POLICY PURPOSE

To have a process in place to help evaluate the quality of care of institutions where our members receive care.

SCOPE

Medicare Advantage population

REFERENCES

Medicare Managed Care Manual Ch. 5, 20.1 Quality Improvement Program; 42 CFR §422.152(f)(3)

RESPONSIBLE PARTIES

● Senior Director of Quality

DEFINITIONS

Healthcare Effectiveness Data and Information Set (HEDIS®): is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

Quality of Care Grievance: A complaint or grievance related to whether the quality of services provided by a plan or provider meets professionally recognized standards of health
care, including whether appropriate health care services have been provided or have been provided in the appropriate settings.

POLICY

Monitoring potential quality of care issues are key to keeping members healthy, safe and satisfied. Tracking and trending will be carried out to identify patterns around a given facility. Comparison of readmission rates, potentially avoidable admission and mortality rates to benchmarks help identify outliers or any areas of inadequate utilization, either under or over. Further analysis will provide information on facilities/practitioner performance and the need to implement processes for improvement from an enhanced discharge planning process and ensure the provision of adequate outpatient care.

PROCEDURE

1. The Quality Improvement Committee will determine which quality of care monitoring measures from the CMS Reporting Requirements to monitor annually in accordance with organizational goals and CMS requirements. These measures are defined in the Quality Department work plan.

2. Potential Quality of Care grievances scored by the Grievance team of greater than a 2b will be forwarded to the Chief Medical Officer and Credentialing for review. A summary of the reviewed cases will be submitted to the Quality Improvement Committee on an ongoing basis.

3. The Senior Director of Quality works with the Chief Medical Officer, VP of Medical Management and other applicable stakeholders to identify data sources, indicators, and benchmarks for over- and underutilization.

4. The Quality team performs the analysis to determine the presence of over- or underutilization based on existing benchmarks.

5. The Senior Director of Quality or another designee of the Quality team, presents results at the Quality Improvement Committee at least quarterly for identification, prioritization, and development of an action plan to address issues for any identified trends or areas of concern.

6. The Senior Director of Quality, with the support of the Quality team, further monitors the process to assess the effectiveness of the interventions.

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES

- Related Policy A: A&G 101 Member Grievances
- Related Policy B: 005 P&P Quality QOC Investigations

APPROVALS

Head of Quality

Date: 11 / 11 / 2022
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