closely informed of the direction of the various components of the system. As the system matures, workgroups may be eliminated or combined for better communication and more efficient use of people’s time.

Since the goal of the QARI system is to promote a collaborative relationship among state agencies, health plans and consumers, early involvement of these parties in system design is desirable. A consistent effort is needed on the state’s part to seek input from the plans and to recognize their issues. The agendas of state agencies and state legislatures may not necessarily coincide with health plan concerns. States are concerned with accountability, contract monitoring, public health goals and relationships with other parts of the system. With input from plans and consumers, the state must design a system wherein the following goals can be accomplished:

- Undue expenditure of resources is not required by either the plans or the state;
- Studies are practical and viable, data is available and measures what is intended, answering the study question;
- Results are measurable and will be of value to both the state and health plans; and
- Activities are coordinated with other efforts in the state.

The demonstration states found the plans willing to attend committee meetings and support this initiative. Although all three demonstration states strongly advocated consumer involvement on project committees, actual experience was somewhat frustrating due to the many barriers facing consumer representatives. Various incentives were offered, such as child care, transportation and meals, but consumer participation was extremely limited. Federal regulations require that each state have a Medical Care Advisory Committee for the overall Medicaid program including providers and consumers. States may wish to consider including
representation from this committee so they are part of the process from the beginning and as a vehicle for including consumer representation. As an alternative, consumer advocate groups, such as legal aid agencies, can be asked to participate. In Ohio they provided an important voice in the process.

B. Establishing the quality improvement specifications

This section focuses on three components of a state’s quality improvement program: requirements for plans’ internal quality assurance programs; specification of areas for in-depth study; and data reporting.

1. Internal Quality Assurance Programs (IQAP) - QARI specifies a series of standards which constitute an effective system for a plan to internally monitor and improve the quality of care delivered by its providers. These standards address a range of activities such as the process used to credential a practitioner for participation in the plan’s network, the establishment and functions of a quality assurance committee, grievance procedures, internal reporting and review of data and standards for medical records. The QARI standards were developed based largely on those in current use by the National Committee for Quality Assurance (NCQA) for their accreditation process with modifications made in areas where it was believed further protections were needed for Medicaid recipients (e.g. enrollee rights and responsibilities).

While there is general agreement that the QARI standards represent important elements of an internal quality assurance program, there is less consensus over the degree of specificity a state should prescribe on how each element is addressed by a plan and the level of documentation required for compliance. The state Medicaid agency, together with other affected agencies, health plans, providers and consumers, should review each standard and its related specifications to determine its applicability and feasibility in light of current requirements and the sophistication of the managed care industry within the state.

The conclusion of the demonstration has been that the sixteen standards represent a reasonable basic structure for a plan’s internal QI program but that modifications to individual specifications were often necessary in order to make them realistic to small, new plans without NCQA accreditation. Washington set forth a schedule for progressive adoption of the standards and their specifications over a three year period. This decision recognized the value of the standards while accommodating the reality that few of their plans could initially comply with their requirements. The burden is on the state to determine what standards must be met as a condition of initial contract to assure the safety of Medicaid enrollees. Standards should be continually reviewed and revised as necessary including the consideration of additional standards beyond QARI which may be relevant to the special needs of the state.
States should be prepared to provide education and technical assistance to the plans during the implementation of the QARI standards. This can be done on a one-to-one basis and by bringing the plans together for training workshops, as is done by Ohio as part of their ongoing plan education.

2. **Study areas for indepth review (focused studies)** - QARI recommends that select clinical conditions or aspects of health care delivery be identified for indepth investigation by the plans and state on at least an annual basis. These focus areas should be based on health conditions of high prevalence or concern to the Medicaid population, and include those for which there are objective criteria for assessing care and opportunities to improve care. The guidelines give states the responsibility for determining the number of studies to be done, which may vary by plan. QARI proposes that states routinely conduct focused studies in the areas of childhood immunization and prenatal care and one additional area of their own choosing (see Appendix A of the QARI guidelines for a suggested list of potential topics). These studies may supplement those performed by plans on issues of particular relevance to their enrolled population.

The state, while not often directly involved in conducting the focused studies, has an important role in establishing their parameters, such as:

- **Selection of areas for study:** As part of the demonstration, the three states were required to study prenatal care and immunization levels of two-year olds. All three states also selected asthma as the third clinical area. Ohio added asthma-related conditions and dental services and Minnesota selected diabetes as a fourth clinical area. Selection of clinical areas to be studied was based on expert opinion, historical trends, findings from previous studies, complaints or the results of consumer satisfaction surveys. There should be established practice guidelines against which the care can be measured, and it is important to consider the availability of the data that would be required to address a particular topic. Studies should be limited in scope in order to address specific questions. Results of studies should be of value in changing practice through education of providers if indicated.

The demonstration states the importance of involving the health plans in identifying problems and selecting study areas. There was also preference for selected study areas not to be repeated annually, as there is not adequate time between receiving the results and affecting care. States should not be over-ambitious in the number of studies. Two or three studies can be carried forward into a subsequent year, but the state should not attempt to add more than one new study a year.

- **Focused study design:** The design of the focused studies was one of the more daunting tasks in this demonstration. The design phase includes the identification of questions to be studied, data or indicators that will be collected to determine the answers to those questions, and the identification of practice guidelines or protocols for assessing performance. Although the QARI guidelines include a list of indicators and methodologies for studies of
childhood immunizations and prenatal care, significantly more work was required to convert those specifications into data collection instruments. Specifically, each data element required further definition, source documents for the information were determined and methods for validation defined. Appendix D includes the study designs used by Minnesota in the areas of prenatal care and childhood immunization. States should refer to a recent publication for state Medicaid agencies, *Health Care Quality Improvement Studies in Managed Care Settings--Design and Assessment*, produced under HCFA contract by the national Committee for Quality Assurance for further guidance on focused study design.7

Workgroups were convened in Minnesota and Ohio around each of the clinical focus area topics. The workgroups framed the question and designed the protocols or procedures to be used in carrying out the study. In Washington, a workgroup was convened only for the asthma area while their external quality review entity was assigned primary responsibility for designing the focused studies for childhood immunization and prenatal care. It is recommended that the external review entity participate in the development of protocols for studies, whether as part of the workgroups or on their own.

- **Determine the approach for conducting the study:** QARI links the focused studies to the annual, independent external quality review function mandated by federal statute. While the scope of the external quality review function is not specified in law, QARI proposes that a state consider using its external review entity to perform and/or validate focused studies in one of three ways: (1) the external review entity simply validates studies conducted by the plan; (2) the external review entity and the plan conduct a study; or (3) the studies are implemented by the external review entity with minimal involvement of the plan (see Section E of this chapter for a discussion of the external review implementation process).

3. **Data reporting** - The retrieval of data for focused studies and ongoing monitoring of plan performance is a major issue for a quality improvement program. The state should be sensitive to the methodological and resource problems of collecting accurate and timely data and balance those concerns with its need to obtain quantifiable and measurable assessments of performance. There are generally four types of data a state requires to conduct its monitoring responsibilities:

- **Indicators for focused studies:** As discussed above, these are measures specific to a particular content area under intense review and, as implemented under the demonstration, may be collected by either the plan or the external quality review entity.

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7 Copies of this study guide, *Health Care Quality Improvement Studies in Managed Care Settings: A Guide for State Medicaid Agencies*, may be ordered from the National Committee for Quality Assurance (202/628-5788).
• **Ongoing performance measures**: Some states may wish to routinely collect aggregate data to track and detect quality issues. Since the publication of QARI, there have been national trends to standardize managed care performance measures for the commercial sector, such as the Health Employer Data Information System (HEDIS). HCFA is currently developing a Medicaid version of the HEDIS which, when published, will adapt the specifications of the commercial measures to the special needs and circumstances of Medicaid managed care. These measures may be used to assist states in defining a minimum data set or to serve as a guide in the development of indicators for focused studies on specific issues. Like the indicators for focused studies data for performance measurements are typically obtained directly from the medical record.

• **Encounter data**: In its most common usage, encounter data is considered a dummy claim containing the same types of information one would want to receive for payment purposes: information on provider, patient, setting, diagnosis and procedures.

• **Administrative data sets**: These are electronic data sets maintained by plans generally capturing provider activity for use in payment and performance monitoring. Administrative data sets vary widely depending on the type of plan and their financial relationship to individual providers. Basic information including demographic information, identification numbers, enrollment dates and insurance information is available, with additional computerized information dependent upon each plan’s capacity to computerize the data.

Many quality improvement data rely heavily on medical chart reviews which, in the absence of electronic medical records, is a time consuming and costly process. Due to the heavy burden placed on plans, states are urged to carefully consider the need and use of data before imposing requirements and to involve the plans in decisions with respect to the collection of data. Any data requirement must have clearly specified definitions and plans for validating data accuracy and comparability.

The demonstration focused primarily on medical record abstraction although efforts were undertaken in Minnesota to test the viability of administrative data sets in supplying information for focused studies. Results of their focused study on adult onset diabetes showed administrative data sets to be a viable option for a limited study. Within the confines of the demonstration, several issues surfaced around the issue of data collection:

• Services provided to enrollees by other community providers that are not part of the plan’s provider network, such as health departments and family planning agencies, are frequently not documented in the plan’s medical record;
• Small sample size in plans due to low Medicaid enrollment and eligibility turnover make generalizations difficult and point to the importance of carefully defining study parameters and populations.

• Information on immunizations administered by out-of-plan providers, such as local health departments, was not included in the medical records; and

• Fluctuating enrollment, due to recipients changing plans or terminating enrollment, and loss of eligibility, resulted in incomplete information.

These issues are probably of greatest significance to the Medicaid population, as they have traditionally been higher users of the public health system. Until such time that all parties can be assured of the accuracy of the data and consistency of reporting methods, the state or its contracting entity should use the focused studies as an opportunity to work individually with plans to clarify study design and data specifications where inconsistencies are found. If the state has on-staff expertise, they may meet with the plan’s QA committee to discuss the special needs and issues of Medicaid recipients which are identified through study findings. States may prefer to use their external review entity to provide assistance, provided the contract with the external quality review entity includes this role.

Two of the demonstration states (Ohio and Minnesota) found additional ways to assist plans in meeting data requirements. Ohio used project funds to contract for computer software to simplify the collection of required data and supplied each plan with their own laptop computer. Minnesota also created software programs for the collection of data requested as part of their prenatal care focused studies.

C. Implementation strategies

The implementation of the quality improvement program addresses two principal questions: how the state enforces their proposed specifications and whether there is a phased-in approach to their adoption. Each of these issues are addressed in the following sections.

1. Contracts and rule-making - The two principal vehicles for enforcing a state’s requirements are through contracts and rule-making. Some states have the ability to impose standards through the contract process, without going to rule-making, while other states have statutory provisions requiring that regulations be adopted through certain administrative procedures. Most states operate under a combination of both with general broad provisions contained in statute or administrative code and the more detailed requirements specified in individual contracts. This approach enhances enforcement powers while easing the time and effort required to make modifications on a more frequent basis than typically available through rule-making. Generally, rules that have been adopted through an administrative process of hearings and public comments will carry greater weight in a regulatory proceeding.
Appendix E reviews regulatory and contractual requirements for commercial and Medicaid contracting in the states of Minnesota and Ohio. While not always specified under the quality improvement section of the contract, confidentiality of data is an important protection to address within the contract. Contracts should include provisions for maintaining confidentiality of data submitted by plans that may identify enrollees directly or by inference.

2. Phase-in approaches - As part of their participation in the QARI demonstration, each of the participating plans was asked to implement the internal QA program standards as proposed in the guidelines. This was an ambitious undertaking on two fronts. First, each of the states had current standards in place which formed the basis of their existing managed care contracts. Without legislative authority and substantial education, it was not possible to simply mandate new requirements for these plans. Secondly, the QARI standards represent a goal - one which would take effort over time to achieve. The QARI standards were intended to be flexible so they can be adopted to the needs of each state. While not abandoning the goal of the demonstration to test the implementation of the standards, a more incremental approach had to unfold.

The guidelines recognize that not all managed care organizations currently meet the internal QA program standards. Therefore, states are encouraged to work with plans to achieve full compliance, or phased-in compliance if necessary, with the guidelines the state chooses to adopt. Assistance can be provided on a one-to-one basis, as was done as part of the educational process for plans found lacking on the baseline assessments. Specific areas not meeting the standards were identified, and the state staff with experience in working with managed care plans were able to provide guidance. Workshops were also convened to address standards found lacking in multiple plans. This was an effective way to assist plans, as they were also able to share experiences in these areas with other plans.

Although the baseline assessments in Minnesota and Ohio indicated some problem areas, these states were in a position to implement all sixteen internal QA program standards. Washington opted to phase-in their internal QA program standards since, with limited prior regulation and history in risk-based managed care, few of the plans could immediately comply with the QARI requirements. Project Staff, with input from the advisory committees and plans, have spent considerable time assessing the relative importance of the standards and developing a set of core specifications that could reasonably be required of new plans at the time of initial contracting, while assuring that all clients have access to quality health care. They combined and condensed some of the guidelines; excluded those guidelines for areas which other sections of their contract addressed; excluded those which are especially subjective or difficult to interpret; and those which require passage of time to demonstrate. A phase-in period of three years has been proposed during which time plans must show progressively higher compliance with the standards. Appendix F presents Washington's reduced requirements for internal QA program standards at the time of initial contracting.
D. Monitoring Performance

States must have in place effective procedures to monitor whether plans are, in fact, following their own internal quality assurance plan and meeting other provisions of their state contracts. Also, under federal statute, states must monitor the quality of services provided to their Medicaid recipients. This latter function is principally performed under the external review process but may be supplemented by direct activities within the state and/or other contractual assistance.

1. **Baseline assessments** - The internal QA program standards are effective only to the extent that plans comply with them. Since managed care plans are likely to be at different levels of maturity in their internal QA programs, the demonstration states conducted baseline assessments of each plan's program at the time of project start-up. Even in the states that had Medicaid risk-based managed care contracts for many years, there were elements within the QARI guidelines that plans did not meet. The baseline assessments were generally completed by the plans themselves, using a form developed by the state with input from the advisory committee, and then reviewed and validated through follow-up visits by project staff or the state's quality assurance unit. Appendix G contains Ohio's the baseline assessment form used in the Ohio project. It is important that plans understand that the baseline assessments are educational purposes, and that there will be no regulatory sanctions for failure to meet the standards.

In states just beginning to contract with new managed care organizations, many of the internal QA program standards may not be met, as evidenced by the Washington experience. States may find it necessary to proceed slowly in order to achieve access to managed care entities. The guidelines intentionally allow for this flexibility.

2. **On-going monitoring** - As the system is implemented and standards are enforced, states have a responsibility for assuring that health plans carry out an effective internal quality assurance program. As previously noted, multiple state agencies have oversight responsibilities for managed care. To the extent feasible, state agencies should coordinate and consolidate their monitoring activities so as to minimize burden on plans. State agencies can share information, do joint visits, agree on standards and data to be collected, and enhance the system in many ways through joint efforts. It is advisable to have one agency designated as the “lead agency.” The lead agency should be aware of outside entities also monitoring health plans (e.g. accreditation bodies).

Monitoring includes on-site visits; review of medical records, complaint logs and other documentation at the plans; and collection of data for analysis. An educational or collegial approach is thought to be most effective in bringing about change. However, the state and the external review entity note areas that do not meet the standards. Plans will be expected to have and to implement corrective action plans for any deficiencies in their quality assurance programs which the states will then be responsible for monitoring.
Monitoring of health plans for the Medicaid agency can be done directly by the state or in combination with a contract with an outside organization. Oftentimes, states expand the scope of work of their external review entity to include the monitoring of a plan's compliance with internal quality assurance program standards in addition to their required review of the quality of services. Other monitoring activities may include:

- **Complaints/grievances** - Monitoring techniques include a review of complaints, both at the plan and at the state level. Enrollees are encouraged to resolve complaints at the plan level first, although states should have a second level grievance procedure to which clients can go directly. A review of the plans' logs may help identify any potential shortcomings in the services provided and is another mechanism for monitoring the plan's internal quality assurance program. Of greater benefit may be the assessment of a plan's own tracking system for handling complaints or reviewing a plan's analysis of their own patient complaints to determine the presence and effectiveness of their methods. In Ohio, plans are required as part of the re-credentialing process to review complaints against specific providers.

Minnesota has a many faceted consumer complaint and grievance system. Each county participating in managed care has consumer advocates available to respond to complaints and grievances. In addition, consumers may contact the state ombudsman office with complaints and grievances. Staff of the ombudsman office work closely with the contract managers assigned to each health plan on issues requiring contract interpretation or enforcement.

The nature of complaints and observed trends in complaints should be noted and shared with the external review entity for possible inclusion in the independent review of that plan. The software program designed in Washington for tracking and analyzing complaints will assist in identifying populations which might be having difficulties with the Medicaid managed care delivery system (see Appendix K).

- **Consumer satisfaction** - A number of mechanisms are available to states to monitor consumer satisfaction with their managed care plans. Consumer satisfaction surveys are being conducted by all of the demonstration states. The Data Institute in Minnesota is designing a consumer satisfaction survey for both commercial and Medicaid enrollees. Ohio contracted with an outside entity to develop a common format for a consumer satisfaction survey which could be administered directly by the state or used to supplement plans' current survey efforts. The overall purpose of this initiative is to develop uniform satisfaction data on Medicaid recipients of managed care. In Washington, project staff conduct surveys on a monthly basis of a sample of current enrollees of plans, those losing Medicaid eligibility, and all enrollees who changed plans or dropped out of managed
care. In addition to the English version, the survey is translated into five other languages. These surveys are discussed in more detail in Chapter VI. A copy of the consumer satisfaction survey from Washington state is included in Appendix H.

Minnesota tested the concept of focus groups as a mechanism for assessing consumer satisfaction on select topics of interest, initially including asthma and diabetes. In each case, plans were requested to provide the state with names of enrollees meeting certain diagnostic specifications. Letters of invitation were sent from the state with assurances that information would be kept confidential and with incentives of child care, transportation and a nominal participation fee. Despite these planning efforts, attendance was limited and insufficient to guide future decisions on program effectiveness.

- **Utilization/performance review** - States may require certain data to be submitted on an ongoing basis, not part of any specific focused study. Both Minnesota and Washington are working toward the routine submission of encounter data to monitor overall utilization of services under capitated managed care systems. States need to define what is meant by "encounter data," as there is no consistent definition. Data that is available from any source, which might include other state agencies, can be incorporated into the monitoring system. It is important, however, not to place additional data demands on managed care plans unless it can be determined that the data is valid, easily retrievable and serves a useful purpose. States should be able to justify the purpose of the data being requested, explain how it will be used and disseminate any resulting analyses back to the health plans.

- **Coordination of monitoring functions** - States should create more fluid boundaries among their agencies with oversight responsibilities in order to fully achieve the intent of QARI. QARI was conceived and is now perceived as a guideline for state Medicaid agencies when in fact its successful implementation requires the full involvement of other state entities. The structure within state government does not lend itself easily to coordination, given slightly differing roles, reporting requirements and constituencies. States must become responsive to the understandable frustration of plans as they confront redundant reviews, inconsistent data requests and incompatible standards for performance. While states are unable to control the federal oversight function, there is a great deal of coordination that can be achieved at the state level to eliminate redundancy and inconsistency.
E. External Quality Review Organization (EQRO)

The external quality review function is one of the major means of assessing the quality of a plan's service. While this function is mandated, a state has a great deal of flexibility in how to construct and use this vehicle to enhance its monitoring capacity.

1. Role of EQRO - States are required to contract with a Peer Review Organization (PRO); a PRO-like entity or a private accrediting body to perform an annual "independent, external review of the quality of services furnished under" each contract. Each state must decide on the most effective working relationships among the state, the EQRO and the plans, recognizing that it is the state and federal government, that must be in control of the activities that are implemented. The EQRO is the contractor to the state and serves as an independent assessor, on behalf of the state and federal government, of the quality of care provided by plans. The contract with the EQRO should clearly specify the tasks and work products expected and the requirements for working with the health plans.

States have considerable latitude in defining the scope of work to be conducted under the external review contract. Some of these activities may include:

- assist in the early design of clinical focused studies with the state Medicaid agency and participating plans;
- conduct and/or validate clinical focused studies within plans;
- monitor compliance with state internal quality assurance program standards;
- validate mandated encounter or other data reports submitted to the state by plans;
- conduct statewide consumer satisfaction surveys;
- conduct on-site facility reviews for accessibility and availability of services.

All three demonstration sites engaged the EQRO at different points in the development of the system. Minnesota's proposal for the demonstration included the National Committee for Quality Assurance (NCQA), with whom they had a contract, to serve both as their external quality review entity and to assist workgroups in the development of the clinical focused study protocols. To expedite the process, NCQA abstracted all data for the immunization study; plans collected the data for the prenatal care, asthma and diabetes studies and submitted their data to NCQA for analysis and verification. Collection of prenatal care data was accomplished through the use of a computer software program developed under the Minnesota project.

Ohio awarded a contract to Peer Review Systems of Columbus, Ohio to review the protocols developed by the state through their work groups, to assist in determining the best approach for collecting the data, and to independently conduct the clinical focused studies. A separate contract was issued to develop computer software and to supply each plan with a laptop computer and/or software to simplify the data collection effort. However, given delays in contract award, these systems were not available in time for the initial data collection cycle, requiring the
PRO to abstract the data for some or all of the clinical studies directly. Washington contracted with OMPRO (Oregon Medical Professional Review Organization) to review the protocols for clinical focused studies conducted in prior years under the external review function and to make necessary revisions to assure their consistency with the QARI guidelines. In addition, OMPRO validated immunization data submitted by plans and collected and analyzed data for the prenatal care and pediatric asthma studies.

2. **Selection of an external review entity.** States should set forth clearly in the solicitation for an EQRO what the roles and responsibilities will be and what is expected for accountability. Clear contracts, including specifics and samples of scope of work, are essential to avoid conflicts as the work proceeds. States should seek out references from other states prior to selecting an EQRO and verify the adequacy of their resources to provide the services being requested. States should be clear in their requests for proposals that PROs are not the only entities eligible to bid. Other organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations or other PRO-like entities (as defined by HCFA) can also provide this independent review. While these other entities qualify as an EQRO, only PROs are subject to 75 percent federal financial participation (FFP).

3. **Scope of work** - Depending on the scope of work requested of the EQRO, many of their activities are likely to duplicate what plans experience when seeking accreditation. While states cannot exempt plans from the EQRO requirement, state agencies can strive to make their review processes complimentary with other review entities where feasible, recognizing that Medicaid has areas of special interest which often do not apply to commercial populations.

As noted earlier, the EQRO can perform a range of activities for the state to help enhance their monitoring capacity. The QARI guidelines address only one of those activities - the focused studies. Three options are described for structuring the external review function with respect to the focused studies:

- The EQRO reviews HMO designed and conducted studies, validating the data, study designs and findings. If these studies are supported by the EQRO findings, then these can be utilized as evidence of plan performance.

- The EQRO may design studies in collaboration with a plan. Under this scenario, the study would be implemented by the plan and the EQRO would validate the findings.

- The EQRO may design and implement focused studies without the direct participation of a plan. In this design, the plan must provide or allow access to clinical or health services data required for the study.

Although the EQRO can take full responsibility for the design of focused studies, the demonstration states recommend that health plans be involved in this activity. The input of the plans can provide insights into what is feasible and realistic for
study design, which can result in improved results of studies. Appendix I identifies the scope of work for the EQRO contract in Minnesota and Ohio.

Summary

The leadership role of the state is critical to the successful development of a quality improvement system as envisioned by the QARI guidelines. The infrastructure within state government must be adequate to support an effective program. The health plans, other state agencies and levels of government, and consumers and their advocates need to be involved in developing the system, establishing standards and designing studies. It is recommended that the role of the independent entity under contract to do external reviews be developed with input from health plans. It must be clear that, although the EQRO and the state may work collaboratively, the EQRO is a contractor to the state. All final decisions with respect to the scope of work, study parameters and use of findings is the responsibility of the state agency.
CHAPTER IV
Managed Care Plans—Building Capacity

The primary vehicle for promoting good quality care is the internal quality assurance program of a health plan. Current Federal law and regulations require such a program but, prior to the QARI guidelines, there were no standards. The standards as set forth in the Guidelines cover a wide range of issues impacting on quality, which will not be addressed separately in this Primer. They are summarized in Chapter 2 of this Primer and described in detail in the QARI guidelines. This chapter will address the following issues that surfaced during the three-state demonstration:

- Plan perspectives, including inequities between managed care versus fee-for-service quality assurance, resource requirements and redundancy of reviews.

- Issues in QARI implementation, including the findings from baseline assessments of internal QA programs and clinical focused studies.

- Other considerations, such as the impact of plan model type, size and level of maturity in internal QA program implementation.

This section of the Primer shifts the focus from the state leadership role to the issues and concerns faced by managed care plans during the design and implementation of the quality improvement program. Although this experience is expected to vary based on the character of individual states and their plans, this section is written to raise awareness among state policymakers of the challenges their standards may impose on participating plans and of the types of assistance which can be offered to ameliorate those effects.

What’s Required: Federal regulations require each health plan participating in the Medicaid program to have in place an internal quality assurance system. The QARI guidelines set forth sixteen standards covering a wide range of issues impacting on quality, which states may use or modify to establish the state standards for the internal quality assurance program. The QA program consists of systematic activities, undertaken by the managed care organization itself, to monitor and evaluate the care delivered to enrollees according to predetermined, objective standards, and effect improvements as needed. The standards for the internal QA program are summarized in Chapter 2 of this Primer.

A. Plan perspectives

1. Inequity between fee-for-service and managed care - Risk-based managed care plans are subject to quality improvement requirements that are not equally imposed on the fee-for-service system. Historically this resulted from the heightened awareness by payers and policymakers of the features inherent in managed care that make it particularly vulnerable to potential abuses. Many of these regulations were
triggered by early scandals in the 1970s when some Medicaid managed care plans rendered very poor service and had few protections for dissatisfied recipients. The results were severe underservice and financial insolvencies, and recipients were left with no recourse or alternatives.

Even today, many policymakers and consumer advocates resist moving to managed care until quality assurance programs are improved for monitoring services provided to Medicaid enrollees. The development of formal quality assurance programs is important, particularly given the limitations on choice of providers and financial incentives that are characteristic of managed care plans. Legitimate questions, however, linger on why fee-for-service has so little oversight.

Traditionally, the fee-for-service system under Medicaid has been monitored by the Surveillance and Utilization Review System (SURS). Based on submitted claims data, utilization patterns of individual recipients and providers are monitored and "outliers" identified. As a consequence of these reviews, individuals may be targeted for closer case management, prior authorization restrictions or the restricted recipient program. SURS programs do conduct medical chart reviews to determine whether and how services for which claims were submitted were actually delivered. SURS also targets provider types for data analysis, often resulting in policy changes. Within the resources available they focus on areas of clearly identified abuse. Issues of quality are "triggered" for case review related to prescription drug mis-utilization. Medical chart reviews and data analysis are not typically based on clinical diagnosis or health service delivery areas nor do they study the impact on health outcome. SURS programs also review under-utilization, particularly for children for whom services are not being billed. Lacking the mandate, resources and funding to extend their surveillance activities, these provisions constitute the extent of quality improvement within the fee-for-service sectors of most states.

As states progress in developing quality assurance programs for their risk-based managed care systems, obvious questions arise on their relevance to the fee-for-service environment, particularly primary care case management systems. Two of the demonstration states, Washington and Minnesota, are working toward a quality assurance system that applies to both systems. QARI has raised awareness of the inequity between the two systems and the relevance of this needs to be considered in planning quality assurance programs. The lack of similar requirements for fee-for-service care could provide an incentive for primary care providers to choose not to participate in managed care for Medicaid enrollees.

2. Resource requirements - One of the challenges of implementing the QARI guidelines is getting the plans on board and building their capacity to meet the standards established by the state. Strategies are likely to differ depending on the mix of plans with NCQA accreditation, those seeking accreditation, and small plans without immediate objectives to become accredited. Plans with NCQA accreditation largely meet the QARI standards and have acquired the resources to carry out internal studies and meet the other standards for an effective quality assurance program. Their issues center on the reasonableness of the state's additional
requirements and whether it is worth the burden to comply for their anticipated Medicaid market. States should be prepared to defend the need for additional protections for Medicaid recipients for whom the state is directly responsible.

Small plans and those with Medicaid-only enrollees may find the QARI standards for quality assurance far more burdensome and costly, without perceived benefit. There must be a Medical Director with "substantial involvement" in the quality assurance activities, as well as other staff with the necessary skills to implement studies, including selection of guidelines, data collection, analysis and follow-up action. Plans often find it difficult to find quality people to fill these positions. To accomplish these tasks efficiently, the management information systems of plans must have the capacity to collect and analyze data and produce reports. The staff involved in quality assurance must meet regularly, document activities, submit reports and assure that systems are in place for other standards to be met. Plans may also need to develop the MIS capacity to collect and collate data and develop reports. Plans that do not have in-house expertise to implement a quality assurance program may need to contract with an outside consultant or agency. Plans needing to put these additional resources into place will require reasonable time frames for the implementation of the QARI standards. The state agency should be prepared to provide ongoing education and technical assistance to assist these plans as they gear up to comply with the standards.

3. Redundancy of reviews - While public and private purchasers enhance their capacity to oversee and improve the quality of care to their managed care enrollees, plans feel burdened by cumbersome and often redundant standards and review processes imposed by these entities. All risk-bearing managed care plans must, at a minimum, meet state licensing and survey requirements. Plans may voluntarily seek federal qualification or private accreditation, designations which, although optional, may serve as conditions of participation among a growing number of purchasers. Any plan contracting with the Medicare and Medicaid programs is subject to additional requirements. HCFA regional offices conduct ongoing monitoring of a Medicare contracting plan's internal quality assurance program in addition to the required annual review of the quality of services by a peer review organization. Although state Medicaid agencies vary in their requirements for participating plans, all states are required to contract for an annual, independent external review of a plan's quality of care.

Each of these requirements carry with them the expenditure of resources by the plan, the state and the federal government. In addition to these burdens, many plans feel that compliance with multiple, conflicting and/or varied standards may divert and diffuse attention from carrying out their quality improvement programs.

Recent strides by the private sector have helped to standardize data reporting requirements, such as with the Health Employer Data Information System (HEDIS). HCFA as well recognizes that the proliferation of quality improvement requirements, while laudable in many respects, may result in costly duplication of effort. Recent initiatives by HCFA's Office of Managed Care aim to coordinate Medicare/Medicaid quality improvement requirements and, to the extent feasible,
link those efforts to private sector initiatives. Similarly, some states are attempting to coordinate their review processes among Departments of Health, Insurance and the state Medicaid agency.

While moving to streamline standards and review processes, federal and state policymakers must be cautious to recognize differences between Medicare/Medicaid beneficiaries and the privately insured which warrant special protections and monitoring practices. Efforts must respect the unique roles and motives of each review entity and coordinate standards and practices only to the extent that those needs are complimentary. States have a great deal of latitude, even absent any federal statutory or regulatory reform in this area, to reduce if not eliminate duplication of state-imposed quality improvement requirements for Medicaid managed care. Deeming another state agency's review or that of a private accrediting body as compliance with comparable Medicaid requirements reduces the time and burden associated with Medicaid's own reviews. Sharing informational sources, developing common reporting formats that serve multiple state agency data requirements, and conducting joint reviews with private and public sector review entities are other means of retaining Medicaid's unique focus and interests while reducing burden on plans.

B. Issues in QARI Implementation

1. Findings from baseline assessments of internal QA programs - The guidelines recognize that not all managed care organizations currently meet the QARI standards and encourage states to work with plans in bringing them into compliance with adopted state internal QA program standards. An early first task in the demonstration was the development of baseline self-assessment tools for plans to review their current compliance with the QARI and/or state adopted standards. This tool performed two simultaneous functions. First, it helped educate plans on the nature and scope of the internal QA program requirements and, secondly, provided important information to the project staff for determining their own strategies with respect to whether and how to adopt the QARI guidelines as their own standards.

In Washington the QARI staff did an on-site visit to the plans and completed the baseline assessment collaboratively. In the other two states the baseline assessment form was sent to the plans to complete, followed by site visits to validate the information submitted. This was done in a supportive, rather than regulatory mode. A critical part of this process was to remove any threat of sanctions associated with the baseline assessment and to use this time as an opportunity to explore how best the state could assist the plans in meeting the requirements in the future. Copies of the baseline assessment form from Ohio are included in Appendix G.

Although both Minnesota and Ohio are perceived as advanced Medicaid managed care states, since they had Medicaid contracts with managed care plans over many years, a number of plans did not meet all the standards within the guidelines. In Ohio the standards most frequently not met were Adequate
Resources, Delegation of QAP Activities and Credentialing and Re-credentialing of Professionals. Preliminary review of the self-administered baseline assessments in Minnesota found that five of the health plans appeared to be in substantial compliance with the standards; two health plans had a significant number of standards not met; and one health plan had several areas to be brought into compliance. Plans in Washington, with limited history and regulation in managed care and a preponderance of smaller plans, were deficient in many areas of the standards, with many of the elements not met in the categories of Enrollee Rights and Responsibilities, Medical Records and Credentialing.

2. **Focused studies** - Plans are required to do studies selected by the state, which may be combined with ones on topics of their own choosing. The purpose of the focused studies selected by the state is to assess plan performance over time in a given clinical or health service area of interest to the Medicaid program. The intention is to review findings from these studies with each plan and its providers to jointly determine areas for improvement and possible strategies or interventions which could be undertaken to assist in the process.

The data required to conduct focused studies of clinical conditions requires tedious abstraction of medical records. Several plans participating in the demonstration objected to the workload and expense entailed in doing these reviews. Most plans have computerized administrative data sets although data is typically limited to demographics, diagnoses, insurance coverage and perhaps hospitalization dates and thus of limited use for purposes of focused clinical studies.

Plans are required to do their own studies, which can be done as part of statewide studies of the same topic area, or they may design and carry out studies of areas of particular interest to that plan. Many of the mature plans have studies of different clinical areas underway on an ongoing basis, with as many as 10-12 studies in process in some plans in Ohio. As part of the preparation for the post-QARI planning process in Minnesota, all the health plans were asked to compile a list of areas currently being studied. Sixty-seven areas across eight health plans were under review, a much greater number and variety of areas than expected. On the other hand, small plans may not have the expertise or resources to conduct their own studies and may require the assistance of outside consultants. QARI recognizes this reality and advocates that states use the external quality review function as an opportunity to train and educate less mature plans in the technical and analytic components of study design, data collection, verification and analysis. While the immediate goal is to perform required state studies, the residual effect is that plans develop skills and expertise to conduct their own internal studies in the future.

The focused study is not completed until findings are reviewed and followed-up by the plan's practitioners. Physicians respond best to feed-back and peer comparison, with results that are understandable and statistically reliable. Appropriate clinicians, preferably multidisciplinary teams, should review the findings of the studies conducted by either the external review entity or the plan. It is only in this phase of the process that a feedback loop to the actual practice and patterns of individual practitioners can be established. When focused studies are
conducted as part of a state's external quality review process, plans must provide written descriptions of how they intend to follow-up on any deficiencies found as a result of these studies. Young plans may require additional assistance and, as part of the scope of work for the external quality review or with internal resources, states may provide needed help.

Experience of the demonstration would indicate that, at least initially, findings of these studies not become the basis for cross-plan comparisons. It is inevitable that there will be interest in doing these cross comparisons, so it is important that when the data is released that it is with the caveat that the data is not comparable. Until such time that all parties can be assured of the accuracy of the data and consistency of reporting methods, the state should use the focused studies as an opportunity to work individually with plans and to provide necessary technical assistance. Subsequent studies should measure whether any action was taken or change occurred as a result of studies that were done.

C. Other Considerations

1. Plan model and size - Staff-model plans directly employ physicians and offer many advantages which can ease the implementation of a quality improvement system such as is described in QARI. Provider participation in QI-related activities, the use of standard reporting forms, procedural codes and medical records, and direct follow-up on potential quality problems are all facilitated through the proximity and central organization of the staff model. From a state monitoring perspective, the task is simplified due to the centralization of administrative functions and the compatibility of records and systems across sites.

Under other forms of managed care, including group, Independent Physicians Association (IPA) and network models, the health plan contracts with multiple physicians and/or groups of physicians to provide services. Physicians are not employees of the health plan. Providers often contract with multiple plans and/or retain a fee-for-service component of their practice. This arrangement diffuses the leverage of any one plan and increases the burden on providers to comply with often conflicting requirements of each plan and their fee-for-service patients. The proliferation of these models has in part been the impetus for standardization of performance measurements and reporting forms. However, vigilance is still required by the managed care plan to oversee the quality of care, including site visits to primary care physician offices during the credentialing and oftentimes the recredentialing process. The dispersion of practitioners also creates special challenges in engaging their active and frequent participation in committee meetings, training programs and peer review activities. While project experience indicates that IPA models are well equipped to emulate the QARI standards, the decentralized nature of these plans may require special arrangements and incentives to assure that a plan's standards of quality are upheld by all participating providers.
2. **Level of Maturity** - In Ohio and Minnesota, where Medicaid managed care had been implemented in 1978 and 1986 respectively, state regulations relative to quality improvement were in place and plans generally had well developed internal quality assurance programs. Emphases in these states under the demonstration have been on refinement of their focused studies, improvement of information systems and developing better ways of capturing consumer input into the quality improvement process. The expertise and experience of mature plans offer both opportunities and challenges to the state. It is important to find ways to "harness" the knowledge and learn from the direct experience of plans so that the system as a whole can grow. The imposition of new standards should not "drag down" more experienced plans yet create realistic goals for younger plans.

The impact of QARI on health plans was significantly greater in Washington state, even though there had been a limited risk-based Medicaid managed care program since 1981. With no state standards for internal quality assurance programs, and no guidance from the Federal level on what a health plan’s quality assurance program should include, plans were left to their own designs. Consequently, when QARI was implemented as part of the demonstration, few of the plans could immediately comply with the requirements.

**Summary**

There are many issues concerning the internal quality assurance programs of health plans. Well-managed health plans recognize the importance of their own internal quality controls, and most of the older mature plans have self-developed systems for quality studies and follow-through with their provider network to constantly enhance the effectiveness of their services. Given the incentives in risk-based health plans, it is in their own best interests to provide quality services, keep people healthy, avoid complications of illness and reduce unnecessary services. States may want to experiment with different approaches to working with plans, educating providers and assuring that Medicaid recipients have access to appropriate services.
CHAPTER V
Consumer Participation

The actual recipients of Medicaid managed care services are a vital component of a state's quality improvement system. Although federal regulations relating to consumer involvement address only grievance procedures at both the plan and the state level, the QARI guidelines recommend that Medicaid recipients be given a stronger voice in assuring the availability, accessibility and acceptability of the health care services they receive. Despite this endorsement for consumer participation, however, QARI offers no real guidance on how to facilitate and sustain this participation.

The involvement of consumers includes enrollees as well as their advocates. While it has generally been very difficult to find meaningful ways for involving Medicaid enrollees directly in this process, states are encouraged to take an active role in working with their plans, especially marketing and consumer relations staff, to seek out individuals and to offer them the support necessary for breaking down traditional barriers to participation (e.g. training programs, transportation, child care, etc.). States may wish to turn to their mandated Medical Care Advisory Committees which must have consumer representation as another possible source for consumer participation. Advocates may include representatives of publicly funded legal services corporations, organized low income groups, foster home associations, area agencies on aging and other groups and organizations whose missions include the enhancement of health care service access, availability and quality.

This chapter describes approaches used within the demonstration to involve consumers in the quality improvement system in both the design of those systems and in their evaluation. The following are discussed:

- **Planning/Design/Educational strategies**: participation on committees and subcommittees, consumer advisory councils, newsletters and education/peer counselling;

- **Feedback strategies**: satisfaction surveys, focus groups and analysis of complaints/grievances.

Since no one approach is sufficient, states must find multiple ways for actively involving consumers in the process and to move beyond superficial involvement into a more sustained and meaningful participation in the process.

**What is required**: There are two areas where the guidelines address consumer involvement. Chapter 1 provides a general statement on the value of consumers assuming proactive roles as advocates for quality medical care. In this context, the Guidelines suggest that the views of consumers be sought out when defining quality measures and effecting desired changes in the provision of medical care when problems are detected.
The standards for Internal Quality Assurance Programs in Chapter 2 of the guide include a section on enrollee rights and responsibilities which specifically address grievance procedures, enrollee suggestions and assessment of enrollee satisfaction.

A. Planning/Design/Educational strategies

The following section reviews mechanisms for involving consumers and/or their advocates in active decision-making and advisory roles within the managed care system in general and quality improvement in particular.

1. Committees and subcommittees - Efforts to involve consumers in state level advisory committees were not generally successful in the demonstration states. One Medicaid recipient attended two meetings of the Advisory Committee in Ohio. An advocate from the legal aid organization was also on the committee and attended regularly.

Advocates are generally from legal services, an entity established to represent either the poor or the elderly. Legal services are at least partially federally funded and generally see one of their primary missions as advocating in behalf of their constituency. In many states, legal services have been strong opponents of Medicaid managed care, fearing that the incentives in risk-based payment systems may negatively impact service quality. By including advocates early in the design of the quality improvement system, the state is better able to address the need for adequate protections and, in the process, solidify the support of a potentially divisive constituency.

Health plans have also involved consumers to some extent in their quality assurance advisory committees. Although state regulations in Minnesota require a consumer on a plan’s Governing Body, it is not necessarily a Medicaid enrollee. One plan in Ohio has had a Medicaid enrollee on the QA committee who has attended all meetings, a situation facilitated by the enrollee’s job being located in the same building as the plan. Another HMO had two members on their QA committee, but both have left and have not been replaced. Some plans were concerned about enrollees attending QA committee meetings due to confidentiality concerns as well as a general lack of medical knowledge. Without a better understanding of the processes for developing public policy and the interactions of the key players, it is no doubt intimidating for a Medicaid recipient to be expected to speak up in committee meetings. It takes an unusual Medicaid recipient to feel comfortable in the midst of management level state officials and health plan administrators or medical directors. Unless they feel they are contributing, there is little incentive for them to make the effort to attend. It is not sufficient to simply invite consumers to participate in the process without providing adequate education, training and ongoing support to assist them in becoming active and knowledgeable participants in the process.
2. **Consumer Advisory Councils** - States may wish to consider the formation of Consumer Advisory Committees, made up entirely of Medicaid enrollees in managed care plans. While the purpose of such committees may span issues beyond quality improvement, it offers an excellent opportunity to focus exclusively on matters of importance to the user of the system and their recommendations for improvement. Washington State piggy-backed on existing consumer consortia set up at the county level to facilitate enrollment and education for their rapidly expanding managed care initiative. By using this existing structure, QARI project staff were able to benefit from a group of knowledgeable consumers whose input was seen as having immediate and tangible relevance to the design and implementation of the managed care system for the state.

In Ohio, at least six plans convened member advisory councils which included Medicaid recipients, with varying degrees of success. Food was provided at meetings, one plan recognized participants with certificates or acknowledged their contributions in their newsletter. Another plan provided stipends, transportation and child care. Attendance varied and often depended on the relevance of the topics that were scheduled for discussion. Regular attendance at meetings by Medicaid recipients was a major shortcoming despite incentives such as transportation, child care and free meals. In order to gain the participation of Medicaid enrollees, plans need to provide a safe, non-threatening environment and appropriate topics for discussion.

3. **Newsletters** - Many health plans publish newsletters, usually quarterly. These include health-related articles and invite suggestions from enrollees about policies or procedures. Although newsletters are sent to all enrollees of a health plan, not only Medicaid enrollees, they do offer information and provide a reminder that their input is important to the health plan. There is also value in having Medicaid enrollees feel they are part of the "mainstream" and receiving the same information being sent to commercial enrollees. The language and content of these newsletters must be kept within reach of recipients but provide yet another means to educate and seek the involvement of the actual users of care.

4. **Education and peer counselling** - More must be done to educate consumers about the health care system generally and their own needs specifically. As they become better informed they are more likely to take an active role in initiatives to monitor the quality of care. States should be creative about bringing this education to consumers. Videos in enrollment offices, doctors' and health centers' waiting rooms are one technique. Handouts in easily understood language at an appropriate literacy level and in foreign languages are another resource, particularly for specific health conditions. Health plans must inform enrollees in writing of their rights and responsibilities. This is an opportunity to educate about the system. Some plans mail health information "cards" on specific topics or educational reminders to all their enrollees.
Peer counselling is a technique that has been used in some Medicaid programs to encourage enrollment in managed care plans and to obtain feedback from Medicaid enrollees. Peer counsellors must have certain qualifications to be effective, and confidentiality must be maintained. They must be able to understand the policies related to managed care, be able to explain them to other enrollees and be able to respond to questions and concerns of the person they are counselling.

Peer counselling has been tried within neighborhoods, where a person is recognized and accepted by his/her neighbors as being a resource to assist other enrollees. This support can help with access issues, appropriate utilization of health care services, getting children in for preventive care and generally improving the quality of services provided, thereby benefitting both the plans and the enrollees.

While few of these techniques were actually employed in the demonstration, each of the states continues to examine how they can better link the consumer into the decision-making process. This must be a long term effort and reinforced through multi-faceted approaches.

B. Feedback Strategies

Quality improvement is an ongoing process and requires the active feedback from consumers on the services provided. Following are some strategies for facilitating that feedback and incorporating findings into a state's quality improvement system.

1. Consumer Satisfaction surveys - All three of the demonstration states developed consumer satisfaction surveys as part of the quality improvement initiative. A written survey, mailed to recipients, was the most frequently used method of seeking consumer input by the states. Washington and Minnesota surveyed a sample of current enrollees; recipients who have changed plans; and those no longer enrolled in managed care plans. Any written material must be written to be readable and clearly understood by those recipients whose literacy level is limited. No more than a sixth grade reading level is recommended for any printed materials for this population and surveys should be written in the languages of the major populations served through the managed care program.

A number of survey instruments are currently in circulation for assessing enrollee satisfaction with managed care systems. Most notable among these include the Employee Health Care Value Survey and the Group Health Association of America (GHAA) Consumer Satisfaction Survey. Washington designed its survey based on existing tools, paying particular attention to constraints of the management information systems of its Medicaid contractors. The state administers monthly mailed surveys to 4,000 recipients (2,200 who are currently enrolled; 1,300 recipients who have changed plans; and 500 who are no longer enrolled in managed care). To date, the state has averaged a 22 percent return rate. A software program was developed to help analyze survey findings on a quarterly basis. This software will be
interactive with the MMIS eligibility files to assist in identifying populations which might be having difficulties with managed care delivery systems.

Ohio issued an RFP for the design of a consumer satisfaction survey that could be administered periodically by the state as well as by individual plans to supplement their existing survey instruments.

Telephone surveys are yet another alternative that require substantially more resources but generally have higher response rates. The response rate from a Kaiser Family Foundation survey of Medicaid recipients in California, for example, was above 80 percent. Ideally, such surveys should be done by trained interviewers. None of the states did telephone surveys, although some of the plans report they telephone enrollees to determine satisfaction with the services received. Face-to-face interviews can also be highly effective in getting feedback from enrollees. Both telephone and face-to-face surveys provide the opportunity to ask probing questions and encourage more open dialogue than can be done with a written survey. However, both of these techniques require a certain degree of sophistication and investment of resources.

Health plans also do member satisfaction surveys, although not limited to Medicaid enrollees. Ohio reported that phone interviews were the most frequent method by which satisfaction surveys were performed by plans, and this method had a 30-40 percent response rate. Plans also may have suggestion boxes or send representatives out to talk to members and ask open-ended questions. While these methods provide opportunities for commercial and Medicaid enrollees alike, experience indicates that they must be supplemented with surveys particular to the needs and circumstances of Medicaid recipients if they are to be useful in understanding the unique barriers and issues they face in accessing their care.

2. Focus groups - Focus groups bring small groups (usually 10-15) of Medicaid recipients together in a non-threatening environment, where there can be an open and supportive exchange of experience. Minnesota conducted four such focus groups, two each around the issues of pediatric asthma and diabetes. In each case, the state invited enrollees whose names were provided by individual plans as meeting clinical criteria defined by the state. Using an independent facilitator, attendees were requested to describe and evaluate their experience in seeking care for these conditions with particular attention on factors enhancing and inhibiting service access and quality. Meetings were held during the day at two different locations and in two different counties.

To attract attendance at these focus groups, the state offered child care and a small $20 honorarium to be used for transportation or whatever was needed to facilitate their attendance. One hundred enrollees were sent letters about the focus groups; twenty responded that they would attend; a total of ten actually attended.

The largest group had five people present. Satisfaction with services varied considerably, but did provide a sense of what is working. Due to the low response rate, it was felt this was not a useful way to gather information. The protocol and questions for Minnesota's focus groups are shown in Appendix J.

Plans to conduct the Minnesota focus groups in rural areas were set aside fearing that confidentiality may be violated and attendees may be less likely to speak out given the limited number of providers serving an area.

3. Complaints and grievances - Health plans are required to document complaints and formal grievances and to respond in a timely manner. They are also required to analyze complaint and grievance data and to use it for quality improvement. For the system to work effectively, enrollees must be aware of their right to question or complain about access, availability and quality of services. Typically, this information is included in a handbook distributed at the time of enrollment and provided on an annual basis thereafter. Plans should be encouraged to simplify the method and message, making it easily readable at an appropriate level and an in languages of the major population groups served. As part of state monitoring, complaint logs at the health plans should be reviewed to identify any pattern of complaints and issues that need to be addressed.

The QARI system and Federal regulations require that there also be procedures for complaints or grievances to be received within the State Medicaid agency, including provisions for Fair Hearings if a Medicaid enrollee has a complaint or grievance that has not been addressed to the satisfaction of the enrollee. The frequency of complaints being lodged at the state level varies considerably among the demonstration states. Ohio receives few complaints at the state level, and these primarily through the Department of Insurance. Project staff believe the reason for so few complaints is the monthly disenrollment option. On the other hand, Washington reports receiving two-three complaints a day directly to the managed care unit through the client "hotline." States may wish to consider having an "800" number for enrollees to call both for information and complaints. Washington has employed a client advocate to assist in responding to complaints. They have also automated the complaint log in order to analyze the data more easily. Appendix K presents the Washington complaint log data base information key and tracking sheet. Minnesota has three ombudsmen from whom enrollees can seek assistance or seek redress of complaints.

States may also ask the external review organization to review certain categories of complaints, such as all complaints of denial of emergency care. Complaints can be a valuable technique for consumers to identify quality of care issues that should be addressed to improve the overall quality of care being delivered in managed care systems.
Summary

Consumers can be effective advocates in their own behalf if they are brought into the process in a meaningful way. It begins with having them become active participants in developing their own care plans, establishing a relationship with a health care provider with whom they are comfortable and can talk freely, and in understanding the system for delivering those services. Education of consumers is critical for them to understand not only their rights as Medicaid enrollees, but also their responsibilities for keeping appointments, following instructions and guidelines given as part of their health care, providing complete information about their health problems and for the appropriate use of the available covered services. Consumers also need to recognize their responsibility to participate in quality assurance programs and efforts to improve the health care delivery system. They can make a difference!!
CHAPTER VI
The Federal Role*

Like the roles of the other key players in the quality improvement system conceptualized in the QARI guidelines, the Federal role continues to evolve. However, the demonstration shed less light on the Federal role and experience than on the role of other key players, for several related reasons:

- States were the focus of the demonstration.
- The QARI guidelines are quite vague concerning the Federal role.
- The Health Care Financing Administration has devoted more effort to policy issues than operational concerns.

The Federal government will continue to monitor states to assure that they are in compliance with Federal laws governing quality of care. (QARI guidelines, page 10). Though the Federal role in the demonstration was somewhat limited, and the larger question of the appropriate Federal role in quality oversight remains to be answered, the QARI guidelines understate the HCFA role. It is more useful to view Federal involvement in three basic categories of activity, which were evident to varying degrees in the demonstration.

A. Policy development, promotion, application, interpretation, and evaluation

The primary HCFA role in the demonstration centered on Federal policy:

- The pre-demonstration groundwork of developing and promoting the QARI guidelines, in concert with the National Academy, states, the managed care industry, and other partners; and

- Applying, interpreting, and evaluating the policy guidelines, in concert with its demonstration partners.

This role was carried out by the HCFA Office of Managed Care, and its predecessor organization in the Medicaid Bureau. From the HCFA perspective, a key shortcoming of the demonstration was the marginal involvement of the HCFA Regional Offices, which carry primary agency responsibility for the oversight of state managed care programs.

One of HCFA’s central demonstration responsibilities is only now beginning in earnest using the demonstration lessons to improve the 1993 guidelines. However, HCFA has already applied early, apparent results of the demonstration in several important ways, including:

* This section was prepared by Greg Scott, Office of Managed Care, Health Care Financing Administration.
• Broadening and expediting HCFA efforts to encourage cooperation between various organizations at the state level with quality oversight responsibilities.

• Using the experience of the demonstration states' efforts to compile childhood immunization and pregnancy care/outcomes clinical indicators to inform development of the Medicaid version of the Health Plan Employer Data and Information Set (HEDIS).

Outside the context of the demonstration, quality management policy is only increasing in importance on the HCFA agenda. Many major new activities are underway. For example,

• HCFA is working with the National Committee for Quality Assurance, states, managed care plans, and others to develop new national policy on Medicaid managed care plan performance measurement.

• HCFA is actively promoting use of the QARI guidelines in non-demonstration states. In waiver programs, HCFA commonly applies portions of the QARI guidelines as terms and conditions of waiver approval.

In addition, HCFA Central Office and Regional Office staff routinely help states and others interpret the QARI guidelines, in the interest of operationalizing QARI concepts. One important aspect of this interpretation is assisting states apply the guidelines in a manner consistent with Federal law and regulation. A frequent example of this effort is aiding states in developing strategies for more collaborative, CQI-based approaches to external review (as per Chapter 4 of the QARI guidelines), within the limiting constraints of section 1902(a)(30)(c) of the Social Security Act, and related provisions on Federal Financial Participation.

B. Technical assistance

In the ambitious effort to foster stronger state quality improvement systems through QARI, HCFA is committed to providing states and others with as much technical assistance as the agency can muster. The most visible technical assistance effort is the provision of quality improvement tools for states and plans.

HCFA sees a clear distinction between its increasing emphasis on tools, and more traditional Federal approaches to program administration, such as statute, regulations, and manual instructions. HCFA sees practical and cost-effective tools, provided to states as guidance, as enabling instruments that allow states to pursue state-specific quality management programs that meet broad Federal statutory and regulatory requirements. Tools, such as the QARI guidelines, do not just facilitate state flexibility. Because they are more readily refined, replaced, or otherwise modified, they often offer better approaches to furthering Federal programmatic objectives in a dynamic environment.
HCFA has just released the latest QARI tool for state Medicaid agencies, Health Care Quality Improvement Studies in Managed Care Settings--Design and Assessment, produced under HCFA contract by the National Committee for Quality Assurance. Other new tools--most notably, the Medicaid Managed Care Performance Measurement Set (Medicaid HEDIS)--are currently under development. In addition to the development of tools for State agencies, HCFA is committed to other forms of technical assistance, such as training sessions and conferences.

C. Monitoring and evaluation

The aspect of the Federal role that the QARI guidelines address most explicitly--Federal monitoring of state activities--is the aspect in most need of further definition. The HCFA vision is already well established. HCFA will--

- in specific terms, continue to hold state agencies accountable for adherence to Federal law and regulation.
- in broader terms, expect state managed care programs to design and operate quality management programs that foster improvement in access, quality, outcomes, and health status.

The open question: what HCFA operational approaches are best suited to pursuing this vision? HCFA is presently engaged in several intensive efforts to help answer this question. These include:

- Examining and improving Central Office-to-Regional Office and inter-Regional communication and coordination.
- Developing strategies and tools for monitoring State demonstration (section 1115) and freedom-of-choice (section 1915) waiver programs.
- Identifying and encouraging opportunities for coordination between the monitoring responsibilities and approaches of Medicare, Medicaid, and other oversight entities.
- Intensifying HCFA efforts to develop new monitoring tools, such as performance measures and beneficiary satisfaction surveys.

Like the other elements of the Medicaid managed care quality improvement system, the Federal oversight role is dynamic. As HCFA, its partners, and other stakeholders seek to identify the most appropriate and productive Federal functions, it is crucial that those new approaches be positioned to respond to the next set of emerging demands.
CHAPTER VII
Monitoring and Evaluating the System

The quality improvement system developed by a state is itself subject to the principles of continuous improvement which it embodies. QARI was never intended as a static document but must evolve through the insights and experience of its many stakeholders and the findings surfacing out of the system itself. This chapter of the QI Primer identifies the ongoing role which state agencies and others must play in assuring a state-of-the-art quality improvement system capable of responding to the changing needs and circumstances of managed care recipients and providers.

All of the demonstration states set up a formalized structure for implementing the QARI guidelines, including the assignment of staff, establishment of committees and inter-agency relationships. Since the function of these components is likely to change over the course of implementation, it is important to periodically review the infrastructure/organizational structure of a state's quality improvement program. This becomes especially important as major shifts occur in the scope of managed care, number of plans, market penetration and sophistication of the market. Staff expertise, outside consultant requirements, committee composition and workgroup assignments must all undergo periodic assessment.

Issues identified for specific attention by states as they consider their responsibilities for monitoring and evaluating their quality improvement system include:

- Roles for ongoing participants;
- Measuring success; and
- Enhancing the system.

*What is required*: Monitoring and evaluating the quality improvement system is a requirement of the QARI guidelines, but little guidance is given. The guidelines recommend "that there be a mechanism for formally monitoring, evaluating, and revising the Medicaid managed care Health Care Quality Improvement System and all of its elements on a periodic and regular basis." It is further noted that "if Medicaid Managed Care is to assure that it keeps pace with the developments in quality improvement and the managed care industry, it should implement a process for review and appropriate revision of the HCQIS overall and each of its component elements on a periodic basis."

A. Responsibility for system review

Since the state Medicaid agency has the statutory responsibility for overseeing the quality of services to its Medicaid recipients, it has a vested interest in making certain that the quality assurance system put into place is effective. Whether or not the Medicaid agency designs or implements the quality assurance system, there is an important leadership role for it to play in the monitoring and evaluation process.

For purposes of this discussion, we can distinguish the distinct functions of monitoring from periodic evaluation. Monitoring pertains to an ongoing process of assuring that systems are implemented as designed and are producing accurate accounts of state and plan managed care
For purposes of this discussion, we can distinguish the distinct functions of monitoring from periodic evaluation. Monitoring pertains to an ongoing process of assuring that systems are implemented as designed and are producing accurate accounts of state and plan managed care performance. Monitoring is both a mindset and a technology and is most effectively accomplished by those closest to the actual implementation of the system. Evaluation, on the other hand, typically represents a more system-wide assessment of whether the established processes, procedures and mechanisms for quality improvement are indeed effective in bringing about desired changes. Evaluations are often conducted by those who are sufficiently removed from the actual implementation so as not to be biased on the utility of the system. While the distinctions between monitoring and evaluation are not absolute, they offer a framework for considering the various functions and responsibilities for assessing an existing quality improvement system.

1. **Advisory groups** - Provisions for ongoing monitoring must be built into the design of a QI system with periodic reporting back to the State Medicaid agency and others responsible for the system's implementation. Under the demonstration, Advisory Committees have served as valuable resources and sounding boards for maintaining vigilance over the operations of the quality improvement system. Representing the perspectives of state officials, managed care plans and consumers, committees have enabled the ongoing monitoring to be conducted in a collaborative manner with close interaction with the staff responsible for system implementation. Since all parties had a stake in developing the system, they share a common interest in making certain that it functions efficiently. There are, however, circumstances when committees may become entrenched and narrow in perspective and serve to protect rather than critique the process.

2. **Outside organizations** - States may wish to extend the involvement of others outside of the process to evaluate their quality improvement system. One option may be to include the review and evaluation of the system in the contract with the EQRO. Quality assurance and improvement technology is still evolving as a science, and an independent outside agency whose sole mission is quality improvement is more likely to stay abreast of advances in this field. This is particularly true on matters pertaining to clinical focused studies and the use of practice guidelines and indicators to guide and track practice patterns. The external review entity is also in the best position to evaluate the outcome of the quality assurance program and to offer comparative assessments of the efficacy of a given quality assurance program. While there is much to be gained (including the ability to capture federal financial participation) by having the external review entity involved, the EQRO function itself should come under periodic scrutiny. State representatives may wish to take an active role in critically evaluating the EQRO process and its relationship to and impact on the overall quality assurance system.

States may prefer establishing special committees and/or contractual relationships for monitoring and evaluating their quality assurance systems. There are a number of entities with an interest in the provision of quality services under Medicaid Managed Care. The challenge is to find persons with the requisite skills
and resources to assess the complexity of a comprehensive, multi-dimensional quality assurance system. University-based health policy research programs may be one resource for states to tap into to provide an independent voice on the effectiveness of their quality improvement programs.

3. **Role of other state agencies** - The review of the system should also address the role and relationship of other state agencies with quality oversight responsibilities. An evaluation of their level of participation in the process, coordination of activities and opportunities for joint planning all provide important information on areas to be enhanced in the future. State Medicaid agencies should conduct a self-assessment of how well Medicaid oversight is integrated with the quality oversight activities of other agencies.

B. **Measuring success**

1. **Indicators** - States should define indicators for measuring success. Established in advance of the evaluation, indicators serve as tangible, measurable outputs which the state is hoping to achieve under the quality improvement system. While improved health outcome may be the ultimate indicator, other more process-oriented measures can be devised for monitoring a state’s progress. Demonstration states considered the following indicators:

   - Surveys of plans, showing greater compliance with the standards for the internal quality assurance programs;
   - Efficiency of the system, including the more efficient use of state resources through the coordination of the system and reduction in inconsistent and conflicting requirements;
   - Improved accuracy of data obtained by the state as confirmed through external validation processes;
   - Greater attendance and participation in QI activities, such as attendance at committees and workgroups and survey response rates;
   - Increased support of Medicaid managed care by consumer advocacy groups; and
   - Consistent improvement in performance measurements.

States should set up methods for tracking these and other tangible indicators of the effectiveness of the system. Where results fail to show incremental success, efforts should be directed at tracing back through the quality improvement system to determine potential obstacles or problems. The state itself should develop follow-up plans which refine the system to be more responsive and effective.
2. **Use of data** - Data collected as part of a state's quality assurance system is a valuable source of information to judge the effectiveness of the system. To the extent possible, states should be wary of defining supplemental data requirements for evaluating the system but instead should make full use of available quantitative analyses conducted as part of clinical focused studies, HEDIS-like performance measurements and other special studies. Beyond providing a means of tracking clinical performance, these data should be evaluated to determine: their utility; their accuracy and consistency within and across plans; their timeliness and their impact on addressing quality problems. The evaluation is also an opportunity to assess the potential for coordinating data requests among state agencies and other private review bodies thereby reducing duplicative requests.

3. **Options for EQRO function** - As previously noted, the QARI guidelines permit considerable flexibility in defining the role of the external review organization. The role and scope of work of the EQRO should be assessed as part of the formal evaluation of the system. This is an area that is apt to change as the system and the health plans mature. Have the plans developed their own systems and expertise so they can take on more responsibility for clinical studies? Have state agency capacity and resources changed so the state is now better positioned to carry out some of the functions that were delegated to the EQRO?

   Multi-year contracts are recommended for the EQRO, but there should be provisions for reviewing and updating those contracts on at least an annual basis. The overall evaluation needs to review the process for negotiating contracts and evaluating the functions of the EQRO.

C. **Enhancing the system**

1. **Impact of Monitoring** - When all is said and done, the final question must be: did monitoring make a difference in the quality of care provided to Medicaid enrollees?

   While it may not be possible to create a causal relationship, the evaluation should review reports gathered from a state's monitoring activities to determine if positive change occurred. Particular attention should be directed at persistent problems, whether across plans or by individual plans over time. Are there other actions that could be taken to improve the quality of care that both the plan and the state agency might have overlooked? Are health care delivery issues, such as access, being monitored, as well as clinical conditions? What trends can be detected for particular population groups by age, gender, ethnic category or geography?

   Evaluation must incorporate an assessment of the external review organization and whether it is offering the detailed analysis a state requires to adequately identify and correct potential quality problems. What is the plans' perception of the utility of the external review activity and are there ways to make it more relevant to the issues impeding their delivery of quality care to the Medicaid enrollee?
The state must also assess its own performance and responsibilities in following up on deficiencies or providing support and resources to its plans to improve Medicaid managed care services. It is often too easy in the pressure of workloads to get caught up in the work at hand without ever stepping back and considering whether any impact is occurring as a result of the activities in place for a quality improvement system.

Feedback from case management staff, ombudsmen and advocates also may help identify the impact of a state’s quality improvement system on care. State agencies should seek their input in the formal evaluation of the quality improvement system. Advisory groups and workgroups should also be continuously reassessing whether the system that has been put in place is making a difference in the quality of services provided to Medicaid enrollees.

2. Maintaining a state-of-the-art quality improvement system - The Health Care Quality Improvement System must keep pace with evolving technology and developments in quality improvement and the managed care industry. Access to current literature, workshops and seminars is critical to maintain and enhance the skills of the key persons responsible for quality assurance for risk-based managed care. Much of what is developed under the system will be done either by statute or rule-making and may be time-consuming to change. States are cautioned to carefully consider deleting those aspects of the system from rule-making which are most prone to change and which are subject to outside influences. For example, states adopting NCQA standards must be prepared to revise them on an annual basis and may prefer placing their provisions in contracts rather than state regulations.

The monitoring and evaluation plan should include a periodic process for reviewing the overall system in the light of current practice. This review needs to identify any components of the system that should be revised with strategies for implementing the changes. Particular attention should be focused on aspects of clinical care, practice guidelines and/or indicators which undergo continuous refinement and which, when identified in a state’s system, should be assessed periodically for continued relevance.

Summary

The formal, periodic evaluation of the Health Care Quality Improvement System is the key to determining whether the quality of care is being improved under the system proposed in the QARI guidelines. Through this oversight by an objective process, changes can be made that will more effectively protect the interests of Medicaid enrollees in risk-based managed care plans.
APPENDIX A

QARI Project Organizational Charts
APPENDIX B

Ohio Job Descriptions for
Nurse Specialist Supervisor & Nurse Specialist
POSITION DESCRIPTION

OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES
PERSONNEL DIVISION

AGENCY
Human Services
DIVISION OR INSTITUTION
Medical Assistance
UNIT OR OFFICE
Managed Health Care

STATE AGENCY : County Agency : New Position : Change
COUNTY OF EMPLOYMENT
Franklin

USUAL WORKING TITLE OF POSITION
Nurse Specialist Supervisor

POSITION NO. AND TITLE OF IMMEDIATE SUPERVISOR
83501.0, Human Services Program Admin 3

NORMAL WORKING HOURS (Explain unusual or rotating shift)
FROM: 8:00 AM TO: 5:00 PM

JOB DESCRIPTION AND WORKER CHARACTERISTICS

<table>
<thead>
<tr>
<th>%</th>
<th>Job Duties in order of importance</th>
<th>Minimum Acceptable Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>40%</td>
<td>Under direction from Bureau Chief, supervises nurse specialists assigned to assess &amp; monitor quality assurance plans of health maintenance organizations (HMOs): Conducts on-site monitoring &amp; supervision of nurse specialists &amp; contractors; conducts quality assurance audits &amp; monitors follow up; communicates orally &amp; in writing to nurse specialists, HMOs providers &amp; contract monitors instructions &amp; information regarding corrective actions to be taken; evaluates providers' utilization review processes; analyzes &amp; monitors Medicaid rules &amp; regulations related to utilization reporting systems.</td>
<td>Knowledge of 1) management, 2) public relations, 3) supervision, 4) nursing, 5) government structure, 6) office practices &amp; procedures, 7) medical terminology; ability to 8) deal with large number of variables &amp; determine course of action, 9) understand field of study, 10) write instructions, policies &amp; programs, 11) collect &amp; assimilate data, 12) prepare meaningful, concise &amp; accurate report, 13) establish friendly atmosphere as supervisor.</td>
</tr>
<tr>
<td>30%</td>
<td>Maintains, evaluates &amp; approves providers' quality assurance plans &amp; procedures; analyzes &amp; interprets data, &amp; prepares &amp; maintains reports regarding same; consults with &amp; provides general technical assistance to other program supervisors, contract monitors, OHDS &amp; Bureau staff regarding utilization &amp; quality assurance of HMO program; evaluates administration &amp; implementation of Medicaid rules &amp; regulations involving quality assurance &amp; utilization.</td>
<td>Knowledge of 1, 3, 4, 5, 6, 7, 8, 11, 14) Medicaid rules &amp; regulations; ability to 9, 10, 12, 13.</td>
</tr>
<tr>
<td>10%</td>
<td>Assists in the development of procedures &amp; guidelines as they relate to the quality assurance plan &amp; implementation. Prepares reports &amp; other correspondence as required.</td>
<td>Knowledge of 1, 2, 3; ability to 8, 9, 10, 12</td>
</tr>
</tbody>
</table>

List Position Numbers and Class Titles of positions directly supervised
83523.0, 83525.0; Nurse Specialist

SIGNATURE OF AGENCY REPRESENTATIVE

DATE

8/24/93

An Equal Opportunity Employer
**POSITION DESCRIPTION**

**Ohio Department of Administrative Services**

**Personnel Division**

<table>
<thead>
<tr>
<th>XX State Agency</th>
<th>County Agency</th>
<th>New Position</th>
<th>XX Change</th>
<th>County of Employment</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Franklin</td>
</tr>
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</table>

**Usual Working Title of Position**: Nurse Specialist Supervisor

**Position No. and Title of Immediate Supervisor**: 83501.0, Human Services Program Admin 3

**Normal Working Hours**: (Explain unusual or rotating shift)

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 AM</td>
<td>5:00 PM</td>
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</table>

**JOB DESCRIPTION AND WORKER CHARACTERISTICS**

<table>
<thead>
<tr>
<th>%</th>
<th>Job Duties in Order of Importance</th>
<th>Minimum Acceptable Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>Plans, develops &amp; participates in in-service education programs, seminars &amp; training sessions for contract monitors &amp; providers.Coordinates activities &amp; acts as liaison with other ODHS units, other government agencies, contractors, &amp; general public; clarifies/interprets regulations policies &amp;/or procedures related to quality assurance in HMOs.</td>
<td>Knowledge of 1, 2, 3, 13, 15) employee training &amp; development; ability to 8, 9, 16) prepare &amp; give speeches.</td>
</tr>
<tr>
<td>10%</td>
<td>Prepares special reports relative to program activity &amp; productivity. Performs other related duties as assigned. Must possess a valid driver's license &amp; must be available to travel. May require overnight travel.</td>
<td>Knowledge of 2, 15) ability to 8, 10, 13, 17) requires a valid Ohio driver's license.</td>
</tr>
</tbody>
</table>

**This Position Requires an Ohio State Registered Nursing License.**

**Signature of Agency Representative**: [Signature]

**Date**: 8/24/93
## POSITION DESCRIPTION

**AGENCY:** Human Services  
**DIVISION OR INSTITUTION:** Bureau of Medical Assistance  
**UNIT OR OFFICE:** Managed Health Care Section

### Usual Working Title of Position
**Nurse Specialist**

### Normal Working Hours (Explain unusual or rotating shift)
**FROM:** 8:00 AM  
**TO:** 5:00 PM

### Job Description and Worker Characteristics

<table>
<thead>
<tr>
<th>Job Duties in order of Importance</th>
<th>Minimum Acceptable Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>30% Under the supervision of the Nurse Specialist Supervisor, is responsible for the assessment &amp; monitoring of quality assurance plans for health maintenance organizations (HMOs), &amp; other managed care systems servicing public assistance clients. Travels frequently to monitor, on-site, quality assurance corrective action plans. Initiates verbal &amp; written communications to HMO &amp; managed care providers regarding quality assurance plan design, modification &amp; evaluation of corrective action plans.</td>
<td>Knowledge of 1) nursing, 2) state &amp; federal laws, rules &amp; regulations regarding Title XIX &amp; the Medicaid program, 3) medical terminology, 4) government structure &amp; policies, 5) natural sciences. Ability to 6) define problems, collect &amp; assimilate data, interpret reports, establish facts &amp; draw valid conclusions.</td>
</tr>
<tr>
<td>25% Develops reporting format &amp; collects, maintains &amp; analyzes utilization data from HMOs &amp; other managed care arrangements. Prepares summary &amp; in-depth reports regarding same. Develops &amp; refines quality assurance protocols &amp; procedures for new or expanded managed health care arrangements. Conducts quality assessment reviews as appropriate &amp; assists in the conduct of quality assurance review by independent contractors under agreement with ODHS.</td>
<td>Knowledge of 1, 2, 3, 4, 5. Ability to 6, 7) use statistical analysis, 8) prepare concise, factual reports, 9) prepare correspondence, 10) gather, collect &amp; classify information about data, people or things.</td>
</tr>
<tr>
<td>15% Plans, develops &amp; participates in in-service education programs, seminars &amp; workshops. Acts as liaison with other governmental agencies, contractors &amp; general public. Prepares special reports &amp; other duties as assigned.</td>
<td>Knowledge of 1, 2, 3, 4. Ability to 8, 9, 11) interpret extensive variety of technical material in books, journals &amp; manuals, 12) handle sensitive telephone &amp; face-to-face contacts with providers &amp; recipients.</td>
</tr>
</tbody>
</table>

### Class Title
**NURSE SPECIALIST**  
**65381**

### List Position Numbers and Class Titles of positions directly supervised

### Signature of Agency Representative

**Catherine Green**  
**DATE:** 8/24/93

---

An Equal Opportunity Employer
POSITION DESCRIPTION

Ohio Department of Administrative Services
Personnel Division

Agency: Human Services
Division or Institution: Bureau of Medical Assistance
Unit or Office: Managed Health Care Section

XX State Agency ☐ County Agency ☐ New Position ☑ Change

County of Employment: Franklin

Usual Working Title of Position: Nurse Specialist

Position No. and Title of Immediate Supervisor:
83520.0, Nurse Specialist Supervisor

Normal Working Hours (Explain unusual or rotating shift):
From: 8:00 AM
To: 5:00 PM

Job Description and Worker Characteristics

<table>
<thead>
<tr>
<th>%</th>
<th>Job Duties in Order of Importance</th>
<th>Minimum Acceptable Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>Consults with &amp; provides general technical support to other program supervisors, contract monitors, program planners &amp; other ODHS staff regarding utilization &amp; quality assurance of the HMO &amp; other managed care arrangements.</td>
<td>Knowledge of 1, 2, 3, 4.</td>
</tr>
<tr>
<td>10%</td>
<td>Identifies conditions of interest prevalent to the respective populations for future quality assurance audits. Proposes &amp; prepares new or revised administrative rules for quality assurance in managed care programs.</td>
<td>Knowledge of 2, 4; ability to 10, 11, 13) prepare meaningful, concise &amp; accurate reports.</td>
</tr>
<tr>
<td>10%</td>
<td>Service as assistant to quality assurance task force with providers, ODHS &amp; other administrative units. Prepares summary &amp; in-depth reports regarding same.</td>
<td>Knowledge of 2, 4; ability to 9, 12.</td>
</tr>
</tbody>
</table>

Additional Qualifications:

Requires experience in quality assurance &/or utilization review activities of prepaid health plans or public assistance providers & recent experience in clinical activities pertaining to medical services for public assistance &/or other populations groups.

This position requires a valid Ohio State Registered Nursing License, a valid Ohio Driver's License & the ability to travel overnight.

List Position Numbers and Class Titles of Positions Directly Supervised

Signature of Agency Representative: [Signature]
Date: 8/24/93
APPENDIX C

Committee & Workgroup Composition
in Demonstration States
APPENDIX D

Minnesota Prenatal Care & Childhood Immunization

Instruments for Focussed Study
MINNESOTA QARI DEMONSTRATION PROJECT
PREGNATAL CARE INSTRUMENT

Introductory Screen

1. Date abstracted: 
   (Mandatory; Automatic from computer)

2. Abstracter ID number: 
   (3-digit alpha-numeric)

3. Health plan number: 
   (Mandatory; 3-digit numeric)

4. NCQA line number: 
   (Mandatory; 4-digit numeric)

Abstraction Elements

5. Medical Assistance ID number: 
   (from an 8-16 digit alphanumeric. Not mandatory)

6. Mother's Date of birth: 
   (Mandatory; Calculate age at the time of delivery (see question 12) from date entered. Allow between and including ages 10 to 50 for this question. Allow 9s in this field. If date is entered outside this range, flash this message:

"This date falls outside the study parameters. Please check date and re-enter.")

7. Name:
   Last               First              Middle Initial
   (Mandatory only if question 5 is not complete; 15-digit alpha field for last, and 15-digit field for first, and a one-digit alpha for the middle initial. Add a line comment section under this variable.)

8. Health plan member ID number: 
   (16-digit numeric)

9. Enrollment (coverage) date: 

Legend: Plain type=study questions; Bold type=additional text to be shown to abstracter; Bold italic type=programming instructions.
10. Is the enrollee’s medical record available for abstraction? (Y or N) ___ (Mandatory. If "Y" entered, allow abstractor to proceed with next question. If "N" entered, skip to end message.)

11. Race of mother: ___ (Enter only one answer.)

   a. White, not of Hispanic origin
   b. Black, not of Hispanic origin
   c. Native American
   d. Asian or Pacific Islander
   e. Hispanic
   f. Other/Mixed
   g. Unknown

"If the pregnancy under study resulted in multiple births, please press "M"."

(Note to programmer: If "M" is pressed, "pop-up" questions 12 through 15 on one screen (if possible) under the following headings: Baby # 1 Baby # 2 Baby #3. Questions 12 through 15 should be placed under each heading. The following should be placed above the headings:

"For each baby, complete the following information."

12. Delivery date: ________

(Mandatory. Allow dates from January 1, 1993 through December 31, 1993.)

13. Type of delivery: _____

   a. Vaginal, no prior C-Section
   b. Vaginal, with prior C-Section
   c. C-Section
   d. Unknown

(Programmer: Allow only one answer for each baby for Q 13.)

14. Pregnancy outcome: _____

   a. Live birth
   b. Fetal death
(Programmer: Allow only one answer for each baby for Q 14 and 15.)

15. Enter the estimated gestational age of the newborn at the time of delivery:
   ___________ weeks

16. Baby's birth weight: ___________ grams

   "If grams are not available, press ___ (Programmer—please designate.) to fill in pounds/ounces."

   (Programming instructions: If grams are completed, use this number and proceed to the next question. If grams are not available, abtractor will push the designated key, and a pop-up screen should appear which looks like this:)

Please enter the pounds and ounces of the newborn:

   ___________ pounds ___________ ounces

   (Programmer: If pounds and ounces is entered, convert this to grams using the following formula:

   Convert pounds to grams: multiply pounds by 16. Add to ounces. Multiply this number by 28.35 grams. Place this number in the space designated for grams above. Remember, in the case where there are multiple births (where "M" is pressed, three of these should be available on the screen.))

17. Date of last menstrual period:
   ___________

18. Date of the first sonogram performed:
   ___________

   (Programmer: For Q17, do not allow dates outside the following parameters: Q12-330 days to the date in Q12. If Q18 is used, pop-up Q19. Allow use of 9s to fill in for missing data.)

19. Estimated weeks gestation at the time of the first sonogram:

   a. If documented in weeks and days:
      ___________ weeks ___________ days

      "If the "days" portion of the estimated gestational age is in decimal form, press ___." (Programmer—please specify. If this option is chosen, pop-up the text in b.)

   (Programming instructions: If days are less than or equal to 3, take only the number of weeks. If days are greater than 3, add one week to
the response in the weeks field and store for future calculations.)

b. If days are documented ONLY in decimal tenths: ___.___ weeks

(Programming instructions: If decimal is less than or equal to 4, take only the number of weeks for future calculations. If decimal is greater than or equal to 5, add one week to the response for weeks and store for future calculations.)

(Programming instructions: allow only one response in either a. or b. for this question.)

(Programming: If there is no answer in Qs 17 or 18, pop-up the following message:

"Since dates for last menstrual period or sonogram are not available, please check for an EDD/EDC elsewhere in the record."

20. Estimated date of delivery from other sources: ___/___/___

Enter the code corresponding to the source in determining the EDD/EDC: ___

1-Menstrual dates 3-Other source
2-Sonography 4-Source not documented

(Programming: The following logic will prevail in using questions 17 through 20 to determine the estimated weeks gestation at enrollment:

- if question 17 is complete, and question 18 is not, use question 17;
- if question 18 is complete and question 17 is not, use 18;
- if question 18 is complete, always pop-up question 19;
- if neither question 17 or 18 are complete, "pop-up" question 20;
- if both questions 17 and 18 are complete,
  • and question 19 is > 22 weeks; use question 17 for further data analysis; or
  • if question 19 is less than or equal to 22 weeks; use questions 17 and 18 for further data analysis.

21. Were any prenatal care visits scheduled or did any prenatal care visits occur for this enrollee during the pregnancy? (Y/N) ___

(Programming: If yes, go on to question 22. If no, skip to question 24.)
22. Enter the dates of all visits and failed visits occurring within the following time frame:

Date = Q.12-330 days to Date = Q.12

Also enter if the visit was completed (C) or failed/canceled (F).

(*Programmer: For each date entered below, the date should not be later than Q12 or earlier than (Q12 - 330 days). If a date is entered outside this range, flash a message:

"This date falls outside the member's pregnancy dates. Please re-enter."*)

<table>
<thead>
<tr>
<th>Date</th>
<th>Completed or Failed visit?</th>
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<tbody>
<tr>
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<td>(Enter C or F)</td>
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</table>

etc. to 24.

(*Programming instructions:*

*Automatically order the dates chronologically as they are entered. Allow a comment option at end of date series. If a date is entered, a "C" or "F" is required. If a duplicate date is entered, "pop-up" a message indicating a duplicate and allow abstractor an option to enter duplicate date.*)

23. Enter the code from the list below for each risk factor assessed at any time between the following dates:
Date = Q.12-330 days to Date = Q.12

1-Screened at least once; negative findings throughout pregnancy
2-Screened at least once; positive findings at any time during the pregnancy
3-Screened at least once; unclear findings
4-No screening documented

a. History of preterm labor
b. Current use of "street" drugs
c. Current use of alcohol
d. Current use of tobacco
e. Current nutritional status/needs
f. Chlamydia screen/test performed during pregnancy

(Programming instructions: Each entry a. through f. is a mandatory field. Allow a comment section to "pop-up" at the end of the series.)

25. The following prenatal risk assessment documentation forms were found in the medical record (answer Y or N for each):

a. Minnesota Medical Assistance Prenatal Risk Assessment Form (DHS Form # 2867)

b. Minnesota Unified High Risk Assessment Form (DHS Form # 3060)

c. Other form or section of a preprinted form specifically itemizing prenatal risk assessment

(Programming instructions: Each entry a. through c. is a mandatory field. If a "Y" is inserted in c., "pop-up" a comment screen with the following format:

Please insert the name/number of form: __________________________.)

Below are fields for optional use by each health plan. For instructions on how to use these fields, please consult with your health plan project manager.

26. Was there indication that the member’s pregnancy was intended? ___

Y = yes
N = no

27. ___
(Programming instructions: Please allow a comment section for each of the question from 24 through 34. Also allow abstractor to exit at any time while in this section.)
Childhood Immunization
THE MINNESOTA QARI DEMONSTRATION PROJECT

Study Description For Assessment of Childhood Immunizations

Instructions for Identifying Enrollees for the Childhood Immunization Study

In selecting the sample of enrollees for the study, a two-step process will be followed.

I. Drawing the Sample Frame

The Department of Human Services staff will identify the children eligible for inclusion in the study by first identifying enrollees in each health plan according to the following specifications:

a. All Medicaid enrollees who were or attained 2-years of age in the 12 months from September 1, 1992 through August 31, 1993 (e.g., birth dates between September 1, 1990 and August 31, 1991). The total number of children meeting this criterion will be reported.

b. From this group a subset of all members enrolled continuously between the ages of 18 months to 24 months. The total number of children meeting this criterion will be reported.

c. For each member the following will be identified:

- name (last name, first name);
- date of birth;
- sex;
- zip code; and
- Medical Assistance (MA) ID number.

d. The information from c. will be sorted by ascending MA ID number.

1 "Paper" disenrollment is not a criterion for omission from the sample. Paper disenrollment is defined as a disenrollment period of less than 31 days from one health plan, provided re-enrollment occurred in the same health plan without a break in service.
II. Choosing the Random Sample

From the list produced in d. above, a random sample of 100 enrollees will be chosen by NCQA.

In the case where less than 100 enrollees are eligible for the study using the above criteria, all enrolled children meeting the criteria will be included in the study.

The Abstraction Process

This phase of the study is divided into two steps: I.) Selection and training of the abstractors; and, II.) Medical record abstraction.

I. Selection and Training of Abstractors

NCQA will select and train qualified abstractors to abstract the medical records chosen for the study.

II. Medical Record Abstraction

NCQA request that copies of the records chosen for abstraction be forwarded from the health plans to NCQA by a specified date. The records will be abstracted by trained abstractors, and key-punched into a data file.

Results

Results of the data collection and validation processes will be analyzed by NCQA. Plan-specific immunization and immunizing rates, among other elements, will be reported to the Department of Human Services and the health plans.
THE MINNESOTA QARI DEMONSTRATION PROJECT

Childhood Immunization Tool Content

Introductory Information

1. Date abstracted: 
   
   (Mandatory)
   mm/dd/yy

2. Abstractor ID number: 
   
   (3-digit alpha-numeric)

3. Health plan number: 
   
   (Mandatory; 3-digit numeric)

Choose one of the following to indicate your health plan:

- 050 Medica
- 051 Group Health, Inc.
- 053 Metropolitan Health Plan
- 054 Blue Plus
- 056 UCare Minnesota
- 060 Itasca Medical Center (IMCare)
- 089 RamseyCare/NWNL

4. NCQA line number 
   
   (3-digit numeric)

Abstraction Elements

5. Medical Assistance ID number: 
   
   (up to a 16-digit alpha-numeric)

6. Date of birth: 
   
   mm/dd/yy (Do not allow from outside the following range: September 1, 1990 through August 31, 1991)

7. Name: 

   Last  First  Middle Initial
   
   (15-digit alpha field for last, 15-digit field for first, and a one-digit alpha for the middle (middle should be optional).
8. Is the enrollee's medical record available for abstraction? (Y or N) (If yes, complete remainder of the tool. If no, abstraction is complete.)

9. Zip code: (5-digit numeric)

10. Health plan member ID number: (16-digit alpha-numeric)

11. Race (enter one of the following): (Enter only one answer).
   a. White, not of Hispanic origin
   b. Black, not of Hispanic origin
   c. Native American
   d. Asian or Pacific Islander
   e. Hispanic
   f. Other/Mixed
   g. Unknown

12. Please complete the immunization record contained in the following grid. All spaces in the grid should be filled with a designated date or letter.

   a. In the shaded grid below, insert the appropriate codes for each vaccine administered to the member between the following dates:

      from _________ (Q6) to _________ (Q6 + 2-years).

      (Abstractor: insert dates).

      Also include in the graph any parental refusals or contraindications to vaccines.

      Below is a chart which indicates the number and type of immunizations required for a child to be considered fully immunized by the age of 2. Use this as your guide to determine if a child is fully immunized by the age of 2.

      | Immunization | Required Number By Age Two |
      |--------------|-----------------------------|
      | Polio        | 3                           |
      | DTP          | 4                           |
      | MMR          | 1                           |
      | Hib          | 3 or 4                      |
      | Hepatitis B  | 0-4                         |
### A. Immunization Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Health Care Event (Enter a V, A, or F)</th>
<th>Was the service rendered out-of-plan? (Enter a Y or N)</th>
<th>Contraindications/Refusals</th>
<th>DTP</th>
<th>DT</th>
<th>Polio (Enter a Y or N in the columns E through J)</th>
<th>HiB</th>
<th>MMR</th>
<th>Hep B</th>
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b. If the member did not receive all the vaccines as specified under a., insert all encounters or potential encounters with the health care system between the ages of 18-months to 2-years in the designated chart.

Record the encounter or potential encounter dates between the following dates in the medical record:

________________ (Q6 + 18-months) to ____________ (Q6 + 2-years)
(Abstractor: insert dates).
<table>
<thead>
<tr>
<th>Date</th>
<th>Health Care Event (Enter a V, A, or F)</th>
<th>Was the service rendered out-of-plan? (Enter a Y or N)</th>
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<th>Health Care Event</th>
<th>Was the service rendered out-of-plan?</th>
<th>Contraindications/Refusals</th>
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CODES

COLUMN B--HEALTH CARE EVENT

Your options for characterizing this encounter are:

V  Visit;
A  Attempted Notification; or
F  Failed visit;

Enter one of the above letters for each encounter with the health care system in the time frame identified at the top of the immunization record.

COLUMN C--WAS THE SERVICE RENDERED OUT-OF-PLAN?

Your options for characterizing this encounter are:

Y  A specific reference to services received in a location or by an out-of-plan provider are present in the documentation for this vaccine or visit;
N  There is not a specific reference to services received in a location or by a provider not affiliated with the health plan.

Enter one of the above letters for each vaccine administered or encounter with the health care system from 18 through 24 months of age."

COLUMN D--CONTRAINDICATIONS/REFUSALS

Your options for characterizing this encounter are:

C  Indicates a contraindication to the vaccine existed (after entering a "C" a pop-up screen will appear which allows you to choose the contraindication documented in the medical record*).
N  Indicates a contraindication and/or refusal were not documented;
R  Indicates parental/guardian refusal of vaccine;

*When "C" is entered, include the following information in the same cell. Contraindications to immunization are listed below. Choose only one to describe the reason the child did not receive the immunization/s:
01. Anaphylactic reaction to vaccine
02. Anaphylactic reaction to vaccine constituent
03. Moderate to severe illness, with or without fever (see guidelines for definitions of this item)
04. Encephalopathy within 7-days of administration of previous dose of
05. Fever 40.5 C (105 F) or higher within 48-hours after prior dose
06. Collapse or shock-like state within 48-hours after prior dose
07. Seizures within 3-days of prior dose
08. Persistent inconsolable crying lasting longer than 3 hours within 48 hours of prior dose
09. Infection with HIV or household contact with HIV
10. Anaphylactic reaction to neomycin or streptomycin
11. Anaphylactic reaction to egg ingestion or neomycin
12. Known altered immunodeficiency (hematologic and solid congenital immunodeficiency; long-term immunosuppressive therapy)
13. Recent (within 3-months) immunoglobulin (Ig) administration

In the case where a contraindication to immunization is documented which does not appear in the numbers 01 to 13 above, use the following code:

14. Other--any other contraindication to vaccination which is documented in the medical record but does not appear on the above list. If documentation refers to a contraindication, but the contraindication is not described in the medical record, choose this option.

COLUMN E THROUGH J--VACCINES/ANTIGENS

Your options for characterizing this encounter are:

Y  Indicates vaccine was administered;
N  Indicates vaccine was not administered;

Enter one of the above letters for each encounter with the health care system in the time frame identified at the top of the immunization record.
APPENDIX E

Quality Assurance Standards for Managed Care Plans
(Commercial & Medicaid) in Ohio and Minnesota
Quality Assurance Standards for Managed Care Plans
(Commercial & Medicaid) in Ohio
ORGANIZATION AND PROCESS

I.A. Type of organization/background/purpose

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.

I.B. Frequency of review/period of effectiveness

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.C. Review team requirements

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.

I.D. Review process/Components of review

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.

I.E. Status conferred

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.F. Release of information

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].
I.G. Fee

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)].

OPERATIONS

II.A. Enrollment composition

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)(f)].

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)].

II.B. Incentive arrangements

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].

II.C. Network adequacy

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)].
II.C. Network adequacy (cont'd.)

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)].

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].
II.D. Access/Timeliness of service

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].

II.E. Preventive health

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.F. Medical records

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)(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)].

II.G. Continuity of care

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;
II.G. Continuity of care (cont’d.)

- 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)].

II.H.1. Quality assurance program/Program description/Activities

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

- 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)].

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)].

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

**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)].
II.H.3. Quality assurance program/Structure

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)].

II.H.4. Quality assurance program/Resources, people and material

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)].

II.H.5. Quality assurance program/Performance measurement

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)].
II.H.6. Quality assurance program/Systematic data collection

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)].

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)].

II.H.7. Quality assurance program/Peer review/Practitioner participation

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 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 5101:3-26-071(B)].

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

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
II.H.8. Quality assurance program/Continuous improvement plan/Process (cont’d.)

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.9. Quality assurance program/Effectiveness assessment

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)].

II.I. External review

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.
II.I. External review (cont’d.)

*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.J.1. Credentialing/Recredentialing/Frequency

*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)].

II.J.2. Credentialing/Recredentialing/Verification

*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
II.J.2. Credentialing/Recredentialing/Verification (cont’d.)

- 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)].

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.
II.J.2. Credentialing/Recredentialing/Verification (cont’d.)

- 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)].

II.K. Utilization management/Underutilization

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)].

II.L. QA integration into operations

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.M. Complaint resolution

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.N. Rights and responsibilities--Plan

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;
II.N. Rights and responsibilities--Plan (cont’d.)

- 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.O. Rights and responsibilities--Member

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;
II.O. Rights and responsibilities--Member (cont’d.)

- 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)].

II.P. Member satisfaction

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)].

II.Q. Accountability

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].
II.Q. Accountability (cont’d.)

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)].

II.R. Delegation

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)].

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)].
II.S. Provider contracts

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].

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)].

II.T. Information systems adequacy

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].
II.T. Information systems adequacy (cont’d.)

Start Eligible Populations in Ohio, State of Ohio Department of Human Services, May 19, 1994, V.4, p. 22-23].

**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].

II.U. Confidentiality

**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 5101:3-26-077(A)(3)].

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)].
II.V. Cultural sensitivity

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(D)(2)].

The subcontractor 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.W. Consumer participation

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.11].
Quality Assurance Standards for Managed Care Plans
(Commercial & Medicaid) in Minnesota
MINNESOTA

ORGANIZATION AND PROCESS

I.A. Type of organization/background/purpose

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.

I.B. Frequency of review/period of effectiveness

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.
I.C. Review team requirements

**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.

I.D. Review process/Components of review

**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 inspect any 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, II.D.1-4].

I.E. Status conferred

**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.
I.F. Release of information

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].

I.G. Fee

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.

OPERATIONS

II.A. Enrollment composition

No standard specified.

II.B. Incentive arrangements

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].
II.C. Network adequacy

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].

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].

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].
II.D. Access/Timeliness of service

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.(1)].

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.(1)].

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].

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].
II.D. Access/Timeliness of service (cont’d.)

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 to 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.E. Preventive health

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, MMO, 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].

II.F. Medical records

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].

II.G. Continuity of care

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].
II.G. Continuity of care (cont’d.)

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].

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].

II.H.1. Quality assurance program/Program description/Activities

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.

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

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].

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

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.

II.H.3. Quality assurance program/Structure

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].

II.H.4. Quality assurance program/Resources, people and material

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].
II.H.5. Quality assurance program/Performance measurement

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].

II.H.6. Quality assurance program/Systematic data collection

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(c)].

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.

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].

II.H.7. Quality assurance program/Peer review/Practitioner participation

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].
II.H.7. Quality assurance program/Peer review/Practitioner participation (cont’d.)

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

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].

II.H.9. Quality assurance program/Effectiveness assessment

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.I. External review

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].
II.J.1. Credentialing/Recredentialing/Frequency

No standard specified.

II.J.2. Credentialing/Recredentialing/Verification

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].

II.K. Utilization management/Underutilization

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.L. QA integration into operations

No standard specified.
II.M. Complaint resolution

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.
II.M. Complaint resolution (cont’d.)

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.N. Rights and responsibilities--Plan

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].
II.N. Rights and responsibilities--Plan (cont’d.)

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.O. Rights and responsibilities--Member

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.)

**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].

II.P. Member satisfaction

**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].

II.Q. Accountability

**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].
II.R. Delegation

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].

II.S. Provider contracts

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].

II.T. Information systems adequacy

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].

II.U. Confidentiality

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].
II.U. Confidentiality (cont’d.)

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].

II.V. Cultural sensitivity

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].
II.W. Consumer participation

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. 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].
APPENDIX F
Modified Internal Quality Assurance Standards
Developed for Washington State
I. WRITTEN QUALITY ASSURANCE PROGRAM DESCRIPTION - The Contractor shall have a written description of its quality assurance program. This description shall contain quality assurance objectives and shall include a timetable for implementation and accomplishment.

The scope of the quality assurance program shall be comprehensive, addressing both the quality of clinical care and the non-clinical aspects of service and shall assure that all demographic groups, care settings, and types of services are included in the scope of the review. (This review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.)

The quality assurance program shall provide for review by providers of the process followed in the provision of health services; and feedback to providers and other Contractor staff regarding performance and patient results.

II. SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT - The Contractor shall objectively and systematically monitor and evaluate the quality and appropriateness of care and service to Members, through quality of care studies and related activities, and shall pursue opportunities for improvement on an ongoing basis.

III. ACTIVE QA COMMITTEE - The Contractor shall maintain an active QA committee or other structure which shall be responsible for carrying out the planned activities of the quality assurance program. This Committee or other structure shall have regular meetings, shall demonstrate active participation by providers, and shall be accountable and report regularly to the governing body or its designee for quality assurance and quality improvement. The Contractor shall maintain records documenting the committee's findings, recommendations, and actions.

IV. SUPERVISION - The Contractor shall designate a senior executive who shall be responsible for program implementation. The Contractor's Medical Director shall have substantial involvement in QA activities.

V. DELEGATION OF QUALITY ASSURANCE PROGRAM ACTIVITIES - The Contractor shall remain accountable for all quality assurance program functions, such as credentialing, and utilization review, which are delegated to other entities.

VI. CREDENTIALING - The Contractor shall have written policies and procedures for provider credentialing that identify those providers who fall under its scope of authority and action. The Contractor shall obtain and review verification of the following information, at a minimum:

1. the practitioner holds a current valid license to practice;
2. valid CEA or CDS certificate, as applicable;
3. graduation from medical school and completion of a residency or other post-graduate training, as applicable;
4. work history;
5. professional liability claims history;
6. good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility. (This requirement may be waived for practices which do not have or do not need access to hospitals.)
7. the practitioner holds current, adequate malpractice insurance according to the plan's policy;
8. any revocation or suspension of a state license or DEA/BNDD number;
9. any curtailment or suspension of medical staff privileges (other than for incomplete medical records).
10. any sanctions imposed by Medicare and/or Medicaid; and

11. any censure by the State or County Medical Association.

12. The organization requests information on the practitioner from the National Data Bank and the State Board of Medical Examiners.

13. The application process includes a statement by the applicant regarding:

   a. any physical or mental health problems that may affect current ability to provide health care;

   b. any history of chemical dependency/substance abuse;

   c. history of loss of license and/or felony convictions;

   d. history of loss or limitation of privileges or disciplinary activity; and

   e. an attestation to the correctness/completeness of the application.

The Contractor shall use this information to evaluate the practitioner’s current ability to practice.

VII. MEDICAL RECORD STANDARDS - The Contractor shall set standards for medical records. The records shall reflect all aspects of patient care, including ancillary services. These standards shall, at a minimum, include requirements for:

1. patient identification information - Each page or electronic file in the record contains the patient’s name or patient ID number.

2. personal/biographical data - Personal/biographical data includes: age, sex, address, employer, home and work telephone numbers, and marital status.

3. entry date - All entries are dated.

4. provider identification - All entries are identified as to the author.

5. legibility - The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.

6. allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies - NKA) is noted in an easily recognizable fashion.

7. past medical history - (for patients seen 3 or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For children, past medical history relates to prenatal care and birth.

8. immunizations - for pediatric records (ages 12 and under) there is a completed immunization record or a notation that immunizations are up-to-date.

9. diagnostic information

10. medication information

11. identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record.

12. smoking/ETOH substance abuse - Notation concerning cigarettes and alcohol use and substance abuse is present (For patients 12 years and over and seen 3 or more times.) Abbreviations and symbols may be appropriate.

13. consultations, referrals, and specialist reports - Notes from any consultations are in the record. Consultation,
lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of follow-up plans.

14. emergency care

15. hospital discharge summaries - Discharge summaries are included as part of the medical record for: (1) all hospital admissions which occur while the patient is enrolled in the managed care organization and (2) prior admissions as necessary.

16. advance directives - As stipulated in Article V Section 5.6c of this Contract.

17. documentation of individual encounters shall provide adequate evidence of, at a minimum:
   a. History and physical examination - Appropriate subjective and objective information is obtained for presenting complaints.
   b. plan of treatment;
   c. diagnostic tests;
   d. therapies and other prescribed regimens;
   e. follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months or PRN. Unresolved problems from previous visits are addressed on subsequent visits.
   f. referrals and results thereof; and
   g. all other aspects of patient care, including ancillary services.

VIII. UTILIZATION REVIEW - the Contractor shall have a utilization management program which is consistent with 42 CFR 456 and includes mechanisms to detect underutilization as well as overutilization.

Effective date: January 1, 1995

Revised:

Note: Additional requirements similar to QARI on patient rights and responsibilities, grievance procedures, and a requirement that the plan provide access to its facilities and financial and medical records are contained in other portions of the plan contract.
APPENDIX G

State of Ohio

Baseline Assessment Instrument to Determine
Managed Care Plan Compliance

with QARI Internal Quality Assurance Program (IQAP) Standards
Ohio Department of Human Services
30 East Broad Street, Columbus, Ohio 43266-0323

September 8, 1993

TO: Administrators of Medicaid-Serving HMOs
FROM: Jennifer Jisa Lopez, Ohio QARI Project Director
SUBJECT: QAP BASELINE ASSESSMENT FOR OHIO QARI PROJECT

As part of the Quality Assurance Reform Initiative (QARI) project, Ohio's Medicaid-serving HMOs are asked to complete a baseline assessment survey about their internal Quality Assurance Programs (QAPs). The QAP standards listed in the survey were taken from Chapter 2 of HCFA's QARI guidelines. After QARI has been implemented in Ohio, HMOs will be asked to complete another self-assessment survey. Comparing the results of both surveys will help the HMO and ODHS determine the impact and success of QARI. The QAP standards might also be used by an EQRO in the annual QA surveys.

Your copy of the QAP baseline (self) assessment survey is enclosed. Please complete the survey by circling the number that best indicates your HMO's status with regard to the corresponding statement. Should you want to comment or describe any of your survey responses, feel free to do so in the margins or on back of the pages.

Circle Number: If statement shows:

5 = Substantial compliance - all major components are met
4 = Significant compliance - most of the components are met
3 = Partial compliance - some of the components are met
2 = Minimal compliance - few components are met
0 = No compliance - no components are met

The results of the survey will be confidential. Results will be used only by the state, the HMO and QARI evaluator Mathematica to assess strengths and shortcomings of the HMO's QAP throughout implementation of QARI.
Thank you for taking the time to complete your baseline assessment. Please return a copy of your survey to me before noon on September 30, 1993. Mathematica and/or I will review your HMO's results with you after all surveys have been tabulated. If you have questions or concerns, please feel free to call me at (614) 466-4693.

JL:jl

Enclosure

cc: Cynthia Burnell, Chief, MHCS 
Ruth Vowell, R.N., MHCS
QUALITY ASSURANCE PROGRAM (QAP)  
BASELINE ASSESSMENT FOR QARI PURPOSES  

September 8, 1993

Name of Plan or Organization: _______________________________

Name of Contact Person: ___________________________ Phone: ____________

Initial Assessment (pre-QARI)/Date Completed: ________________________

Final Assessment (post-QARI)/Date Completed: ________________________

Note: Further explanation/clarification of the specific standards in this document can be found in Chapter 2 of HCFA's QARI guidelines.

STANDARD I: WRITTEN QAP DESCRIPTION

A. The organization has a written description of its QAP that contains a detailed set of QA objectives that are developed annually and include a timetable for implementation and accomplishment. 5 4 3 2 0

B. The QAP is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination and continuity of care. 5 4 3 2 0

C. The QAP methodology provides for review of the entire range of care provided by the organization, by assuring that all demographic groups, care settings (e.g. inpatient, ambulatory [including care provided in private practice offices] and home care), and types of services (e.g. preventive, primary, specialty care, and ancillary) are included in the scope of the review. (This review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.) 5 4 3 2 0
D. The written description specifies quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them.

E. Individuals responsible for the studies and other activities are clearly identified and are appropriate.

F. The written description provides for continuous performance of the activities, including tracking of issues over time.

G. The QAP provides for review by physicians and other health professionals of the process followed in providing health services; and for feedback to health professionals and HMO staff regarding performance and patient results.

H. The QAP addresses health outcomes consistent with existing technology.

STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT

A. The QAP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.

B. The QAP specifies clinical or health services delivery areas to be monitored reflecting the population served in terms of age groups, disease categories, and special risk status; and at a minimum, care and services in certain priority areas of concern (preferably from HCFA guidelines, and jointly determined by the state and the organization).
C. Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area.

D. Clinical care standards/practice guidelines are used in quality assessment and improvement studies.

E. 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 and related service. For quality issues identified in the QAP's targeted clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines. Clinical and related service areas requiring improvement are identified.

F. The QAP includes written procedures for taking appropriate remedial action whenever, as determined under the QAP, inappropriate or substandard services are furnished, or services that should have been furnished were not.

G. The organization monitors and evaluates the effectiveness of corrective actions.

H. The organization conducts a regular and periodic examination of the continuity and effectiveness of the QAP. At the end of each year, a written report on the QAP is prepared, which addresses QA studies and other activities completed, trending of clinical and service indicators and other performance data, demonstrated improvements in quality, areas of deficiency and recommendations for corrective action, and an evaluation of the overall effectiveness of the QAP. There is evidence that QA activities have contributed to significant improvements in the care delivered to members.
STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY

A. The organization's governing body is the board of directors or a designated committee of senior management. 5 4 3 2 0

B. Documentation exists that the governing body has approved the overall QAP and an annual QA plan. 5 4 3 2 0

C. The governing body formally designated an accountable entity or entities within the organization to provide oversight of QA. 5 4 3 2 0

D. The governing body routinely receives written reports from the QAP describing actions taken, progress in meeting QA objectives and improvements made. 5 4 3 2 0

E. The governing body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QAP which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered, to assess the QAP's continuity, effectiveness and current acceptability. 5 4 3 2 0

F. The governing body takes action regarding the QAP when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review findings and issues of concern with the organization. 5 4 3 2 0

G. When the governing body takes action, it is documented in the minutes of the meetings of the governing board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Assurance. 5 4 3 2 0

STANDARD IV: ACTIVE QA COMMITTEE

A. The QAP delineates an identifiable structure (committee) responsible for performing QA functions within the organization. 5 4 3 2 0
B. The committee meets on a regular basis with specified frequency to oversee QAP activities.

C. The roles, structure and function of the committee are specified.

D. Documentation exists of the committee's activities, findings, recommendations and actions.

E. The QA committee is accountable to the governing body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.

F. Active participation exists in the QA committee from health plan providers who are representative of the composition of the health plan's providers.

STANDARD V: QAP SUPERVISION

A. A designated senior executive is responsible for QAP implementation and the organization's medical director has substantial involvement in QA activities.

STANDARD VI: ADEQUATE RESOURCES

A. The QAP has sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.

STANDARD VII: PROVIDER PARTICIPATION IN THE QAP

A. Participating physicians and other providers are informed about the written QAP.

B. Organization includes in all its provider contracts and employment agreements, for both physicians and non-physician providers, a requirement securing cooperation with the QAP.
C. Contracts with hospitals and other contractors are written to allow the organization access to its members' medical records.

STANDARD VIII: DELEGATION OF QAP ACTIVITIES

A. Organization remains accountable for all QAP functions, even if certain functions are delegated to other entities.

B. If organization delegates any QA activities, there is a written description of: the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the managed care organization.

C. Organization has a written procedure for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

D. Evidence exists of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

STANDARD IX: CREDENTIALING AND RE-CREDENTIALING OF PROFESSIONALS

A. Written policies and procedures exist for the initial credentialing of practitioners, as well as subsequent recredentialing, recertifying and/or reappointment of practitioners.

B. Governing body has reviewed and approved the credentialing policies and procedures.

C. A credentialing committee or other peer review body is designated to make recommendations regarding credentialing decisions.
D. Practitioners who fall under the organization's scope of authority and action are identified in the organization's literature.

E.1. Initial credentialing process verifies that practitioners hold current valid licenses to practice.

E.2. Initial credentialing process verifies that practitioners have valid DEA or CDS certificates, as applicable.

E.3. Initial credentialing process verifies that practitioners have graduated from medical school and completed a residency, or other post-graduate training, as applicable.

E.4. Initial credentialing process reviews the work history of practitioners.

E.5. Initial credentialing process reviews for a history of professional liability claims.

E.6. Initial credentialing process verifies if the professional is in good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility.

E.7. Initial credentialing process verifies the practitioner holds current, adequate malpractice insurance according to the plan's policy.

E.8. Initial credentialing process verifies the practitioner has not had any revocation or suspension of a state license or DEA/BNDD number.

E.9. Initial credentialing process verifies the practitioner has not had any sanctions imposed by Medicare and/or Medicaid.

E.10. Initial credentialing process verifies any censure by the state or county medical association.
F. Organization requests information on the practitioner from the National Practitioner Data Bank and the State Board of Medical Examiners.

G.1. Practitioner application process includes a statement by the applicant regarding any physical or mental health problems that may affect current ability to provide health care.

G.2. Practitioner application process includes a statement by the applicant regarding any history of chemical dependency/substance abuse.

G.3. Practitioner application process includes a statement by the applicant regarding any history of loss of license and/or felony convictions.

G.4. Practitioner application process includes a statement by the applicant regarding any history of loss or limitation of privileges or disciplinary activity.

G.5. Practitioner application process includes a statement by the applicant regarding an attestation to correctness/completeness of the application.

H. There is an initial visit to each potential primary care practitioner's office including documentation of conformance with the organization's standards.

I. Recredentialing process for the periodic recredentialing of clinical credentials (recredentialing, reappointment, or recertification) is described in organization's policies and procedures.

J. Recredentialing procedure is implemented at least every two years.
K. Organization conducts periodic reviews of information from the National Practitioner Data Bank along with performance data on all physicians to decide whether to renew the participating physician agreement.

L. Recredentialing process includes reviewing member complaints, results of quality reviews, utilization management, the member satisfaction surveys, and re-verification of hospital privileges and current licensure.

M. If organization delegates the credentialing/recredentialing activities, there is a written description of the delegated activities, and the delegate's accountability for these activities.

N. Evidence exists that the delegate accomplished the credentialing activities.

O. Organization monitors the effectiveness of the delegate's credentialing/recredentialing process.

P. Organization retains the right to approve new providers and sites, and to terminate or suspend individual providers.

Q. Organization has policies and procedures for the suspension, reduction or termination of practitioner privileges.

R. Organization has a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.

S. A provider appellate process is in place for instances where the organization chooses to reduce, suspend or terminate a practitioner's privileges with the organization.
STANDARD X: ENROLLEE RIGHTS AND RESPONSIBILITIES

A. Organization has a written policy that recognizes enrollee rights. 5 4 3 2 0

B.1. Members' policy of rights addresses their right to be treated with respect, and recognizes their dignity and need for privacy. 5 4 3 2 0

B.2. Members' rights outlines information about the organization, its services, the practitioners providing care, and member rights and responsibilities. 5 4 3 2 0

B.3. Members' rights informs patients they are able to choose a primary care practitioner, within the limits of the plan network, including the right to refuse care from specific practitioners. 5 4 3 2 0

B.4. Members' rights informs patients of their right to participate in decision-making regarding their health care. 5 4 3 2 0

B.5. Members' rights informs patients of their right to voice grievances about the organization or care provided. 5 4 3 2 0

B.6. Members' rights informs patients of their right to formulate an advance directive. 5 4 3 2 0

B.7. Members' rights informs patients of their right to have access to their medical records in accordance with applicable federal and state laws. 5 4 3 2 0

C. Organization has a written policy that addresses members' responsibility for cooperating with those providing health care services. 5 4 3 2 0

D.1. Members' responsibility policy addresses members' responsibility for providing, to the extent possible, information needed by professional staff in caring for the member. 5 4 3 2 0
D.2. Members' responsibility policy addresses members' responsibility for following instructions and guidelines given by those providing health care services.

E. All participating providers have a copy of the organization's policies on members' rights and responsibilities.

F.1. Members are provided on enrollment a written statement that outlines their rights and responsibilities as a member.

F.2. Members are provided on enrollment a written statement that outlines their benefits and services included and excluded as a condition of membership, and how to obtain them.

F.3. Members are provided on enrollment a written statement that outlines any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to service obtained outside the system.

F.4. Members are provided on enrollment a written statement that outlines the procedures for obtaining out-of-area coverage.

F.5. Members are provided on enrollment a written statement that outlines the provisions for after-hours and emergency coverage.

F.6. Members are provided on enrollment a written statement that outlines the organization's policy on referrals for specialty care.

F.7. Members are provided on enrollment a written statement that outlines the charges to members, if applicable.
F.8. Members are provided on enrollment a written statement that outlines organization's procedures for notifying those members affected by the termination or change in any benefits, services, or service delivery office/site.

F.9. Members are provided on enrollment a written statement that outlines organization's procedures for appealing decisions adversely affecting the members' coverage, benefits, or relationship to the organization.

F.10. Members are provided on enrollment a written statement that outlines organization's procedures for changing practitioners.

F.11. Members are provided on enrollment a written statement that outlines organization's procedures for disenrollment.

F.12. Members are provided on enrollment a written statement that outlines organization's procedures for voicing complaints and/or grievances and for recommending changes in policies and services.

G. Organization has a system(s), linked to the QAF, for resolving members' complaints and formal grievances.

H.1. System includes procedures for registering and responding to complaints and grievances in a timely fashion.

H.2. System includes documentation of the substance of complaints or grievances, and actions taken.

H.3. System includes procedures to ensure a resolution of the complaint or grievance.
H.4. System includes aggregation and analysis of complaint and grievance data and use of the data for quality improvement.

H.5. System includes an appeal process for grievances.

I. Members are given the opportunity to offer suggestions for changes in policies and procedures.

J. Accessibility of services offered to members is assured by identifying points of access to primary care, specialty care, and hospital services.

K. Organization explains to members how to obtain services during regular hours of operation.

L. Organization explains to members how to obtain emergency and after-hours care.

M. Organization explains to members how to obtain the names, qualifications and titles of the professionals providing and/or responsible for their care.

N. Member information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood.

O. Written information is available as needed in the languages of the major population groups served. (A "major" population group is one which represents at least 10% of a plan's membership.)

P. Organization has established in writing and enforced policies and procedures on confidentiality, including confidentiality of medical records.
Q. Organization ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization.

R. Organization holds confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and does not divulge it without the enrollee's authorization, unless: a) it is required by law; b) it is necessary to coordinate the patient's care with physicians, hospitals or other health care entities, or to coordinate insurance or other matters pertaining to payment; c) it is necessary in compelling circumstances to protect the health or safety of an individual.

S. Release of information in response to court order is reported to the patient in a timely manner.

T. Organization has written policies regarding the appropriate treatment of minors.

U. Organization conducts periodic surveys of member satisfaction with its services.

V.1. Satisfaction surveys include content on perceived problems in the quality, availability, and accessibility of care.

V.2. Satisfaction surveys assess at least a sample of: a) all Medicaid members, b) Medicaid member requests to change practitioners and/or facilities, c) disenrollment by Medicaid members.

V.3. As a result of the surveys, organization identifies and investigates sources of dissatisfaction, outlines action steps to follow-up on the findings, and informs practitioners and providers of assessment results.
W. Organization re-evaluates the effects of the surveys.

STANDARD XI: AVAILABILITY AND ACCESSIBILITY

A. Organization has established standards for access (to routine, urgent and emergency care; telephone appointments; advice; member service lines), and performance on access is assessed against the standards.

STANDARD XII: MEDICAL RECORD STANDARDS

A. Provisions exist in provider contracts for appropriate access to the medical records of the organization's enrollees for purposes of quality reviews conducted by the Secretary, state Medicaid agencies, or agents thereof.

B. Enrollees' medical records are available to health care practitioners at each encounter.

C.1. Organization takes steps to maintain medical records, either on paper or electronic, in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review. Medical records reflect all aspects of patient care, including ancillary services.

C.2. On each medical record page is the patient's name or patient ID number.

C.3. Medical records have personal/biographical data that includes age, sex, address, employer, home and work telephone numbers, and marital status.

C.4. All entries are dated on the medical records.

C.5. Medical records have all the entries identified as to author.
C.6. Medical records are legible to someone other than the writer. 5 4 3 2 0
C.7. Medical records prominently note the patients' medication allergies; if none, then there is a notation of NKA. 5 4 3 2 0
C.8. Past medical history is easily identified including serious accidents, operations, illnesses. 5 4 3 2 0
C.9. Medical records have completed immunization records or a notation that immunizations are up-to-date. 5 4 3 2 0
C.10. Medical records have diagnostic information. 5 4 3 2 0
C.11. Medical records have medication information. 5 4 3 2 0
C.12. Medical records identify current problems. 5 4 3 2 0
C.13. Medical records of patients 12 years and older who have been seen 3 or more times have notations concerning cigarette and alcohol use and substance abuse. 5 4 3 2 0
C.14. Medical records note consultations, referrals, specialist reports and results thereof. 5 4 3 2 0
C.15. Medical records note emergency care. 5 4 3 2 0
C.16. Medical records contain hospital discharge summaries. 5 4 3 2 0
C.17. Medical records document whether or not the adult patient has executed an advance directive. 5 4 3 2 0

In medical records, patient visit data contains the following components:

D.1. History and physical examination entries: appropriate subjective and objective information is obtained for the presenting complaints. 5 4 3 2 0
D.2. A plan of treatment. 5 4 3 2 0
D.3. Diagnostic tests.  5 4 3 2 0

D.4. Entries from therapies and other other prescribed regimens.  5 4 3 2 0

D.5. Follow-up entries: encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit; specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.  5 4 3 2 0

D.6. Referrals and results thereof.  5 4 3 2 0

D.7. All other aspects of patient care including ancillary services.  5 4 3 2 0

E. A system exists (record review process) to assess the content of medical records for legibility, organization, completion and conformance to the organization's standards.  5 4 3 2 0

STANDARD XIII: UTILIZATION REVIEW

A. Organization has a written utilization management program description which includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.  5 4 3 2 0

B. Utilization program has mechanisms to detect underutilization as well as overutilization.  5 4 3 2 0

For organizations with preauthorization and concurrent review programs:

C.1. Preauthorization and concurrent review decisions are supervised by qualified medical professionals.  5 4 3 2 0

C.2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.  5 4 3 2 0

17
C.3. The reasons for decisions are clearly documented and available to the member.

C.4. There are well-publicized and readily available appeals mechanisms for both providers and patients. Notification of denial includes a description of how to file an appeal.

C.5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.

C.6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.

D. If organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

STANDARD XIV: CONTINUITY OF CARE SYSTEM

A. Organization has a basic system in place which promotes continuity of care and case management.

STANDARD XV: QAP DOCUMENTATION

A. Organization documents that it is monitoring the quality of care across all services and all treatment modalities, according to its written QAP.

B. Organization maintains and makes available to the state, and on request to the Secretary, studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QA activities and corrective actions.
STANDARD XVI: COORDINATION OF QA ACTIVITY WITH OTHER MANAGEMENT ACTIVITY

A. The findings, conclusions, recommendations, actions taken and results of the actions taken as a result of QA activity, are documented and reported to appropriate individuals within the organization and through the established QA channels.

B. QA information is used in recredentialing, recontracting and/or annual performance evaluations.

C. QA activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.

D. A linkage exists between QA and other management functions of the organization such as network changes, benefits redesign, medical management systems (e.g. precertification), practice feedback to physicians, patient education, and member services.
APPENDIX H
State of Washington
Client Satisfaction Survey
Client Satisfaction Survey

SAMPLE
DSHS Form#13-670

"Clients Enrolled In Same Plan"
HEALTHY OPTIONS IS THE MANAGED HEALTH CARE PROGRAM FOR CLIENTS ELIGIBLE FOR MEDICAID. THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS) IS SURVEYING CLIENTS TO SEE HOW HEALTHY OPTIONS AND THE PLANS ARE DOING. A PLAN IS THE INSURER YOUR PRIMARY CARE PROVIDER WORKS WITH. A PRIMARY CARE PROVIDER MEANS YOUR FAMILY OR GENERAL DOCTOR, YOUR CHILD'S DOCTOR, A PHYSICIAN ASSISTANT, A CLINIC, OR AN ADVANCED REGISTERED NURSE PRACTITIONER. WE CHOSE YOUR NAME AT RANDOM TO RECEIVE THIS SURVEY. PLEASE HELP US PROVIDE YOU WITH BETTER MEDICAL CARE BY COMPLETING THIS SURVEY AND RETURNING IT, THIS WEEK, IN THE SELF-ADDRESSED STAMPED ENVELOPE PROVIDED. THE FOLLOWING QUESTIONS ARE ABOUT THE CARE YOU HAVE RECEIVED FROM HEALTHY OPTIONS. YOUR ANSWERS AND COMMENTS ARE CONFIDENTIAL. THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS SURVEY!

IF YOU WOULD LIKE THE STATE TO RESPOND TO SPECIFIC CONCERNS YOU HAVE, YOU MAY WRITE TO: OFFICE OF MANAGED CARE, P.O. BOX 45506, OLYMPIA, WA 98504-5506 OR YOU MAY CALL THE HEALTHY OPTIONS TOLL-FREE LINE 1-800-546-5015.
1. DO YOU KNOW WHO THE PRIMARY CARE PROVIDER IS FOR EACH OF YOUR FAMILY MEMBERS? YES ___ NO ___

2. DID YOU AND/OR YOUR FAMILY CHOOSE YOUR HEALTH CARE PROVIDER OR WERE YOU ASSIGNED, BY THE STATE, A HEALTH CARE PROVIDER? PLEASE CIRCLE YOUR ANSWER: 
   MY CHOICE  ASSIGNED

3. DO YOU UNDERSTAND HOW TO GET HEALTH CARE USING HEALTHY OPTIONS? YES ___ NO ___

4. SINCE JOINING HEALTHY OPTIONS HAVE YOU OR YOUR FAMILY NEEDED HEALTH CARE? YES ___ NO ___. 
   IF NO, YOU DON'T NEED TO COMPLETE THE REST OF THIS SURVEY. PLEASE RETURN IT IN THE ENCLOSED ENVELOPE.

THE REST OF THE QUESTIONS ARE FOR FAMILIES WHO HAVE NEEDED HEALTH CARE SINCE JOINING HEALTHY OPTIONS. WHEN ANSWERING THE QUESTIONS, PLEASE THINK ABOUT THE OVERALL HEALTH CARE EXPERIENCES OF YOUR ENTIRE FAMILY.

5. SINCE JOINING HEALTHY OPTIONS, HOW MANY TIMES HAVE YOU OR YOUR FAMILY GONE TO HEALTH CARE PROVIDERS (DOCTORS, NURSES, CLINICS, PHYSICIAN ASSISTANTS)? ______________

6. SINCE YOU JOINED HEALTHY OPTIONS, HOW WOULD YOU RATE YOUR ABILITY TO SCHEDULE APPOINTMENTS WITH YOUR PRIMARY CARE PROVIDER? PLEASE CIRCLE ONE BELOW:
   
   EXCELLENT  VERY GOOD  GOOD  FAIR  POOR

7. SINCE YOU JOINED HEALTHY OPTIONS, HOW WOULD YOU RATE YOUR ABILITY TO GET APPOINTMENTS WITH HEALTH CARE PROVIDERS SUCH AS THERAPISTS OR DOCTORS WHO ARE SPECIALISTS? PLEASE CIRCLE ONE BELOW:

   EXCELLENT  VERY GOOD  GOOD  FAIR  POOR

BLUE CROSS-CHPW/ADAMS-COLUMBIA/01/7500846  03/01/95 - 12/31/99
RACE: 1  AGE:  44  SEX: 2
DSHS 13-670 (07/94) TRANSLATED  (2)
8. SINCE YOU JOINED HEALTHY OPTIONS, HOW WOULD YOU RATE YOUR SATISFACTION WITH THE HEALTH CARE YOU OR YOUR FAMILY MEMBERS HAVE RECEIVED IN YOUR PLAN FROM YOUR PRIMARY CARE PROVIDER? PLEASE CIRCLE ONE BELOW:

EXCELLENT  VERY GOOD  GOOD  FAIR  POOR

9. SINCE YOU JOINED HEALTHY OPTIONS, HAVE YOU BEEN ABLE TO GET EMERGENCY HEALTH CARE WHEN YOU NEEDED IT?
YES _____ NO _____ NO EMERGENCIES _____

10. SINCE YOU JOINED HEALTHY OPTIONS, HAVE YOU HAD ANY PROBLEMS WITH NOT BEING HOSPITALIZED WHEN YOU NEEDED IT?
YES _____  NO _____

11. SINCE YOU JOINED HEALTHY OPTIONS, HAVE YOU BEEN ASKED TO PAY FOR ANY MEDICAL SERVICES?  YES _____  NO _____

12. ARE YOU GETTING BETTER MEDICAL CARE THROUGH HEALTHY OPTIONS THAN YOU WERE GETTING BEFORE YOU JOINED HEALTHY OPTIONS?
YES _____  NO _____

13. HAVE YOU HAD ANY PROBLEMS WITH HEALTHY OPTIONS?
YES _____  NO _____ IF YOU ANSWERED YES, PLEASE DESCRIBE THE PROBLEMS:

14. PLEASE ADD ANY OTHER COMMENTS YOU THINK WILL HELP US IMPROVE HEALTHY OPTIONS. ATTACH ADDITIONAL SHEETS IF NECESSARY.
Client Satisfaction Survey

SAMPLE
DSHS Form#13-671

"Clients Switching Plans"
HEALTHY OPTIONS IS THE MANAGED HEALTH CARE PROGRAM FOR CLIENTS ELIGIBLE FOR MEDICAID. THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DHS) IS SURVEYING CLIENTS TO SEE HOW HEALTHY OPTIONS AND THE PLANS ARE DOING. A PLAN IS THE INSURER YOUR PRIMARY CARE PROVIDER WORKS WITH. A PRIMARY CARE PROVIDER MEANS YOUR FAMILY OR GENERAL DOCTOR, YOUR CHILD'S DOCTOR, A PHYSICIAN ASSISTANT, A CLINIC, OR AN ADVANCED REGISTERED NURSE PRACTITIONER. WE CHOSE YOUR NAME AT RANDOM, FROM CLIENTS WHO ARE SWITCHING PLANS, TO RECEIVE THIS SURVEY. PLEASE HELP US PROVIDE YOU WITH BETTER MEDICAL CARE BY COMPLETING THIS SURVEY AND RETURNING IT, THIS WEEK, IN THE SELF-ADDRESSED, STAMPED ENVELOPE PROVIDED. THE FOLLOWING QUESTIONS ARE ABOUT THE CARE YOU HAVE RECEIVED FROM THE PLAN YOU HAVE JUST LEFT. YOUR ANSWERS AND COMMENTS ARE CONFIDENTIAL. THANK YOU VERY MUCH FOR TAKING THE TIME TO FILL THIS SURVEY OUT!

IF YOU WOULD LIKE THE STATE TO RESPOND TO SPECIFIC CONCERNS YOU HAVE, YOU MAY WRITE TO: OFFICE OF MANAGED CARE, P.O. BOX 45506, OLYMPIA, WA 98504-5506 OR YOU MAY CALL THE HEALTHY OPTIONS TOLL-FREE LINE 1-800-546-5015.
1. UNDER YOUR PREVIOUS PLAN DID YOU OR A FAMILY MEMBER SEE YOUR PRIMARY CARE PROVIDER? YES ___ NO ___

2. IN YOUR PREVIOUS PLAN DID YOU AND/OR YOUR FAMILY CHOOSE YOUR HEALTH CARE PROVIDER OR WERE YOU ASSIGNED, BY THE STATE, A HEALTH CARE PROVIDER? CIRCLE YOUR ANSWER:

   MY CHOICE  ASSIGNED

3. UNDER YOUR PREVIOUS PLAN, HOW SATISFIED WERE YOU, IN GENERAL, WITH THE CARE YOU WERE GETTING FROM YOUR PRIMARY CARE PROVIDER? CIRCLE YOUR RESPONSE BELOW:

   EXCELLENT  VERY GOOD  GOOD  FAIR  POOR

4. WHY DID YOU CHANGE PLANS? CHECK ALL THAT APPLY, BUT NUMBER THEM IN IMPORTANCE ("1" AS YOUR MOST IMPORTANT REASON).

   ___ A. THE PRIMARY CARE PROVIDER I WANTED WAS IN ANOTHER PLAN.
   ___ B. I HAD APPOINTMENT SCHEDULING PROBLEMS.
   ___ C. I HAD TO WAIT TOO LONG IN THE WAITING ROOM TO SEE MY PRIMARY CARE PROVIDER.
   ___ D. IT WAS INCONVENIENT TO TRAVEL TO MY PRIMARY CARE PROVIDER'S OFFICE.
   ___ E. I COULD NOT GET ACCESS TO MY PRIMARY CARE PROVIDER.
   ___ F. I COULD NOT GET ACCESS TO A SPECIALIST.
   ___ G. I COULD NOT GET ACCESS TO MEDICAL CARE IN AN EMERGENCY.
   ___ H. I COULD NOT GET ACCESS TO MEDICAL CARE WHENEVER I NEEDED IT.
   ___ I. I DIDN'T FEEL THE QUALITY OF CARE WAS GOOD.
   ___ J. OTHER (PLEASE DESCRIBE THE REASON(S) ON THE BACK)

5. PLEASE ADD (ON THE BACK OF THIS PAGE) ANY OTHER COMMENTS YOU HAVE EXPLAINING WHY YOU CHANGED PLANS.
Client Satisfaction Survey

SAMPLE
DSHS Form#13-672

"Clients Dropping Healthy Options"
HEALTHY OPTIONS IS THE MANAGED HEALTH CARE PROGRAM FOR CLIENTS ELIGIBLE FOR MEDICAID. THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS) IS SURVEYING CLIENTS TO SEE HOW HEALTHY OPTIONS AND THE PLANS ARE DOING. A PLAN IS THE INSURER YOUR PRIMARY CARE PROVIDER WORKS WITH. A PRIMARY CARE PROVIDER MEANS YOUR FAMILY OR GENERAL DOCTOR, YOUR CHILD'S DOCTOR, A PHYSICIAN ASSISTANT, A CLINIC, OR AN ADVANCED REGISTERED NURSE PRACTITIONER. WE CHOSE YOUR NAME AT RANDOM FROM CLIENTS WHO ARE NO LONGER ON HEALTHY OPTIONS, TO RECEIVE THIS SURVEY. PLEASE HELP US PROVIDE YOU WITH BETTER MEDICAL CARE BY COMPLETING THIS SURVEY AND RETURNING IT, THIS WEEK, IN THE SELF-ADDRESSED, STAMPED ENVELOPE PROVIDED. THE FOLLOWING QUESTIONS ARE ABOUT THE CARE YOU HAVE RECEIVED FROM HEALTHY OPTIONS. YOUR ANSWERS AND COMMENTS ARE CONFIDENTIAL. THANK YOU VERY MUCH FOR TAKING THE TIME TO FILL THIS SURVEY OUT!

IF YOU WOULD LIKE THE STATE TO RESPOND TO SPECIFIC CONCERNS YOU HAVE, YOU MAY WRITE TO: OFFICE OF MANAGED CARE, P.O. BOX 45506, OLYMPIA, WA 98504-5506 OR YOU MAY CALL THE HEALTHY OPTIONS TOLL-FREE LINE 1-800-546-5015.
1. UNDER YOUR PREVIOUS PLAN DID YOU OR A FAMILY MEMBER SEE YOUR PRIMARY CARE PROVIDER? YES ___ NO ___

2. IN GENERAL, HOW SATISFIED WERE YOU WITH THE CARE YOU WERE GETTING FROM YOUR PRIMARY CARE PROVIDER? CIRCLE YOUR RESPONSE BELOW.

EXCELLENT  VERY GOOD  GOOD  FAIR  POOR

3. WHAT IS THE REASON YOU ARE NO LONGER ON HEALTHY OPTIONS? PLEASE CHECK ALL THE REASONS BELOW WHICH APPLY, NUMBERING THEM IN ORDER OF IMPORTANCE, STARTING WITH "1" AS YOUR MOST IMPORTANT REASON:

___ I AM NO LONGER RECEIVING MEDICAID/WELFARE

___ I AM NOW RECEIVING SSI

___ I AM RECEIVING MEDICAID, BUT I RECEIVED AN EXEMPTION FROM HEALTHY OPTIONS.

4. DID YOU HAVE ANY OF THE FOLLOWING PROBLEMS WITH HEALTHY OPTIONS?

___ A. THE PRIMARY CARE PROVIDER I WANTED WAS IN ANOTHER PLAN.

___ B. I HAD APPOINTMENT SCHEDULING PROBLEMS.

___ C. I HAD TO WAIT TOO LONG IN THE WAITING ROOM TO SEE MY PRIMARY CARE PROVIDER.

___ D. IT WAS INCONVENIENT TO TRAVEL TO MY PRIMARY CARE PROVIDER'S OFFICE.

___ E. I COULD NOT GET SEEN BY MY PRIMARY CARE PROVIDER.

___ F. I COULD NOT GET SEEN BY A SPECIALIST.

___ G. I COULD NOT GET MEDICAL CARE IN AN EMERGENCY.

___ H. I COULD NOT GET MEDICAL CARE WHENEVER I NEEDED IT.

___ I. I DIDN'T FEEL THE QUALITY OF CARE WAS GOOD.

___ J. OTHER (PLEASE DESCRIBE THE REASON(S) ON THE BACK OF THIS PAGE.)

5. PLEASE ADD (ON THE BACK) ANY OTHER COMMENTS YOU THINK WILL HELP US IMPROVE HEALTHY OPTIONS.

BLUE CROSS-CHPW/ADAMS-COLUMBIA/01/7500846 01/01/95 - 02/28/95
RACE: 1 AGE: 28 SEX: 2 EXM:

DSHS 13-672 (07/94) TRANSLATED (2)
APPENDIX I
State of Ohio
Scope of Work for External Quality Review Organization
SPECIFICATIONS SECTION III

III. SPECIFICATIONS FOR PHASE II: Phase II of this ITB describes the annual external quality review that will determine HMO compliance to Ohio Administrative Code (OAC) rules 5101:3-26-07 through 5101:3-26-078 and quality of care indicators.

A. NATURE AND SCOPE OF PHASE II:

1. Contracting with HMOs differs significantly from other arrangements that ODHS has with providers of health care services to Medicaid beneficiaries. Most Medicaid services are delivered on a fee-for-service (FFS) basis in which providers are reimbursed after the service is delivered. Each encounter is billed to the agency and a record exists regarding the service which was delivered. In the FFS arena, the potential for abuse exists among providers who may be over-utilizing services, i.e., providing excessive or unnecessary services. Under a prepaid capitated reimbursement system in which providers are paid a fixed amount per person per month, the opposite comes into play. The potential for abuse exists where services may be under-utilized, i.e., services are not being provided as often or as appropriately as the patient requires.

The selected contractor shall provide ODHS with insight as to whether the HMOs are delivering comprehensive health care in accordance with state and federal regulatory requirements. The time period for the survey is October 1, 1994 through June 30, 1995, and ODHS proposes to accomplish this through the following mechanisms: 1) quality of care studies; 2) provider facility and medical record surveys, and 3) HMO administrative surveys. Each HMO receives an overall score calculated according to the scoring methodology developed in Phase I of this ITB and approved by ODHS.

2. Each HMO's individual evaluation consists of a three tier process as follows:

   a. Quality of care studies: a review of medical records by specific criteria which are selected by a stratified two-stage cluster sampling methodology (Attachments E, F, G, H, and I).

      1. The general methodology is a stratified two-stage cluster sample. This sampling scheme acknowledges that HMO differ by the number of physician sites and by the number of enrollees per site. Stratification will assure that an appropriate number of sites of each size, as defined by the number of enrollees per site, are included in the sample. The required sampling method will result in the selection of more sites from HMO's with many and more records from sites with many records.

      2. The sampling procedure will require the determination of:

         • Appropriate boundaries between strata, e.g., cutoff point between high, medium, and low numbers of enrollees;
         • The number of clusters (HMO sites) to sample within each HMO;
         • The number of medical records to sample within each selected HMO site for each of the five conditions under review.

      3. Stratification will consist of the following procedures:

         • A list of sites for each HMO will be constructed and rank-ordered according to the number of enrollees per site. Required data will be provided by each HMO.
         • Three strata will be defined, based on the number of enrollees. These will correspond to high, medium, and low numbers of enrollees. All sites, irrespective of HMO, for which the number of enrollee exceeds the specified cutoff between the high and medium strata will be designated "large sites." Sites for which the number of enrollees exceeds the cutoff between low and medium strata but less than the high/medium cutoff point will be designated "medium sites." Sites for which the number of enrollees is less than the medium/low cutoff point will be designated "small sites." Under this stratification scheme, the sites within each stratum will all be within the same size range, as defined by the number of enrollees, but irrespective of HMO. It is therefore possible that not all HMO's will have sites within each stratum. For example, if, all sites for a given HMO are within the "medium" or "small" ranges, that HMO will not have any sites within the "large" category. This method will permit comparisons among sites of similar size.
SPECIFICATIONS SECTION III (continued)

4. A two-stage cluster sample will be drawn from each stratum.
   - First, a sample of clusters (HMO sites) will be obtained from each stratum, proportionate to the number of sites per HMO. This will result in the selection of more sites from HMO's with a comparatively large number of sites. This will allow for analysis of differences among HMOs with various number of sites. Comparisons within and between HMOs will also be possible. At least one per site per HMO per stratum must be sampled. If an HMO does not have sites within a particular stratum, sites for that HMO will be sampled only from the other strata.
   - In the second stage, each HMO site selected will supply lists of cases for each of the five conditions. A site is eligible for sampling if it has at least one record for any of the conditions under study. From these list, samples of medical records will be drawn in proportion to the number of available medical records. This sampling procedure will be conducted separately for each of the five conditions. This is necessary because individual sites will vary in the number and relative proportion of cases for each condition.

5. Because of the large range in the number of enrollees per HMO site that will be assigned to each stratum, it may be desirable, and is permissible, for the number of medical records per site be obtained according to a method of optimum, rather than proportional, allocation. Proportional allocation may not minimize the variance of the estimated mean (compliance rate). However, if the standard errors anticipated under proportional allocation are not much higher than those for optimum allocation, the simpler proportional sampling may be used.

6. The number of sites selected per HMO and the number of records within each site should not exceed the accepted sampling error rate of 5%. That is, the target sample size should assure precision of 95%. Additionally, a 95% confidence interval for the statewide compliance rate should be calculated.

7. The total number of records to be sampled must not exceed 5000. Once the precise number of eligible sites and the number of records is known, adjustments will be made in consultation with ODHS if the estimated size, based on the sampling rules and criteria specified above, exceeds 5000. Such adjustments may include sampling more records from fewer sites, modification of the stratification scheme, adjustments of the confidence interval criteria, and/or other adjustments as deemed appropriate.

8. The ODHS and an ODHS-contracted statistician will review the EORO's sampling methodology for compliance to the sampling procedure prior to awarding the contract.

b. Provider facility and medical record surveys - include visits to selected provider sites for the purpose of evaluating the physical facilities of the providers to determine whether the provider sites and medical records comply with appropriate OAC rules 5101:3-26-06 through 5101:3-26-078 (Attachment C).

c. HMO administrative survey - The HMOs administrative body is reviewed against OAC rules 5101:3-26-07 through 5101:3-26-078 (Attachment C).

3. Federal Regulations (42 CFR 434.53) require that an annual medical record audit of specific HMO-enrolled Medicaid individuals be performed by an independent organization. The medical record audit must focus on important aspects of patient care in the clinical setting.

4. The EORO shall discuss the findings of the medical record and facility surveys, and the quality of care studies at summation conferences with members of the individual medical practices. A summation conference with HMO staff will be conducted to summarize the findings of the medical record, provider facility and HMO administrative surveys. The contractor will submit a report to ODHS on each HMO surveyed. The report shall include findings, conclusions, recommendations and a score based on the scoring methodology developed in Phase I. A draft copy of each individual report is to be submitted to ODHS for ODHS/HMO review prior to the issuance of the final individual report. In addition, the contractor will submit a draft statewide report to ODHS prior to issuance of the final statewide report.
APPENDIX I
State of Minnesota
Scope of Work for External Quality Review Organization
WHEREAS, paragraph IV provides that:

IV. TERM OF CONTRACT

This contract shall be effective on April 14, 1993, or upon such date as it is executed as to encumbrance by the Minnesota Commissioner of Finance, whichever occurs later, and shall remain in effect until January 31, 1995, or until all obligations set forth in this contract have been satisfactorily fulfilled, whichever occurs first.

NOW THEREFORE IT IS HEREBY AGREED BY AND BETWEEN THE PARTIES HERETO:

That paragraph IA I shall be amended to read:

1. Development of Evaluation Methodologies for Specific Conditions or Services: A Project Advisory Committee shall be established by the STATE to serve as a task force to provide input to the STATE and CONTRACTOR on the QARI project. The Project Advisory Committee shall be composed of representatives from the Pre-Paid Medical Assistance Health Plans (hereinafter "Health Plans"), Minnesota counties, Minnesota Department of Health and other organizations as determined by the STATE. CONTRACTOR will work with the Project Advisory Committee and the STATE's Authorized Agent to develop and establish a mutually agreed upon methodology to assess specific medical conditions and services in the Pre-Paid Medical Assistance Health Plans (PMAPs), as follows:

That paragraphs IA 1(a)-(d) shall be amended to read:

a. Audit No. 1: Childhood Immunizations -- CONTRACTOR in consultation with the STATE, Health Plans, and the Project Advisory Committee shall collect and analyze childhood immunization data and provide the STATE with a final report pursuant to the time schedule set out in Attachment A, which is hereby incorporated into this Agreement. The childhood immunization final report shall contain the methodology used during the collection of the childhood immunization data, the methodology used to analyze the collected data, the methodology used for analyzing the data collection results, a discussion of the data analysis results including recommendations and such other information as may be required pursuant to Section I, Clause A, paragraph 3 of this contract. The tool for assessing childhood immunizations will consist of the required elements as put forth in the July 1993 Medicaid QARI document and enhancements developed by CONTRACTOR and approved by the Project Advisory Committee.
b. **Audit No. 2: Prenatal Care** - CONTRACTOR in consultation with the STATE, Health Plans and the Project Advisory Committee shall develop procedures for the sampling of prenatal care data, ensure the development of a computerized tool (hereinafter "tool") which can be used in the collection of prenatal care data, train individuals from the Health Plans in the use of the tool, analyze collected data, and draft a final report pursuant to the time schedule set out in Attachment B, which is hereby incorporated into this Agreement. In conjunction with the development and use of the tool, CONTRACTOR shall provide the STATE with copies of the instructions given to the software company used to develop the tool, deliver to the STATE on computer diskette a copy of the software tool, provide a manual designed to teach persons unfamiliar with the use of the tool how to operate it, train individuals in the collection of prenatal care data and the use of the tool. The tool for assessing prenatal care will consist of the required elements as put forth in the July 1993 Medicaid QARI document and enhancements developed by CONTRACTOR and approved by the Project Advisory Committee.

The prenatal care final report shall include at a minimum the methodology used during the collection of data including any methodology used in the validation or sampling of the data, the methodology used to analyze the collected data, the methodology used for analyzing the data collection results, and a discussion of the data analysis results and such other information as may be required pursuant to Section I, clause A, paragraph 3 of this contract.

c. **Audit No. 3: Diabetes** -- Diabetes is the third focus area of the Minnesota QARI Project. A diabetes focus group shall be designated by the Project Advisory Committee to work in conjunction with the STATE and CONTRACTOR. The focus group, STATE and CONTRACTOR will define and design the limits of a diabetic study and conduct a base line study in the second half of 1994 (or another date as mutually agreed upon by STATE and CONTRACTOR). CONTRACTOR shall specifically complete those tasks according to the time schedule identified in Attachment C, which is hereby incorporated into this Agreement. CONTRACTOR shall also in conjunction with the STATE, Health Plans and the Project Advisory Committee draft a final report which shall include at a minimum the methodology used during the collection of data, the methodology used to analyze the collected data, the methodology used for analyzing the data collection results, a discussion of the data analysis results and such other information as may be required pursuant to Section I, clause A, paragraph 3 of this contract.
d. Audit No. 4: Asthma -- Asthma is the fourth focus area of the Minnesota QARI Project. An asthma focus group shall be designated by the Project Advisory Committee to work in conjunction with the STATE and CONTRACTOR. The focus group, STATE and CONTRACTOR will define and design the limits of asthma care study, establish review criteria, define the study group, and conduct a base line study in the fall of 1994 (or another date as mutually agreed upon by STATE and CONTRACTOR). CONTRACTOR shall specifically complete those tasks according to the time schedule identified in Attachment D, which is hereby incorporated into this Agreement. CONTRACTOR shall also in conjunction with the STATE, Health Plans and the Project Advisory Committee draft a final report which shall include at a minimum the methodology used during the collection of data, the methodology used to analyze the collected data, the methodology used for analyzing the data collection results, a discussion of the data analysis results and such other information as may be required pursuant to Section I, clause A, paragraph 3 of this contract.

That paragraph IA 2 shall be amended to read:

2. Facility Audits and Medical Record Review: CONTRACTOR will conduct facility and medical record audits for each of the Pre-Paid Medical Assistance Health Plans, using evaluation tools that have been developed by the Project Advisory Committee and approved by the STATE's Authorized Agent. The facility and medical record audits will be conducted by a CONTRACTOR physician and site reviewer, at two sites of each Pre-Paid Medical Assistance Health Plan, as determined by the STATE's Authorized Agent, during the Spring of 1994, or another date as mutually agreed upon by STATE and CONTRACTOR. CONTRACTOR shall specifically complete those tasks identified in Attachment E and according to the time schedule in Attachment E, which is hereby incorporated into this Agreement.

That paragraph IA 3 shall be amended to read:

3. Final Report: The CONTRACTOR will provide to the STATE all final analytical information required for the final report of Audits No. 1, 2, 3 and 4. CONTRACTOR shall draft a separate final report for each Health Plan based on each Audit which discusses the data collection results and analysis specific to that Health Plan along with any specific recommendations. In addition, CONTRACTOR shall draft a final report for each Audit based upon the combined data of all Health Plans for each of the Audits. All final reports will identify areas which require improvement and make specific recommendations for corrective action.

The CONTRACTOR shall be available to assist in the development of the final report to be submitted to The Henry J. Kaiser Family Foundation, to the National Academy for State Health Policy, and to the Health Care Financing Administration which is required to be
APPENDIX J
State of Minnesota
Summary of Asthma & Diabetes Focus Groups
Summary of Asthma and Diabetes Focus Groups
carried out in January, 1995.

PURPOSE OF CONSUMER FOCUS GROUPS:

The focus groups were held to find out how satisfied the medical assistance enrollees are with the care they are receiving, related to their diagnosis of asthma or diabetes.

We also wanted to find out enrollees' level of satisfaction with managed care, as compared to fee for service, again related to these diagnoses.

PROCESS:

Letters were sent to the eight participating health plans explaining what we hoped to accomplish with the consumer focus groups, and asking for names/addresses/telephone numbers of enrollees with a diagnosis of asthma or diabetes.

Of the eight health plans, names were received from five of the plans. One of the plans had too few enrollees with these diagnoses to participate, one plan chose not to participate for privacy reasons, and one plan didn't gather the information in time.

A total of 100 letters were sent to enrollees in the participating health plans, about half to each diagnosis. Approximately 20 letters were sent to enrollees in each health plan. The letter explained the focus group process, and was accompanied by a form to fill out and return in a self-addressed, stamped envelope. An incentive of $20 was offered to those who were willing to participate, as well as child care. The focus groups were held at two different locations, to make it more convenient to attend.

Of the 100 enrollees who were sent letters, 20 returned the form saying they would attend. Fifteen letters were returned with no forwarding address. Several letters were returned with a forwarding address, and these letters were all re-sent, except one that was returned too late. One letter was returned - recipient deceased.

Of the 20 enrollees who returned the form saying they would attend, 10 actually did attend the focus groups. The 10 attendees represented four different health plans. (one health plan had no one respond)

Four separate focus groups were held, one for asthma and one for diabetes in both Hennepin and Ramsey counties. Two of the focus groups had only one attendee, one group had three attendees, and the other group had five attendees.
RESULTS:

Results varied considerably, from people being very satisfied with their care, to being dissatisfied with certain aspects of it. Some questions asked were: satisfaction with the expertise of your health care provider, education received related to your diagnosis of asthma or diabetes, and access to care. Some of the participants were more satisfied with their care under the managed care system, others had been more satisfied with fee-for-service. For some it didn’t matter. Some felt they had received adequate educational information at the time of their diagnosis, some stated they had received none. The most common complaint heard throughout the focus groups was the problem of getting to appointments/emergency rooms. A large number of medical assistance recipients don’t drive. It is difficult to use public transportation when you aren’t feeling well, and taxi service is expensive. Some of the health plans provide taxi service for their medical assistance enrollees, but focus group members reported this is difficult to access.

WHAT WE LEARNED:

We learned what things that are working for this population, and what things are not. We plan to report back to each health plan on these issues.

We also learned that, due to the low response rate, we need to explore other avenues for reaching this population. If we decide to do something like this again, we would need to look at other ways of gathering information, such as mailed questionnaires. Another way might be going to the clients, rather than having them come to us, such as going to the clinics where they are being seen.
PROPOSED FOCUS GROUP QUESTIONS

Demographics Questions

1) When were you first diagnosed as having diabetes or asthma? (Years with disease)

2) How does your illness affect your life?
   a) Does it by itself keep you from working? Contribute to keeping you from working?
   b) Does it affect your activities around the home? If yes, how?

Health Care Questions

3) Do you understand the reasons for your particular plan of care? Have you been given education or information on your particular health condition? Was that information given in a way that you found useful? (Literacy, chance to ask questions, chance to practice using equipment, etc.)

4) Has your doctor or clinic helped you and your family adjust to lifestyle changes needed because of your illness? (For example, education of family members about the illness, not smoking in the home in case of asthma, etc.)

5) Do you have difficulty getting referrals to specialists when you feel you need them? Do you have difficulty getting referrals to specialists when your doctor or clinic feels you need them?

6) In the past year, have you ever needed immediate treatment of your asthma or diabetes? Did you receive the immediate attention you needed from your health plan?

7) If you have complaints or concerns about your health care, who addresses them? How long does it take to resolve? Are you satisfied with the resolutions?

8) For those of you who have experience in receiving health care for your asthma or diabetes in a more traditional fee-for-service setting (where you choose your doctor and you or your insurance company or MA paid for your care), how would you compare your level of satisfaction with the care you receive in a fee-for-service setting compared to a managed care setting? For what specific reasons do you prefer one over the other? (How strong is that preference? None, slight, average, strong, very strong?)

9) With regard to the health plan and its treatment of your illness, what is working well?

10) With regard to the health plan and its treatment of your illness, what is not working well?

11) Are there any barriers that keep you from getting the care you need?

12) How satisfied, generally, are you with the care you are receiving, specifically related to your diagnosis of asthma or diabetes?

13) How effective is the health plan in treating your asthma or diabetes?
14) Does your practitioner seem competent to you? If yes, why? If not, why not? (Name indicators.)

15) Do you feel your primary care provider understands your health needs? If yes, what indicates that to you? If not, why not? (Name indicators.)

16) How much control do you feel you have over your own health care? (None, little, average, much, very much) How satisfied are you with your level of control? (Very dissatisfied, dissatisfied, neither satisfied or dissatisfied, satisfied, very satisfied)

17) If you gave a message to your health plan, what one thing would you change? What one thing would you want them to keep?
APPENDIX K
State of Washington
Draft Complaint Log
&
Tracking Process
# Healthy Options Client/Provider Complaint Log

## Demographics

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1. Date and time Inquiry/Complaint Taken</td>
<td>2. Complaint Called in By</td>
</tr>
<tr>
<td>3. Clients' Name</td>
<td>4. Clients' Address</td>
</tr>
<tr>
<td>5. Clients' Telephone Number ( )</td>
<td>6. Clients' Alternate Phone Number ( )</td>
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Only one of the following ID #s is required:

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<tr>
<td>7. Client's PIC</td>
<td>8. Client's S.S.#</td>
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<tr>
<td>9. Client's Case Number</td>
<td>11. Name of PCP within Plan</td>
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<td>10. Name of Plan Enrolled In</td>
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<td>12. Name/Address of PCCM</td>
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### Inquiry / Complaint

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<tr>
<td>13. WHO HAVE YOU DISCUSSED, WITHIN THE PLAN'S QA DEPT., THIS ISSUE/CONCERN WITH: CAN THE STATE DISCUSS YOUR COMPLAINT WITH YOUR PLAN - YES / NO</td>
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<td>14. Issues/Concerns Description:</td>
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<td>15. How does Customer/Client feel the Issues/Concerns should be resolved:</td>
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<tr>
<td>16. Person who initially took the Inquiry/Complaint</td>
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HEALTHY OPTIONS Quality Improvement Team
CLIENT C. A. R. E.** PROGRAM
**Communication And Response Evaluation

COMPLAINT LOG: April 6, 1995

Key for Complaint Types, and Severity Levels:

COMPLAINT TYPES
Systems issues will be categorized in the following TYPES**:

1 = ACCESS BARRIERS TO RECEIVING CARE
  e.g. can't get appointments; can't get a referral; didn't get requested PCP; PCP
  won't approve ER visit; gets treatment over the phone; long waits for
  appointments, etc.

2 = INTERPERSONAL COMPLAINTS
  e.g. treated discourteously; not listened to; didn't spend time with me; sarcastic or
  rude comments, etc.

3 = LACK OF INFORMATION REGARDING HEALTH CARE COVERAGE
  e.g. don't know who assigned to; wants to change PCP and doesn't know how;
  etc.

4 = QUALITY OF CARE ISSUES
  e.g. provider's care isn't working; provider doesn't seem to know what they're
  doing; I've always had a specialist for my needs but my provider says it's too
  expensive; an ongoing treatment is now too expensive to provide; exam areas not
  clean; provider seemed impaired or intoxicated, etc

5 = DISCRIMINATION CLAIMS (TERM USED BY COMPLAINANT)
  Person submitting the complaint specifically uses the word, and feels that because
  they are on "Welfare", "Black", "Hispanic", "a Trouble-maker", etc. they are being
  discriminated against.

6 = BILLING PROBLEM
  e.g. a client is required to pay for a service that should be covered; a provider has a
  claim rejected because a client is enrolled in managed care, etc.

** A complaint type beginning with a number (i.e. 1, 5, etc) indicates a complaint from a CLIENT.
A complaint type beginning with "CS" indicates a complaint from a CLIENT SATISFACTION
SURVEY response.
A complaint type beginning with "FH" indicates a complaint involving a FAIR HEARING
request.
A complaint type beginning with "P" indicates a PROVIDER complaint.
SEVERITY LEVELS

MINIMAL

MODERATE

SEVERE

URGENT/EMERGENT
HEALTHY OPTIONS Quality Improvement Team
CLIENT C. A. R. E.** PROGRAM
**Communication And Response Evaluation

COMPLAINT PROCESS
April 4, 1995

INTAKE:

Complaint information comes to the Quality Improvement Section from various sources. Examples of internal sources would be staff from the Central Enrollment Unit or the Patient Requiring Regulation Unit, any of the Managed Care Contract Managers, or any of the MAA Medical/Nurse/Pharmacy Consultants. Examples of external sources would be staff from the Division of Client Services, the Division of Utilization Services, or the Division of Provider Services, a written response to the monthly, randomly generated Client Satisfaction Survey, or any unsolicited letter or phone call from someone with a complaint or concern.

When one of these sources documents a complaint, it should be placed in the "Complaint Intake" box in the Quality Improvement section. From there the process is as follows:

I. The complaint is reviewed to determine if it is a "medical/clinical" issue or a "systems" issue.

A. "Medical/Clinical" Issues:

Initially, a complaint will NOT BE CONSIDERED a "medical/clinical" issue in the Client C.A.R.E. program if a patient is receiving or has received some kind of medical intervention or an intervention methodology has been established, AND the patient has a plan of care or plan of treatment outlined and/or in action AND the family has received attention.

However, generally speaking, a complaint WILL BE CONSIDERED as a "medical/clinical" issue if a medical need, condition, or situation is currently untreated, unattended, or unresolved at the time the complaint is received; OR if a poor medical outcome has resulted from the intervention, treatment or care provided.

B. "Systems" Issues:

Generally, a complaint is treated as a systems issue if it not medical or clinical as described in I. A.

C. All issues will be categorized in the following TYPES**;

1 = ACCESS BARRIERS TO RECEIVING CARE
e.g. can't get appointments; can't get a referral; didn't get requested PCP; PCP won't approve ER visit; gets treatment over the phone; long waits for appointments, etc.

2 = INTERPERSONAL COMPLAINTS
e.g. treated discourteously; not listened to; didn't spend time with me; sarcastic or rude comments, etc.

3 = LACK OF INFORMATION REGARDING HEALTH CARE COVERAGE
e.g. don't know who assigned to; wants to change PCP and doesn't know how; etc.

4 = QUALITY OF CARE ISSUES
e.g. provider's care isn't working; provider doesn't seem to know what they're doing; I've always had a specialist for my needs but my provider says it's too expensive; an
ongoing treatment is now too expensive to provide; exam areas not clean; provider seemed impaired or intoxicated, etc

5 = DISCRIMINATION CLAIMS (TERM USED BY COMPLAINANT)
Person submitting the complaint specifically uses the word, and feels that because they are on "Welfare", "Black", "Hispanic", "a Trouble-maker", etc. they are being discriminated against.

6 = BILLING PROBLEM
E.g. a client is required to pay for a service that should be covered; a provider has a claim rejected because a client is enrolled in managed care, etc.

** A complaint type beginning with a number (i.e. 1, 5, etc) indicates a complaint from a CLIENT.
A complaint type beginning with "CS" indicates a complaint from a CLIENT SATISFACTION SURVEY response.
A complaint type beginning with "FH" indicates a complaint involving a FAIR HEARING request.
A complaint type beginning with "P" (i.e. P1, P6, etc.) indicates a complaint from a PROVIDER.

D. Work Flow:
1. The name of the contract manager/clinician who will receive the complaint; the complaint type; the date due back, and the plan ID Code is noted on the complaint form.

2. The following information is logged into the "Complaint Log" database:
   * Plan ID Code (A-ZZ)
   * Plan ID (e.g. KPS, MSC, etc)
   * Client County/CSO Number (from Case Number, if available)
   * Client Name (default is "**Client Survey Response-No PIC" for anonymous complaints)
   * Client PIC Code, if available
   * Client Case Number, if available
   * Primary/Secondary/Third Complaint Type (see B. above)
   * Complaint Is Against: PCP/Plan/Pharmacy/State/Misc./etc.
   * Date Complaint Received at MAA
   * First/Second/Third Contract Manager/Clinician To Whom Complaint Is Referred
   * First/Second/Third Date Due Back to Quality Improvement Section
   * Date Case Closed
   * Outcome/Resolution

3. The complaint form and any attachments are photocopied, a CLIENT C.A.R.E. COMPLAINT ACTION-TRACK cover sheet is attached (which communicates information about the Complaint and any action needed, or why no action is required), and the COMPLAINT and COVER SHEET is distributed to the appropriate Contract Manager/Clinician.

4. The contract manager/clinician will contact the client and/or the PCP/Plan, or other resources to resolve the complaint within 30 working days.

5. Frequently a complaint can be resolved at the time it is received - sometimes they are documented, sometimes they are not. However, if the resolution is an EXEMPTION from Healthy Options; DISENROLLMENT from the PLAN/PCCM; a SWITCH to another PLAN/PCP/PCCM; or a request for a FAIR HEARING, these actions are considered significant enough to warrant attention by the appropriate contract manager. Frequent exemptions, disenrollments, fair hearings, etc. may reflect a pattern or trend in the activity of a PLAN/PCP/PCCM, and may affect the department's relationship with the Plan/PCCM at some time in the future. As a result, a courtesy copy of these complaints and resolutions are provided to the appropriate contract manager. In addition, a courtesy copy of any complaint referred to or resolved by a clinician will also be provided to the contract manager.
E. Troubleshooting:

1. A Complaint will be assigned out of the Quality Improvement Section as "REFERRED TO" EITHER a Plan's Contract Manager OR the Quality Improvement Section's choice of Medical/Nurse/Pharmacy Consultant.

If, however, the Contract Manager finds it necessary to involve the clinician in resolution of the complaint, they are very free to do so, but they must keep in mind that the Quality Improvement Section will still have the complaint logged out to the original source as the party responsible for the resolution within 30 working days.

2.

F. Client Satisfaction Surveys:

1. Client Satisfaction Surveys are sent monthly to randomly selected Medicaid Clients who have either continued in the same plan during the month (DSHS Form# 13-670); dropped coverage from Healthy Options during the month (DSHS Form #13-672); or have switched their Plan/PCP/PCCM during the month (DSHS Form# 13-671). Approximately 4,000 surveys are sent out to clients. Approximately 500 of those surveys are sent out each month to clients whose Primary Languages are Spanish, Vietnamese, Cambodian, Laotian, Chinese, Korean, and Russian.

2. English language surveys (for all three types) are computer generated through the MMIS on the 5th of each month (or the first working day after the 5th). These are then sent to the DSHS mailroom for mailing.

At the same time, labels for the clients receiving Foreign language surveys are generated. These labels are sent to the Morningside headquarters office in Olympia, WA, where staff affix them to the appropriate survey type in the appropriate language, stuff them into envelopes and mail them within one week of original receipt of the labels according to a contract with MAA.

Finally, the MMIS generates a report of all clients who were sent surveys for the month, with totals by survey type and primary language.

3. Each week as survey responses are received, MAA staff enter the response information into a Client Satisfaction Survey Database. If a survey question requests a written client response, comments are entered into memo fields on the database.

Any English survey with comments that are complaints or requests for contact or action by department staff are forwarded to the Quality Improvement Section and are put into the COMPLAINT process stream - whether they are anonymous or have client specific information provided. Any Foreign language survey with comments is forwarded to the Language Interpreter Services and Translation (LIST) office for translation and then put into the COMPLAINT process stream if appropriate.
COMPLAINT ACTION-TRACK!

(Revised 4/95)

TO: ___________________________ DATE: __________________

The HEALTHY OPTIONS Quality Improvement Team is sending you a Managed Care CLIENT OR PROVIDER COMPLAINT.

Attached you will find a copy of the complaint form and any attachments as they were submitted to us. WE HAVE LOGGED IT INTO OUR DATABASE AS BEING REFERRED TO YOU. We need a response back to us from you within 30 working days.

* We appreciate your cooperation and prompt action! Please contact the appropriate personnel at the PLAN/PCCM to bring resolution to the issues/concerns presented. PLEASE WRITE YOUR NOTES & FINAL RESOLUTION INFORMATION ON THE ATTACHED FORM AND RETURN IT TO THE QI SECTION!!

If you need any assistance, such as an extension of the date your response is due back to us, a change in coding of our complaint database information, or a re-assignment of the referral, please contact ☑ SUSAN KELLER AT 586-6953; Bldg. 6, 3rd Floor; MS: 5506.

☑ DATE DUE BACK __________________

☑ COMMENTS:

* NO ACTION REQUIRED!! For your files, we have attached a "Courtesy Copy" of a COMPLAINT that has been resolved by:

☐ an MAA PHYSICIAN/NURSE/PHARMACY Consultant
☐ EXEMPTION/DISENROLLMENT
☐ Client SWITCHED Plan/PCP/PCCM
☐ FAIR HEARING Requested.

Please notify the Quality Improvement Section if you have taken further action that should be recorded!!