

## **Section 7. Quality and Appropriateness of Care**

**Guidance: Methods for Evaluating and Monitoring Quality-** Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

**Tools for Evaluating and Monitoring Quality-** Tools and types of information

available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 8.

**Guidance:** The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

**7.1.** Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

### Quality Assurance Structure

The MCO's utilization management and quality assurance program will consist of internal monitoring by the MCOs, oversight by DSS and the federal government, and evaluation by an independent, external review organization (EQRO). These programs are in place for the MCOs currently contracting for Title XIX clients and the same programs will be used for Title XXI. Future RFPs for Managed Care Organizations will include the need to provide services for both the Title XIX and the Title XXI programs. All MCOs must have a quality assurance structure composed of:

- (a) an internal system of monitoring services;
- (b) designated staff with expertise in quality improvement and quality assurance; and
- (c) written policies and procedures for quality assurance and utilization management.

### Quality Assurance System

As with Title XIX, MCOs are required to establish, implement, and adhere to the Quality Assurance and Utilization Management review systems approved by the Department and based on the current HCFA guidelines (A Health Care Quality Improvement System for Medicaid Managed Care issued July 6, 1993) or subsequent revisions thereof (9/2017), and shall:

- (a) ensure that health care is provided as medically necessary in an effective and efficient manner;
- (b) assess the appropriateness and timeliness of care provided;
- (c) evaluate and improve, as necessary, access to care and quality of care with a focus on improving patient outcomes;
- (d) focus on the clinical quality of medical care rendered to enrollees; and
- (e) incorporate all the "Minimum Quality Assurance and Utilization Management Requirements."

MCOs will be held accountable for monitoring, evaluating, and taking action as necessary to improve the health of its members under contract with DSS. MCOs will also be held accountable for the quality of care delivered by sub-contractors, which must comply with all quality management procedures and requirements of this RFP.

### Quality Assurance Policy and Procedures

**NOTE:** These policies and procedures are already in place for Title XIX. MCOs must distinguish between Title XIX and Title XXI for reporting.

Internal policies and procedures must:

- (a) assure that the utilization management and quality assurance committee has established parameters for operating and meets on a regular schedule which is at least quarterly, committee members must be clearly identified and representative of the MCO's providers, accountable to the medical director and governing body, and must maintain appropriate documentation of the committee's activities, findings, recommendations, and actions;
- (b) provide for regular utilization management and quality assurance reporting to the MCO management and MCO providers, including profiling of provider utilization patterns;

- (c) be developed and implemented by professionals with adequate and appropriate experience in quality assurance;
- (d) provide for systematic data collection and analysis of performance and patient results;
- (e) provide for interpretation of this data to practitioners;
- (f) provide for making appropriate changes when problems in quality of care are found; and
- (g) clearly define the roles, functions, and responsibilities of the quality assurance committee and medical director.

#### Internal Quality Assurance Program

The MCO must have an internal written quality assurance plan (QAP) that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas. Emphasis must be placed on, but need not be limited to, clinical areas relating to well baby care, well child care, pediatric and adolescent development, as well as on key access or other priority issues for Title XXI members such as teen age pregnancy and immunizations.

All MCOs are to structure their internal QAPs in a manner consistent with the standards as outlined in the Federal Government's "Quality Assurance Reform Initiative Guide for States" (QARI) or subsequent revisions thereof, for internal and external quality assurance reviews.

#### Provider Profiling

The MCO must have written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State and qualified to perform their services according to CMS's "A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for the States", or subsequent revisions thereof. The MCO also must have written policies and procedures for monitoring its providers and for disciplining providers who are found to be out-of-compliance with the MCO's medical management standards.

#### Quality Assurance Report

As with the existing Title XIX program, plans will also be required to submit periodically to DSS reports regarding results of their internal monitoring. This will include the reporting of The Healthcare Effectiveness Data and Information Set (HEDIS), Volume 3.0 or subsequent revisions, and other targeted health indicators that shall be monitored by DSS as well as other specific quality data periodically requested by the federal government. The MCO must agree to submit a quality assurance report six (6) months after the contract effective date and semi-annually thereafter. These reports will distinguish clearly between the Title XIX and the Title XXI programs.

#### Outcomes Objectives

The State, in conjunction with the MCOs, will develop a system of incentives for reaching outcomes objectives in certain key areas to be defined by the State and MCOs. These outcomes objectives will include, at a minimum, childhood immunizations, well baby and well child care, pediatric asthma, and behavioral health care. MCOs will be required to submit on a periodic basis objective numerical data and/or

narrative reports describing clinical and related information on health services and outcomes of health care for the Title XXI and Title XIX populations. Each program will be handled as separate populations for reporting

#### Internal Staff

The State's enrolled populations for the Title XIX and the Title XXI programs are too small to require separate internal programs for the MCOs. Therefore, internal staff and internal committees may serve both populations. A clear definition will be made during reporting.

The MCO must designate a quality assurance and utilization management coordinator, who is either the MCO's medical director or a person who reports directly to the medical director. This individual is responsible for the development and implementation of the quality assurance program. The coordinator must have adequate and appropriate experience in successful utilization management and quality assurance programs and be given sufficient time and support staff to carry out the MCO's utilization management and quality assurance functions. This person, or group will also be responsible for assuring the interface and support of the EQRO and State quality assurance functions as necessary.

#### Quality Assurance Committee

MCOs must have a quality assurance committee that assists the coordinator in carrying out all quality assurance functions. This committee must satisfy the DSS's requirements and, at a minimum:

- (a) demonstrate that the Committee will have oversight responsibility and input on all quality assurance and utilization management activities;
- (b) demonstrate that the committee has accountability to the MCOs governing board;
- (c) ensure membership on the committee and active participation by individuals representative of the MCOs provider community;
- (d) and demonstrate that the contractor will secure adequate insurance for members of the committee and subcommittees.

#### Quality Assurance and Utilization Management Coordinator

The coordinator and the quality assurance committee must be accountable to the MCO's governing body.

The qualifications and responsibilities must include but need not be limited to what follows below. Specifically, the coordinator must:

- (a) the head of the governing body must be licensed to practice medicine in the United States and be board-certified or board-eligible in his or her field of specialty;
- (b) oversee the development of the MCO's annual written quality assurance description including areas and objectives, scope, specific activities, and methodologies for continuous tracking, provide review and focus on health outcomes;
- (c) oversee the MCO's utilization management and quality assurance committee, direct the development and implementation of the MCO's internal quality assurance plan and utilization management activities, and monitor the quality of care that MCO members receive;
- (d) oversee the development of clinical care standards and practice guidelines and

- protocols for the MCO;
- (e) review all potential quality of care problems and oversee development and implementation of continuous assessment and improvement of the quality of care provided to members;
  - (f) assure that adequate staff and resources are available for the provision of proper medical care and health education to members;
  - (g) specify clinical or health service areas to be monitored;
  - (h) specify the use of quality indicators that are objective, measurable, and based on current knowledge and clinical experience for priority areas selected by DSS as well as for areas the MCO selects; current Health Plan Employer Data and Information Set standards must be used;
  - (i) oversee the MCO's referral process for specialty and out-of-plan services; all denied services must be reviewed by a physician, physician assistant, or advanced nurse practitioner; the reason for the denial must be documented and logged; all denials must identify appeal rights of the member;
  - (j) be involved in the MCO's recruiting and credentialing activities;
  - (k) be involved in the MCO's process for prior authorization and denying services;
  - (l) be involved in the MCO's process for ensuring the confidentiality of medical records and member information;
  - (m) be involved in the MCO's process for ensuring the confidentiality of the appointments, treatments, and required State reporting of adolescent sexually transmitted diseases;
  - (n) work with the special programs coordinator to assure that reports of disease and conditions are made to DSS in accordance with all applicable State statutes, rules, guidelines, and policies and with all metropolitan ordinances and policies;
  - (o) assure that control measures for tuberculosis, sexually transmitted diseases, and communicable disease are carried out in accordance with applicable laws and guidelines and contained in each provider manual;
  - (p) serve as a liaison between the MCO and its providers and communicate regularly with the MCO's providers, including oversight of provider education, in-service training, and orientation;
  - (q) be available to the MCO's medical staff for consultation on referrals, denials, complaints, and problems;
  - (r) attend State medical director's meetings;
  - (s) maintain current medical information pertaining to clinical practice and guidelines;
  - (t) and attend grievance committee meetings when necessary.

#### External Quality Assurance Reviews

DSS will contract with independent, external evaluators to examine the quality of care provided by MCOs. The State will amend the existing contract with its EQRO for the Title XIX program. The amendment will clearly define the need to keep the populations and associated reporting separate.

The MCO will be required to cooperate with any external quality, independent assessment of its performance, which has been duly authorized by DSS. Independent assessments shall include, but not be limited to, the federally required reviews of (1) access to care, quality of care, cost effectiveness, and the effect of case management; (2) the contractor's quality assurance procedures, implementation of the procedures, and the quality of care provided; and (3) consumer satisfaction surveys.

The MCO agrees to assist in the identification and collection of any data or medical records to be reviewed by the independent assessors and/or DSS. The contractor shall ensure that the data, medical records, and workspace are available to the independent assessors or DSS at the contractor's work site.

DSS will monitor each MCO's adherence to Quality Assurance Reform Initiative (QARI) standards through one or more of the following mechanisms:

- (a) Review of each MCO's written QAP prior to contract execution:
- (b) periodic review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes of health care for the enrolled population;
- (c) on-site monitoring by DSS of QAP implementation to ensure compliance with all standards; such monitoring will take place at least once every six (6) months;
- (d) independent, external review of the quality of services furnished by each MCO, conducted by an entity under contract to DSS; such reviews will be conducted at least once each year; the MCO must agree to make available to DSS's external evaluator medical and other records (subject to confidentiality constraints) for review as requested;
- (e) on-site visits and inspections of facilities;
- (f) staff and enrollee interviews;
- (g) review of appointment scheduling logs, emergency room logs, denial of services, and other areas that will indicate quality of care delivered to enrollees;
- (h) medical records reviews;
- (i) all quality assurance procedures, reports, committee activities and recommendations, and corrective actions;
- (j) review of staff and provider qualifications;
- (k) review of grievance procedures and resolutions;
- (l) and review of requests for transfers between primary care providers within each MCO.

The MCO shall submit a corrective action plan (CAP) to resolve any performance or quality of care deficiencies identified by the independent assessors and DSS as determined necessary by DSS.

#### Fraud and Abuse Protections

The MCO may not knowingly:

- have a person who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order 12549 or under guidelines implementing such order, as a

- Director, officer, partner, or person with beneficial ownership of more than 5% of the entity's equity;
- or have an employment, consulting, or other agreement with a person described above for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

The MCO may not distribute directly or indirectly or through any agent or independent contractor marketing materials within the state:

- without prior approval of the State, or
- that contains false or materially misleading information.

The MCO shall develop marketing materials especially for the Title XXI program. These materials will be provided to the State's Health Benefit Manager (HBM). The HBM will include these materials in all mailings to the eligible population.

The MCO shall distribute marketing materials to entire service areas covered under this contract.

The MCO or its subcontractors may not seek to influence an individual's enrollment with the MCO in conjunction with the sale of any other insurance.

The MCO shall comply with such procedures and conditions as the State prescribes in order to ensure that before a member is enrolled with the MCO, the individual is provided accurate oral and written information sufficient to make an informed decision.

The MCO shall not directly or indirectly, conduct door-to-door, telephonic or other "cold-call" marketing of enrollment.

The MCO shall require each professional providing services to members, eligible for the program, to have a unique provider identifier, the method of which will be approved by the State.

The MCO shall report any fraudulent or abusive practices by subcontractors or providers to DSS for investigation or referral to other appropriate authorities and must cooperate with any subsequent investigation. The MCO and its providers are subject to review or investigation by DSS and other State agencies for quality of care, fraud or abuse, and must cooperate fully in the provision of requested information to offices, including, but not limited to, DHSS, the Department of Justice, the State Auditor, the Insurance Department, and the appropriate licensing agencies within the Department of Administrative Services.

#### Member Satisfaction Report

MCOs must survey their members on at least an annual basis to determine satisfaction with MCO's services.

The MCO must agree to collect and assist DSS in collecting annual member satisfaction data through application of a uniform instrument to a randomly selected sample of its members. The State will design a questionnaire to measure satisfaction and include measures of out-of-plan use, to include use of emergency rooms; average waiting time for appointments, including physician office visits; average time and distance to reach providers; access to specialty providers; and the number and causes of disenrollment; and coordination with other health programs. This member satisfaction survey will be based on the CAHPS survey. To ensure comparability of results, all members will receive the same survey. DSS will consider suggestions

from the MCO for questions to be included in this survey. DSS will tally the results of these surveys, which will be published.

- 7.1.1.  Quality standards
- 7.1.2.  Performance measurement
  - 7.1.2 (a) CHIPRA Quality Core Set
  - 7.1.2 (b) Other
- 7.1.3.  Information strategies
- 7.1.4.  Quality improvement strategies

**Guidance:** *Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))*

- 7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

**NOTE:** These policies and procedures are already in place for Title XIX. MCOs must distinguish between Title XIX and Title XXI for reporting.

- 7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

MCO's must have an internal written QAP that monitors, assures, and approves the quality of care delivered over a wide range of clinical and health service delivery areas to include, but are not limited to:

- Well baby care;
- Well child care;
- Pediatric and adolescent development; and
- Immunizations.

Plans are also required to report semi-annual results of their internal monitoring. This will include the reporting of the above-referenced HEDIS indicators.

- 7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

Delaware will expect its contracting Medicaid MCOs to use existing provider panels to provide services to the DHCP. The State requires a 1:2500 patient to primary care provider ratio for DSHP and expects the MCOs to maintain that ratio for the DHCP. The DMES provides weekly reports on MCO capacity. These reports are monitored by DSHP staff. The MCOs are notified of access issues and the need to add providers. Delaware Medicaid's contracting MCOs have contracts with all of the State's hospitals for outpatient and emergency care. A majority of Delaware's physician providers also contract with the Medicaid MCOs. The State's contracting MCOs report percentage of primary providers with open panels on a quarterly basis to DSHP.

The state requires the "prudent layperson" language for emergency services as defined by the BBA of 1997. This regulation also restricts the use of prior authorizations for emergency care and the denial of emergency care provided by non-network providers.

The State will perform consumer satisfaction surveys and will require the MCOs to perform consumer satisfaction surveys. Issues related to access are an integral part of these surveys. The State uses a modified CAHPs survey for the DSHP and will use the same methodology for the DHCP. The State also uses grievance and complaint records for DSHP to identify MCO panels that may be reaching capacity. These methods have worked well for DSHP and we would expect the same results for the DHCP.

- 7.2.3.** Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

Benefit procedures exist for members with chronic, complex, or serious conditions. All of the managed care organizations must comply with regulations regarding access to and adequacy of specialists.

During enrollment, the Health Benefits Manager screens enrollees with chronic, complex, or serious medical conditions and refers this information to the MCOs. The MCOs utilize case managers to assure appropriate access to care for children with serious health care needs.

- 7.2.4.** Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

The state complies with SCHIP requirement of decisions related to the prior authorization of health services within 14 days after receipt of request.