Humboldt IPA

2020 Quality and Medical Management Program

I. Purpose

The IPA's Quality and Medical Management Program (QMMP) supports the IPA's mission of fostering local accountability while providing appropriate, proficient, cost-effective medical care for the people of Humboldt and Del Norte counties. QMMP aims to enhance public health and promotes access to quality care through the IPA's leadership position in working with health plans available in the two-county area.

The IPA's QMMP is designed to monitor, evaluate, and manage the appropriateness of health care services delivered to all health plan members based on the right care at the right time in the right setting to yield optimal clinical outcomes and member satisfaction at a reasonable cost. To ensure this level is achieved or surpassed, programs and activities having a direct or indirect influence on the quality and outcome of clinical care and service delivered to all health plan members are consistently and systematically monitored and evaluated. The evaluation process is fully documented, issues are relevant to the enrolled member population, responsibility is assigned to appropriate individuals, and when opportunities for improvement are noted, recommendations are provided.

II. Goals and Objectives

A. High quality, medically appropriate care, for all members through routine monitoring of health care, utilization management review, member and provider satisfaction surveys.
B. Services are delivered in the appropriate setting based on skills needed.
C. Administer benefits in accordance with the member's health plan coverage.
D. Disease management, population management, and quality improvement efforts are coordinated, centralized, ongoing and effective while involving all relevant practitioners.
E. Office practices and professional performance are evaluated regularly, objectively and reliably.
F. Appropriate, timely communication, reporting and documentation of all quality improvement issues and activities.
G. Measure, review and implement appropriate interventions for under and overutilization of services.
H. Apply quality data in the process of peer review, credentialing and re-credentialing.
I. Develop and implement effective health management systems to reduce overall health care expenditures.
J. Confidentiality, privacy and security of member and provider information.
K. Compliance with all state, federal, accrediting agency and contracted health plan regulations.
L. Maintain appropriate level of staffing to provide the full scope of QMMP services.
M. Ensure the IPA's staff carries out responsibilities designated by their level of expertise.
N. Ongoing monitoring and evaluation of costs of services.
O. Annual review, amendments and approval of the QMMP, medical guidelines, standards and criteria. The IPA refers to Anthem Blue Cross HMO and Blue Shield of California HMO medical policies to assist with determining medical necessity and to comply with health plan requirements.

III. Organizational Structure and Responsibilities of Oversight Committee

A. Governing Body – The IPA Board of Directors (BOD) is responsible for establishing, maintaining and supporting the QMMP. The BOD has delegated ongoing responsibility for the development and implementation of the QMMP to the Quality Management Administrative Committee (QMAC), provides oversight of the QMAC's activities, and participates indirectly with QM issues. The QMAC has delegated procedural aspects of Quality Improvement/Utilization Management (QI/UM) to the Medical Management Committee (MMC), oversight of clinical improvements to the Care Improvement Committee (CIC), and oversight of other ad hoc subcommittees as needed.

The BOD evaluates, approves and makes recommendations on the QM Plan at least annually and at time of revision. The BOD receives copies of the QMAC and any ad hoc committee meeting minutes, discusses reports, requests additional information when warranted and directs action, independent of the QMAC, on opportunities to improve care and services, and resolve problems, when indicated.

B. Chief Executive Officer (CEO)– See QMMP Director.

C. Chief Medical Officer (CMO) – The Chief Medical Officer is the designated physician (holding an unrestricted license to practice in the state of CA) who directs the implementation of the QI process; assures that the QI and UM Programs are compatible and interface appropriately with the practitioner network; oversees compliance with contracted health plans and accrediting agency, state and federal requirements; facilitates consistency in QI/UM operations; formulates and directs policies and procedures to support the QI/UM Operations; acts as a resource to clarify QI/UM processes; analyzes QI and UM Data; provides clinical input; directs the assessment of practitioner activities to ensure high standards of performance and quality of care and service; develops recommendations to improve health care services; and chairs the QI/UM subcommittees.

D. QM Program Director – The Chief Executive Officer (CEO) has organizational responsibility for the QMMP; ensures Program implementation, function and results; and provides for adequate resources and staffing. The CEO oversees compliance activities; reviews service and safety standards; identifies QI indicators for further investigation; conducts, reviews and analyzes quality improvement audits; identifies compliance problems; and oversees formulation of corrective action plans for problem resolution.

E. QM Resources – The IPA requires all managers to participate in quality management and to report to QMAC and its subcommittees on a regular and/or as needed basis. The IPA's programmers are trained and available to support the data needs of the QMMP. Qualified licensed medical professionals supervise preauthorization, concurrent inpatient review, retrospective review and case management decision-making. Non-licensed staff performs data entry and other clerical responsibilities related to the authorization process and may approve certain services based on established guidelines.

F. Frequency and Schedule of Meetings - The QMAC meets monthly. The QMAC, CIC and MMC subcommittees meet monthly and other subcommittees meet as needed.

G. Quality Management Administrative Committee – The QMAC is an interdisciplinary committee of BOD, with membership appointed by the BOD and the CMO It includes IPA staff involved in the quality of care and service, and practitioners who is representative of the practitioner panel. Only licensed IPA physician members have voting rights on issues involving clinical decisions. Three physicians make up a quorum. The terms of office are indefinite; as long as the practitioner is willing to serve they are considered members. The QMAC reports to the BOD at least quarterly. The QMAC

recommends policy decisions, reviews and evaluates the results of QI/UM activities; institutes needed actions, and ensures follow-up, as appropriate. The QMAC physician members also serve as alternate CMO in the event of absence. When additional resources are needed, approval is obtained from the BOD, along with necessary budgeted items for implementation.

H. QMAC Processes and Activities

1. Responsibilities of the QMAC and QMAC Subcommittees - The QMAC oversees QMMP activities and reports directly to the IPA BOD. The QMAC also reports directly to the delegated representative of health plans who have contracted to receive medical management services. Specific health plan reporting responsibilities are stated in the contracts with the health plans. QMAC also functions as the Credentialing and Peer Review Committee and as alternate CMO in the event of absence.
2. Responsibilities of the QMAC Subcommittees – The QMAC currently has two subcommittees: MMC and CIC. Additional ad hoc committees are formed as needed to address operational issues and focused medical and mental health decision-making issues such as therapeutics utilization, emergency room utilization, radiological utilization and other topics requiring a term of focused committee input. Additional clinical leaders groups are structured around particular disease management projects as needed and report to the QMAC. QMAC subcommittees meet their program objectives in part by conducting prospective, concurrent, and retrospective review of services for procedures, inpatient hospitalizations, outpatient surgery, rehabilitation, home health and hospice care. Selected services from outpatient ancillary and physician offices are reviewed. The subcommittees monitor quality, continuity and coordination of care. The subcommittees may function as subcommittees of the Peer Review Committee when dealing with a "medical cause or reason" as defined in the Business and Professions Code section 805. All quality of care issues identified by the subcommittees will be brought to the attention of the QMAC. Urgent issues are addressed separately by the CMO and QMAC as needed.
3. Responsibilities of the Committee Chairperson - The CMO acts as chairperson and participates on all QMAC committees. The Chairperson, along with the CEO, is responsible for developing the meeting agenda, scheduling dates, facilitating the meetings, and assuring order, accountability and follow through regarding the topics discussed.
4. Committee composition and voting rules – The IPA CMO attends QMAC meetings and QMAC subcommittees meetings. Other non-staff practitioners are included upon their request and on an as needed basis. Only in-plan physicians with an unrestricted license to practice in the State of California have voting rights on IPA committees. The presence of three in-plan physicians is required to represent a quorum. Voting is based on a simple majority.
5. Health Plan representation at QMAC meetings - Health plan representation on the QMAC is based on contractual agreements with each plan. Health plan staff must sign a confidentiality statement prior to attending the meeting and may attend only that part of the meeting that covers members assigned to their plan.
6. Communication with Staff, Practitioners, Members and Health Plans – The QMMP information is communicated to staff through their managers, who participate in the QMAC and/or subcommittee meetings or through the CEO who ensures information is relayed to the appropriate persons not present at a QM meeting. QMMP information is communicated to practitioners and members using the IPA website and direct mailing as needed and/or requested. The Chairperson is responsible for communicating with providers about their own specific quality issues as needed. The CEO is responsible for reporting issues from QMAC directly to the delegated representative of

contracted health plans. Other specific health plan reporting responsibilities are stated in the contracts with the health plans.

7. Continuity and Coordination of Care Processes – Continuity of care is monitored across practice and provider sites through the medical management department, which includes linkages between Primary Care Physicians and Specialist Care Physicians; general medical and behavioral health care; coordination among specialists; coordinated use of ancillary services inclusive of community and social services; availability of health/medical records to appropriate professionals; and appropriate case management and discharge planning. In compliance with Managed Care Regulations AB 1286 and SB 244, when a primary care or specialty provider terminates their relationship with the Health Plan, the IPA determines which patients will be affected and case managers assist with the coordination of high-risk members continued care with other appropriate providers. Additional information may be found in the following policies and procedures: Continuity and Coordination of Care, Provider Credentialing, and Case Management.
8. Departmental Data Collection Systems – Data requests for reports from IT department staff are submitted to the IT Director for scheduling and dispensation. The CEO meets weekly with the IT Director to monitor priorities to ensure that reporting functions are meeting the IPA's needs.
9. Confidentiality/Privacy/Security (HIPAA, CA Civil Code 1798.85) – See HIPAA Policies and Procedures. Each year QMAC members sign a confidentiality agreement which is kept in the HIPAA binder or employee file as appropriate. Systems in place to assist staff in the processing of claims, authorizations, credentialing files etc. are monitored to ensure data within the systems are not changes after a claim, authorization etc. is finalized. Reports are generated monthly showing any additions, edits or deletes are made. Reports are reviewed by management to ensure data is not being altered. Additionally systems such as EZCAP and Intellicred have role based permissions which also limit staffs ability to access data that in not within their scope and/or limits the ability to make changes without management approval.
10. Problem Resolution - Staff, providers, members and other interested parties may identify problems and potential problems. All such situations are forwarded to the CEO who will triage to the appropriate oversight committee based on the issues involved. The executive staff reviews contractual payment issues with the BOD and all quality of care issues are referred to QMAC. The assigned committee is responsible for investigating, monitoring and evaluating pertinent issues, utilizing performance goals and benchmarks to reach decisions. Problems identified by the QMAC that relate to UM will initially be followed by the QMAC and then referred to the MMC for review and follow up. All UM problems identified by the MMC as quality issues are referred to the QMAC for review and initiation of a corrective action plan when indicated. In the instance of an Urgent issue that cannot wait until the next scheduled QMAC or MMC meeting the CEO and Chief Medical Officer will discuss the issue, call an ad hoc MMC meeting if necessary and address any immediate needs at that time. Corrective action plans must include intervention plan, timelines, measurement of intervention effectiveness and follow-up tracking. All actions or decisions are documented in the QMAC minutes and/or QMAC subcommittee meeting minutes. Actions or decisions affecting process by which medical services are provided to health plan members are reported to the health plan at intervals on the request of the health plan.
11. Required QM, QI, and UM Work Plans and Reports – The IPA has adopted the Industry Collaboration Effort (ICE) report formats and timelines as required by the commercial health plans administered by the IPA. All required QM, QI and UM health plan work plans and reports are reviewed and approved by QMAC and/or MMC according to the required timeframes. Additional review and approval by the BOD is done as required by the health plan. The MMC oversees implementation of work plans, monitors results, and reports back to QMAC.

Meeting Minutes

IPA staff prepares minutes in a consistent format for all committee meetings. Meeting minutes include a list of the members present and those absent. Minutes reflect evaluation, decisions, recommendations, action plans, and delegation of follow-up requested. For confidentiality, provider and member names are de-identified when documenting issues. Peer review records and proceedings are kept confidential according to Section 1157 of the California Evidence Code. Documents presented at meetings are labeled and included as attachments to the minutes. The final approved minutes become a permanent part of the committee's meeting record and are distributed at the next meeting of the committee's reporting body. Previous meeting's minutes are distributed at the following committee meeting as part of the agenda packet for final review, approval and signature by the committee chairperson. Changes requested after the committee's review are incorporated prior to signature. Committee minutes are stored in a secure location and may be accessed only by authorized staff.

V. Activities and Functions

A. Quality Improvement

The MMC conducts initial reviews of policies and procedures, including research and recommended changes. All QI, QM, and UM policies are reviewed and approved by QMAC annually. Policies that are not simply administrative in content, that is, include a medical necessity component, are distributed to appropriate practitioners for review and recommendation. Reviewers are given 30 days to respond before the policy is sent to QMAC for final approval. Standard policies and areas of routine review include but are not limited to the following subjects:

1. Access to Health care Services
2. Continuity and Coordination of Care when MD terminates
3. Grievances and Appeals
4. Credentialing/Re-Credentialing

B. Risk Management

The IPA's practitioner risk management activities are identified in the Credentialing Policy and Procedure, which includes methods for identifying and monitoring through on-site visits. Applicable policies and procedure development and implementation in practitioner offices may include but not be limited to the following:

1. After Hours Calls
2. Treatment Consent
3. Notification of Test Results
4. Protected Health Care Information
5. Infection Control and OSHA/Blood-borne Pathogens
6. Fire/Safety/Disaster
7. Storage of Medications and Narcotics

C. Utilization Management

The scope of the QMMP includes the processing of prospective, concurrent, and retrospective review determinations by qualified personnel. Qualified personnel include RNs, LVNs, PhDs, MDs, DOs and DPMs for cases that require clinical review for medical necessity. Information may be entered into the system by non-licensed staff (see related quality and utilization management policies). The areas of review include:

- Inpatient hospitalizations
- Outpatient surgeries
- Selected outpatient services
- Rehabilitative services
- Selected ancillary services
- Home health care services
- Selected pharmaceutical services
- Selected physician office services
- Out-of network services
- Behavioral health activities
- Coordination with health plans, as appropriate

Physician and Behavioral Health Practitioner Responsibilities

Only a physician reviewer can make a decision to deny services based on medical appropriateness. Every day, a physician reviews all authorization requests that, based on policy, cannot be approved by staff. The physician's review and decision-making is documented in the EZCAP system. When necessary to process an authorization, the physician will initiate a clinical consultation with an appropriate specialist provider and document the results in writing or in EZCAP. Clinical consultation with a psychiatrist or doctoral level clinical psychologist is arranged for review of all potential denials of behavioral healthcare that is based on medical necessity.

Confidentiality and Conflict of Interest

All IPA employees and participants of QMAC maintain patient confidentiality and sign an annual statement of confidentiality. Decision-makers are not reimbursed based on their patterns of approvals or denials and no incentives to approve or deny services are offered by the IPA. Utilization Management (UM) decision making is based only on appropriateness of care and service and existence of coverage. The Humboldt IPA does not specifically reward practitioners or other individuals for issuing denials of coverage or services care. The Humboldt IPA does not offer financial incentives to UM decision makers that encourage decision that result in underutilization. In addition, providers participating on committees may not vote on any case review in which they have been professionally involved (e.g., provider of care, partner of provider, or made the referral to provider of care) or personally involved (e.g. relative or significant other). Participating providers are ensured independence and impartiality in making referral decisions that will not influence, hiring, compensation, termination, promotion or any other similar matters.

Utilization Management Criteria

Services for eligible members are authorized in accordance with health plan-specific benefits based on medical appropriateness and regulatory requirements.

Individual member needs (age, co morbidities, complications, progress of treatment, psychosocial situation, home environment, member desires, ethnic and cultural beliefs and practices plus other

specifics as appropriate), as well as local health care demographics, are considered when applying criteria to a specific individual. When guidelines or criteria are not appropriate for an individual, or criteria may not be met according to the clinical information provided, the case is referred to a Chief Medical Officer or the Medical Management Committee for review. All requests reviewed by the QMMP staff are evaluated to determine medical appropriateness utilizing approved criteria and guidelines in compliance with regulatory timeliness standards.

Efforts are made to obtain all necessary information for case review and authorization or denial of services, including pertinent clinical information and consultation with the treating physician, as appropriate.

The IPA adheres to State of California, NCQA and health plan mandated criteria for consistency of reviewing utilization. The IPA has adopted a list of approved resources (see the Medical Management Policies and Procedures), which are objective and based on sound medical evidence. Additions to the approved resources are reviewed and approved annually by QMAC. Appropriate, actively practicing practitioners assist in the review, revision and acceptance of the criteria and in the development and review of procedures for applying the criteria. The criteria are distributed to the appropriate providers and are available upon request to all participating practitioners and members.

Consistency of medical management decision-making is measured through quarterly inter-rater reliability audits for MMP licensed staff.

Direct or Speedy Referrals

Local in-plan providers may directly refer to any local in-plan specialists without prior authorization. Specific out-of area providers may also be accessed without prior authorization (see Access policy). In addition, all local in-plan providers can refer members directly for routine laboratory and X-ray services.

Utilization Management

- Potential quality-related issues are referred to the QMAC for investigation.
- Potential high risk and chronic care members are identified and referred to case management for evaluation and intervention. Case Managers also assist high-risk patients who are affected when providers terminate from the Health Plan. (See Case Management policy).
- Potential third party liability (TPL) cases are identified and referred to the claims department.
- High cost cases are identified and referred to the appropriate health plan within health plan time frames.
- Potential experimental or investigational treatments are referred to the appropriate health plan for resolution.
- Continuity and coordination of care is monitored and members are assisted with the transition to other care when benefits end.

Utilization Tracking, Notification and Reporting

See IPA Utilization Management Policy for additional details.

Complaints and Appeals

Member complaints and appeals are coordinated per the Grievances and Appeals Policy and in conjunction with the Health Plans. The HMO member appeal process is not delegated to the IPA so

HMO complaints and appeals are forwarded within 24 hours to HMO's Grievances and Appeals unit. Provider appeals related to claims are resolved through the processes described in the Provider Dispute Resolution Policy. PPO member-related provider appeals associated with medical necessity issues are brought to the QMAC committee for second level review. Member complaints and appeals are tracked and used to specifically address member satisfaction with The IPA UM process associated with getting services approved or members obtaining a referral.

D. Audits and Surveys

The IPA's QMMP includes an annual schedule of audits, surveys and studies. These are presented to QMAC for analysis, determination of performance goals thresholds and identified opportunities for intervention, applicable corrective action plan implementation, and measurement of intervention effectiveness. All audits, surveys, and studies are made available upon request to the contracted health plans and network practitioners.

Annual Schedule of Audits and Surveys and Benchmarks

Audit/Survey	Performed	Benchmark
Primary Care Physician and Specialist Care Physician available per 1,000 Members	Fourth quarter of each year	National Benchmark
Population audits to identify membership demographics	First quarter of each year	NA
Humboldt IPA Network Practitioner Satisfaction Survey	Fourth quarter of each year	Overall 80% satisfaction rating
Patient Assessment Survey/Patient Satisfaction Survey	Fourth quarter of each year	IHA Benchmark
Access survey	Third quarter of each year	Health plan Benchmark
Medical Office and Record audits	As needed	80% compliance

D. Health Management Systems

The IPA's health management systems are included in the Humboldt eQuality (HeQ) and the HMO Pay for Performance Program(s) (P4P). The P4P and HeQ programs reflect identified member needs by

- analysis of baseline demographic and epidemiological data (population based studies)
- strategies to ensure that an at-risk population is being identified and reached for the identified condition

E. Peer Review/Disciplinary Action Process

QMAC delegates the review of the annual audits, surveys and studies to MMC to determine if performance goals thresholds are met and to identify opportunities for intervention and applicable corrective action plan implementation. If intervention is appropriate the Chief Medical Officer will contact the provider to develop a plan to improve based on the area of deficiency.

F. Reporting and Reviews

- QMMP policies and procedures are reviewed and revised annually by QMAC.
- A Provider Office Satisfaction Survey is conducted annually to evaluate the effectiveness of the

QMMP. The results of this survey can be found on the Humboldt IPA website.

- A Patient Assessment Survey is conducted annually to evaluate, monitor, and provide feedback to the IPA and member providers about the services they have received.
- Other approved QMMP and health plan reports are submitted in the required time frames.

VI. Program Review

The QMMP is reviewed, updated and approved annually by the QMAC chairperson and the Board of Directors.

Signatures

MD — 1-27-20

Chairperson, QMAC — Date

2/4/20

President, Executive Committee — Date

Document History

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