Part I Section 10

Quality Assessment and Utilization Management Programs

QUALITY ASSESSMENT PROGRAM

CHINESE COMMUNITY HEALTH CARE ASSOCIATION

Quality Assessment Program

The Chinese Community Health Care Association has established a "Quality Assessment and Utilization Review Committee" (QA/UR Committee). The QA/UR Committee has both a Quality Assessment function and a Utilization Review function, which are performed serially by the CCHCA QA/UR Committee. The Quality Assessment function of the Committee is detailed in the Quality Assessment Program (QAP).

I. PURPOSE:

The purpose of CCHCA's Quality Assessment Program is to review all programs having a direct or indirect influence on the quality and outcome of clinical care and services provided to enrollees. The process consistently and systematically monitors and evaluates issues related to accessibility, availability and continuity of care. The process is documented. When issues for improvement are identified, recommendations are implemented, and the effects studied.

II. GOAL:

The goal of the CCHCA Quality Assessment Program is to demonstrate improvement in the care and services provided to all members.

III. OBJECTIVES:

- Achieve a centralized, ongoing, and effective program that involves all providers in action plans to improve care and service to our members.
- Establish priorities for the improvement or resolution of known or potential issues that impact directly or indirectly on care and service.
- Maintain a consistent level of quality care and service in all areas, which meets and/or exceeds the needs and expectations of the customer.
- Continuously measure, assess and improve processes and outcomes of care and service by designing new systems and processes; improving the functioning of existing systems and processes; and, maintaining the stability of existing systems and processes that are functioning well.
- Coordinate quality assessment activities with other performance monitoring and management activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.
- Coordinate the collection of objective, measurable data, based on current knowledge and clinical experience to monitor and evaluate each important aspect of care.
- Provide data for provider recredentialing, rectification or performance appraisal process by identification of trends/patterns regarding quality of care and service.

- Comply with the requirements of all state and federal regulatory agencies and accrediting bodies.
- Ensure that appropriate care is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan, its providers, and others.
- Foster a supportive environment to help providers and practitioners improve the safety of their practice.

IV. QUALITY ASSESSMENT STANDARDS

Quality of care shall be determined in accordance with professionally acceptable standards in the service area that CCHCA shall monitor for compliance with its policies on a regular basis.

A. Medical Group

1. Shall not discriminate in the provision of care between managed care members and other patients.

2. Shall establish criteria and systems to identify potential problems in patient care.

3. Maintain documentation as necessary to ensure program effectiveness.

4. Take actions to correct identified problems and analyze any variations from established criteria that may include but are not limited to, under/over utilization, and continuity/coordination of care.

5. Quality of care shall be determined in accordance with professionally acceptable standards.

B. Physicians

1. Care shall be rendered by primary care physicians who will provide primary services in general or family medicine, internal medicine, pediatrics or obstetrics / gynecology.

2. Specialist physicians and other professionals will provide care to members upon referral from a primary care physician. Specialists shall be either certified by the American Board of Medical Specialties or have the equivalent in training and experience.

3. Primary care physicians will maintain individual patient records which will comply with pre-established medical record standards.

4. Primary care physicians will provide preventive health services in accordance with preventive health standards and notify the patient if prior authorization is required for a procedure.

5. Care relating to pregnancy will be provided only by physicians with delivery privileges at contracting hospitals.

6. Physicians will educate patients about the medical group's authorization process.

7. Primary care physicians will provide after hours and vacation coverage.

8. Access standards for preventive care, routine, urgent, emergent, after hour's care and telephone response time:

    a. Wait time for triage or screening: not to exceed 30 minutes
    b. Urgent care not requiring prior authorization: within 48 hours
    c. Urgent care requiring prior authorization: within 96 hours
    d. Non-urgent primary care: within 10 business days
    e. Non-urgent specialty care: within 15 business days
    f. Non-urgent mental health: within 10 business days
    g. Non-urgent ancillary services for diagnosis or treatment: within 15 business days.

    An extension of the applicable waiting times is allowed when a referring or treating provider has determined and documented that a longer waiting time will not have a detrimental impact on the member's health.

9. Medical records of Health Plan members shall be kept confidential to comply with all applicable Federal and State Laws.

V. Quality Assessment Activities

1. Accessibility of services
2. Availability of practitioners
3. Clinical Practice guidelines
4. Member Satisfaction
5. Practitioner Satisfaction
6. Review of Grievances and Appeals
7. Disease Management Programs
8. Health Education and Wellness Programs
9. Preventive Care

VI. Practitioner Office Administrative Policies and Procedures include but are not limited to the following:

1. Access
2. After Hours Calls
3. Confidentiality
4. Culturally sensitive care
5. Filing and Retrieving Medical Records
6. Fire/Safety/Disaster
7. Grievance Resolution Procedure
8. Handling of Biohazardous Waste
9. Health Care Decisions
10. Infection Control
11. Medical Office and Medical Record keeping On-Site Review
12. Medical Office Standards
13. Medical Record Standards
14. Member Rights and Responsibilities
15. Missed Appointments
16. Non-compliant Behavior with Medical Treatment
17. Notification of Test Results
18. OSHA/ Blood-borne pathogens
19. Patient emergency
20. Reporting Child Abuse/Neglect
21. Reporting Domestic Violence
22. Reporting Elder/Dependent Adult Abuse
23. Risk Management
24. Security Management
25. Sterilization
26. Storage of Mediations and Narcotics
27. Translation Service
28. Treatment Consent
29. Violence Prevention

VII: Audits, Surveys, Studies may include but are not limited to the following:

A. Participation in CCHRI
B. Member/Provider Satisfaction
C. Medical Office Audits
D. Medical Record Audits

VIII. Other areas as appropriate

UTILIZATION REVIEW PROGRAM

Chinese Community Health Care Association

Utilization Program

The CCHCA has established a Quality Assessment/Utilization Review Committee to implement its Utilization Management (UM) Program.

I. PURPOSE

The Utilization Management Program sets standards and reviews utilization issues. The Quality Assurance/Utilization Review (QA/UR) Committee will regularly monitor and evaluate the services provided by all providers to assure that appropriate care is being delivered. The QA/UR Committee and the UM Program are accountable to the Board of Trustees.

II. GOAL

The UM Program will focus on ensuring that care being provided to members is consistent with recognized professional standards and will pursue opportunities for improvement.

III. OBJECTIVES

A. Maintain a centralized, ongoing, and effective program that involves all providers in action plans to improve care and service to our members.
B. Establish priorities for the improvement or resolutions of known or potential issues that affect directly or indirectly on care and services.
C. Maintain a consistent level of high quality care and service in all areas, which meets and/or exceeds the needs and expectations of the member.
D. Provide continuous measurement, assessment and improvement in processes and outcomes of care and service by designing new systems and processes, improving the functioning of existing systems and processes, and maintaining stability of existing systems and processes that are functioning well.
E. Collect objective, measureable data, based on current knowledge and clinical experience to monitor and evaluate each important aspect of care.
F. Coordinate utilization management activities with other performance monitoring and management activities, including quality improvement, risk management, and resolution and monitoring of member complaints and grievances.
G. Provide data for provider re-credentialing, rectification or performance appraisal process by identification of trends/patterns regarding utilization management issues.

H. Maintain compliance with state and federal regulatory agencies and accrediting bodies' requirements.
I. Assure that appropriate care is not withheld or delayed for any reason, including potential financial gain and/or incentive to the plan, its providers, and others.
J. Provide a systemic process for educating providers regarding utilization management issues.

IV. UTILIZATION PROGRAM

A. Organizational Structure and Responsibilities

i. The Medical Director is responsible for overseeing the development and implementation of the UM Program. The Medical Director is a senior physician with an unrestricted license in the state of California.

ii. Utilization Management (UM)/Case Management Staff
The Medical Director is a senior physician with an unrestricted California medical license. The Medical Director is actively involved in key aspects of the UM Program such as setting policies, reviewing cases, reviewing consistency of applying UM decision criteria, overseeing the denial process, and participating in QA/UR Committee meetings. The Medical Director also serves as liaison to the individual physicians.

iii. The Director of Clinical Services, a registered nurse, is responsible for the development, implementation and effective coordination and administration of the UM Program. The Director of Clinical Services is responsible for oversight and evaluation of the UM Program and participates in QA/UR Committee meetings.

iv. Registered nurses, who report to the Director of Clinical Services serve as UM Case Managers and perform the actual authorization of services using established guidelines. Denials of services are performed by physicians only.

V. Committees

A. Quality Assurance/Utilization Review Committee (QA/UR)

The QA/UR Committee coordinates and oversees the effectiveness of monitoring, evaluation and improvement in systems, makes recommendations

based on results and monitors the effectiveness of the interventions. The committee also monitors compliance with state, federal and other accrediting agency regulatory requirements. It develops and approves policies, procedures and guidelines, assuring that they are consistent with regulatory requirements.

The QA/UR Committee meets quarterly to discuss the findings from quality assurance and utilization management activities and to assure that problems are identified and resolved in a timely manner. Urgent issues will be addressed separately either by the Medical Director or at an ad hoc QA/UR committee meeting.

A quorum is required which consists of a minimum of four physician committee members. A majority of votes cast at a meeting duly called, and at which a quorum is present, are required to act. Only licensed physician committee members may have voting rights on issues involving clinical decisions. The CCHCA Board of Trustees appoints the chairpersons and all members of the committee annually for a term of one year with renewable terms. The QA/UR Committee meets four times a year or more frequently as needed.

VI. Committee Activities

A. Data collection and analysis of inpatient and outpatient data are used for tracking, trending and education. Data include but are not limited to bed days/1000, adverse outcomes, under/over utilization and referral patterns.

B. Documentation of delegated activities, including the evaluation of activities and reports.

C. Problem resolution.

D. Annual evaluation of the effectiveness of the UM Program and revision of the program as needed.

E. Annual development of UM work plan.

F. Submission of reports on a timely basis as requested by health plans.

G. The information collected is used in the quality improvement process, the credentialing process and for implementing corrective action plans.

VII. UTILIZATION MANAGEMENT PROCESS

A. Determination of Medical Necessity

Objective criteria, based on sound medical evidence are used in making utilization decisions and are reviewed and updated as necessary, but no less than yearly. The sources of the criteria are:

- Milliman Care Guidelines
- Health Plan medical policy
- Hayes Medical Technology Directory
- Federal Medicare Guidelines
- National standards reflecting best practices
- Other sources as appropriate and available, including contracted health plans' medical policy or UM guidelines

The review process must not interfere with or cause delay in service or preclude delivery of services. The UM process will ensure that the information needed to determine medical necessity has been collected. When making a determination based on medical necessity, only information reasonably necessary to make a decision will be requested.

Appropriately licensed healthcare professionals supervise all medical necessity decisions. Staff members who are not qualified healthcare professionals may collect data for prior authorization and concurrent review under the supervision of appropriately licensed healthcare professionals. They may also have the authority to approve (but not to deny) services for which there are explicit criteria.

B. Inpatient Review

Medical information collected on admission or before admission, concurrently and, in some cases, retrospectively to authorize inpatient care. Authorized lengths of stay are determined by medical necessity in accordance with Milliman criteria. Continued stay may not be denied without concurrent review except in the case when a facility fails to provide timely information on which to base the review.

C. Discharge Planning

Discharge planning begins on admission when goals and treatment plans are established. Based upon the member's needs, post hospital services are arranged when the patient is medically stable for discharge.

D. Retrospective Review

When inpatient services have been provided without prior authorization, medical information shall be obtained from the provider to determine whether the services were medically necessary. The determination shall be made within 30 days of receipt of all information.

E. Inpatient/Outpatient Case Management

Case Management is a comprehensive, multidisciplinary process that coordinates timely, medically appropriate, quality care in the most effective setting. Case management maximizes benefit and community resources by providing assessment, problem identification, planning, outcome monitoring, and re-evaluation to meet the needs of a specific, targeted population with complex health care needs. The case manager is the link between the individual, the provider, the payer and community.

F. Outpatient Services

Outpatient services, including ambulatory services, diagnostic studies and specialty referrals are authorized by UM nursing staff using Milliman criteria. Referrals to medical group specialists for up to four visits per calendar year do not require authorization. If the medical group cannot provide a needed specialty service, authorization for a non-contracted provider shall be given.

G. Emergency Services

Prior authorization is not required for provision of emergency services. Emergency services, including emergency ambulance transportation in accordance with a plan's Evidence of Coverage, are authorized without medical review.

VIII. AUTHORIZATION PROCESS

A. Outpatient Review

Utilization decisions are made in a timely manner in accordance with regulatory requirements and depending on the urgency of the request. The UM Department maintains a tracking system for identifying the status of all authorization requests.

For routine authorizations, decisions are made within 5 working days of obtaining all necessary information for Commercial and Medi-Cal members and within 14 calendar days for Medicare Advantage members. Urgent decisions are made in a timely fashion appropriate for the member's condition, not to exceed 72 hours after receipt of the request. The provider is notified within one working day of the decision. If denied, the member and practitioner are given written or electronic conformation of the denial within two working days of making the decision. If an urgent case is denied, the member and practitioner are notified as to how to initiate an expedited appeal at the time they are notified of the denial.

B. Concurrent Review

For urgent concurrent review, decisions are made within 24 hours receipt of the request and providers are notified by telephone within 24 hours of receipt of the request.

C. Retrospective Review

Medical necessity decisions in retrospective situations are resolved within 30 calendar days of receipt of the request. Providers and members are informed of retrospective approvals and denials within 30 calendar days of receipt of the request.

IX. DENIAL/APPEAL PROCESS

Physician reviewers from the appropriate specialty conduct and document medical appropriateness review on any denial file. A psychiatrist, doctoral-level clinical psychologist, or certified addiction medicine specialist reviews any behavioral health care denials that are based on medical necessity. A description of the reason that the service is denied is documented clearly and the criteria on which the denial is based on available to the practitioner and member on request.

X. CONFLICT OF INTEREST

No person may participate in the review, evaluation or final disposition of any case in which he/she has been professionally involved or where judgment may be compromised. If it is necessary to seek outside physician reviewers in order to eliminate conflict of interest and assure an objective determination, such will be done.

XI. CONFIDENTIALITY

Utilization review activities are confidential and considered neither discoverable nor admissible in a court of law. In addition, the Health Care Quality Improvement Act was enacted to provide a mechanism to improve the quality of medical care. The act provides immunity from liability for damages resulting from actions taken in the course of such review. Peer review records and proceedings will be kept confidential according to Section 1157 of the California Evidence Code.

Confidentiality statements are signed annually by all physicians and guests attending the committee meetings. The proceedings and all documentation of the committee are maintained in a secure area.

Members of the committee will not discuss the proceedings or release any documents of the committee activities to any individual who is not a member of the committee.

XII. EVALUATION

The UM Program shall be reviewed at least annually by the CCHCA QA/UR Committee and revised as necessary.

MEMBER GRIEVANCES AND APPEALS

Purpose:

The Member Grievance Resolution Procedure is designed to handle member issues expeditiously and equitably. The types of questions or complaints addressed include those involving benefits, program administration, and medical care quality.

Definitions:

A member grievance is a member's written or verbal expression of dissatisfaction of any kind and includes all complaints and appeals.

A member appeal is a further request by a member to reverse a denied grievance.

Responsibility:

Initial level grievances are handled at CCHCA where the member is enrolled, only when CCHCA has been delegated this responsibility by the contracted health plan. If CCHCA cannot resolve the issue, then it is referred to the contracted health plan.

If CCHCA has not been delegated the responsibility for handling initial level grievances, all grievances are immediately referred to the contracted health plan.

Policy:

Members are informed through Plan specific literature to contact CCHCA for medical group related concerns, and to contact the Member Services Department of their health plan for all other problems. To the greatest extent possible, CCHCA encourages all of its members to present their problems or dissatisfactions as soon as they occur. If CCHCA cannot resolve a problem, the problem, including all backup information, will be referred to the contracted health plan.

A "Member Complaint (or Grievance) Form" must be made available to all members who wish to submit a complaint. Copies of the forms are found in Part II of this Handbook for each of CCHCA's contracted health plans and are also available from the health plans' Member Services Department. However, the use of the Member Complaint Form is not a required for making a complaint.

When members wish to submit a grievance to CCHCA, they should contact their health plan's Member Services Department. Members must include all pertinent information from the Plan Identification Card and the details and circumstances of their concerns or problems. In addition, members are advised in their Evidence of Coverage that they may seek the assistance of the Department of Corporations in the resolution of a grievance.

Procedure:

Under state law, grievances submitted by members must, whenever possible, be resolved within 30 days. Therefore, the CCHCA must, within 30 days of receipt of a grievance from a member, provide the member with a written statement on the disposition or pending status of the grievance. If a member is dissatisfied or needs assistance, he or she is encouraged to first contact the medical group.

CCHCA is required to periodically report to contracted HMOs the number and types of complaints received, the disposition of those complaints, and the percentage of complaints that were resolved within 30 days.

All reports are logged, tracked and trended. The CCHCA grievance system is audited annually by contracted HMOs.

In the event the member perceives that the medical group is unable to satisfactorily resolve the problem, the member may submit the matter with copies of all documentation directly to the contracted HMO as a formal grievance.

If the member's grievance involves imminent and serious threat to the health of the member, including but not limited to, potential loss of life, limb, or major bodily function, the grievance must be handled expediently. Therefore, CCHCA has established procedures for handling grievances which must be handled on an expedited basis. In such instances, the member must be immediately advised in an acknowledgment letter of their right to request assistance from the Department of Corporations. In addition, the member must be notified in writing of the disposition or pending status of such grievances within 5 days of receipt.

Denial of Services

CCHCA must have a qualified medical review of any claim, emergency, or requested service before a final decision is made concerning a denial of the services. When a case does not meet the criteria for authorized services, the member must be notified in writing of the reasons for the decision by the department denying the requested service.

The written notification must indicate the service that was denied, the reason for the denial, an explanation of how to properly obtain services in the future, a description of the alternative treatment that will be covered in the case of a denied service (if applicable), and a statement explaining the member's right to appeal the denial by contacting their health plan or the Department of Managed Health Care at 1-888-466-2219.

CCHCA cannot review or issue any denial letters for investigational or experimental procedures in cases of terminal illness. CCHCA must notify the contracted health plan immediately about a potential case and forward all pertinent documentation by overnight mail or fax.