
Quality Improvement Program

The Quality Improvement Program (Program) is an ongoing, comprehensive and integrated system designed to actively initiate, monitor and evaluate standards of health care practice and infrastructures essential to the delivery of quality clinical care and service to members.

The goals of the Program are:

- To develop and maintain a well-integrated system that continuously measures clinical and operational performance, identifies the need for and initiates meaningful corrective action when appropriate, and evaluates the result of actions taken to improve quality of care outcomes and service levels;
- To establish a mechanism for the safe, culturally-sensitive delivery of health care that not only promotes efficient, appropriate and effective use of resources, but also supports the physician-patient relationship;
- To ensure access to and availability of qualified and competent providers;
- To engage members in managing, maintaining or improving their current state of health;
- To provide a forum for members, providers and various health care associations and community agencies to provide suggestions regarding the implementation of the Program;
- To ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies.
- To establish and maintain safeguards for member privacy, including confidentiality of member health information.

The Quality Improvement Committee is charged by the organization's Board of Directors with monitoring and evaluating the results of Program initiatives and initiating corrective action when the results are less than desired or when areas needing improvement are identified.

Current Program activities which involve physicians include but are not limited to:

- Review of member medical records;
- Review of member quality complaints and adverse, unexpected events;
- Participation in quality improvement and utilization management activities, including application of clinical practice guidelines, as detailed by contract;
- Participation in focused performance improvement and disease management initiatives, as appropriate;
- Completion of the re-credentialing process.

The Quality Improvement Program incorporates ongoing screening of the medical record to assure compliance with all regulatory and accreditation agency guidelines. Audits will also be conducted on the accessibility, availability, efficiency, safety, efficacy, appropriateness, health screening, high risk diagnosis, and continuity of the patient care and services delivered by the health care providers and the Plan.

A Plan representative will make an appointment to review these items in the provider's office, as necessary.

Upon completion of the review, providers will be provided with a preliminary summary of findings during the exit meeting to outline any deficiencies found during the review. The report will assist provider offices with making any necessary corrections.

If the provider's aggregate score is less than 80 percent a corrective action plan will be requested.

Providers may be asked to participate in formulating the plan of action, as collaborative input will provide the key for a workable solution.

Quality Improvement Participation

Providers contracted with the Plan are required to participate in all quality improvement functions and tasks required by the Ohio Department of Job & Family Services (ODJFS), federal laws and the Plan.

These activities may include but are not limited to:

- Compliance with requests for medical records for quality improvement studies and audits;
- Cooperation with quality improvement initiatives related to collaborative projects;
- Cooperation with efforts to improve care for chronic disease and/or preventive care measures;
- Compliance with requests for information and recommendations formulated by the Plan and ODJFS, in the process of reviewing/resolving beneficiary and/or provider complaints.

The Plan and ODJFS may perform annual audits. . The results of all reviews are maintained in a Physician Profile and utilized at the time of re-credentialing.

Provider Participation with QI Activities

The Program seeks out and invites input from the physician community regarding the implementation of the Program. Ohio-licensed physicians are members of the following Program committees and work groups:

- Medical Advisory Committee
- Credentialing Committee
- Pharmacy and Therapeutics Committee

Provider input is also integral to the development of Preventive Health Guidelines, Clinical Practice Guidelines, Performance Improvement Projects and Case and Disease Management Programs.

In accordance with regulatory contracts and accreditation guidelines, the Plan and its providers contractually agree to participate in quality improvement projects and medical record review activities to:

- Promote the appropriate medical record documentation and management of patients with designated diagnoses;
- Identify areas of medical record documentation and management that may be improved;
- Oversee the quality of the medical record;
- Provide periodic feedback to the physicians;
- Identify areas of practice that require peer review;
- Provide a performance profile to be utilized during the credentialing process.

Access to Records

- Access to the Plan member's medical record in the office or facility for review is required.

Other Requirements

- Copying and providing office records as needed for quality review activities;
- Requests for internal QI data from delegated credentialing entities;
- Copying and providing office records for state, federal and Plan review.

Quality Improvement Activities

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

- Access and availability studies:
 - Primary Care Provider (PCP) turnover rates
 - Children's access to primary care
 - Adults' access to preventive/ambulatory health services
- Hospital readmission reviews
- Referrals for quality issues
- HEDIS[®] reviews
- Performance improvement projects:
 - Identifying children with special health care needs
 - Well-Child visits during the first 15 months of life
 - Dental visits for children ages 2 to 21
- Disease management initiatives
- Appointment availability
- After-Hours availability
- Accuracy, timeliness and completeness of encounter/claims submissions
- Over- and under-utilization of services
- Member satisfaction surveys
- Provider specific issues identified through tracking and trending of complaints or referrals
- Medical Record Content Reviews

Results of all reviews will be housed in a provider profile to utilize during re-credentialing and re-contracting.

Quality of Care Issues

Quality of care referrals may be generated by the Appeals and Grievance department, Risk Management department, Utilization Management department, member or family, or compliance may be identified through routine record review.

Record review identifying possible quality of care issues will be referred to peer review. In the event the peer reviewer/panel feels there is a possible quality of care issue, the provider or facility will be asked, in writing, to provide additional information to address the issue. The response is reviewed and a final determination is rendered.

Quality of Care Categories:

- Procedural Issues
- Medication Issues
- Delay/Omission of Care
- Death or Serious Disability
- Post-op Complications
- Patient Safety
- Member Perception

Quality of Service Categories:

- Access/Availability Issues
- Referral Issues
- Balanced Billing
- Environmental
- Interactions

Determination

- Substantiated-there is evidence of a deviation from the standard of care.
- Unsubstantiated-there is no evidence of a deviation from standard of care.

- Unable to make a determination based on available information

Outcome

- No adverse outcome
- Adverse outcome
- Sentinel event

Action

- Close Case
- Track & Trend
- Request additional information
- Refer to peer reviewer for recommendation
- Refer to external review organization
- Refer to the Credentialing (Peer Review) Committee
- Corrective Action Plan

Reporting By Action*Reportable:*

- Termination as a result of a quality of care issue
- Imposing restriction on privileges

Not Reportable:

- Track & Trend
- Focus review
- Deferment of members
- Requiring CMEs (Continuing Medical Education)
- Counseling

HEDIS[®] Indicators

The following HEDIS[®] indicators may be reviewed and reported on an annual basis. Based on ODJFS and/or Plan initiatives performance indicators may be added or deleted.

- Adolescent Immunization Status
- Appropriate Treatment of Children with URI

- Appropriate Testing for Children with Pharyngitis
- Adult Access to Preventive/Ambulatory Health Services
- Use of Appropriate Medication for People with Asthma
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening for Women
- Childhood Immunization Status
- Comprehensive Diabetes Care-HBA1c Screening
- Comprehensive Diabetes Care-HBA1c-Poorly Controlled
- Comprehensive Diabetes Care-LDL-C Screening
- Comprehensive Diabetes Care-LDL-C Controlled
- Comprehensive Diabetes Care- Dilated Retinal Eye Examination
- Comprehensive Diabetes Care- Monitoring for Nephropathy
- Controlling High Blood Pressure
- Prenatal and Postpartum Care-Timeliness of Prenatal Care
- Prenatal and Postpartum Care-Postpartum Care
- Frequency of Prenatal Care
- Well-Child Visits for Children Ages 3-6
- Well-Child Visits in the First 15 Months of Life
- Annual Dental Visits
- Lead Screening
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C Screening Performed
- Follow up After Hospitalization for Mental Illness

Health-Quality Improvement and Disease-Management Initiatives

The Quality Improvement Program includes programs for the Covered Families and Children (CFC) population for case and disease management for children with special health care needs, for members with asthma, diabetes, HIV/AIDS, elevated lead levels, teen pregnancy, high-risk pregnancy, and other complex conditions.

In addition, programs to ensure members are receiving Healthchek screenings, lead screenings and immunizations are instituted to encourage members to obtain needed preventive health care screenings.

Fraud and Abuse

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

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

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

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

Fraud and Abuse Definitions

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

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

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

health plan member for the purpose of obtaining wrongful payment.

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

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

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

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

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

Special Investigations Unit

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

The mission of the corporate SIU is outlined below:

- Comply with applicable federal and state statutory, regulatory, and contractual requirements regarding fraud, waste, and abuse;

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