

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS FOR SPECIALTY PRE-PAID INPATIENT HEALTH PLANS

July 2008

[Note: Proposed revisions for FY'09-10 are in bold]

The State requires that each specialty Prepaid Inpatient Health Plan (PIHP) have a quality assessment and performance improvement program (QAPIP) which meets the standards below. These standards are based upon the Guidelines for Internal Quality Assurance Programs as distributed by then Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993; the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358 of 2002. This document also reflects: concepts and standards more appropriate to the population of persons served under Michigan's current 1915(b) specialty services and supports waiver; Michigan state law; and existing requirements, processes and procedures implemented in Michigan.

Michigan Standards

- I The PIHP must have a written description of its QAPIP which specifies 1) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2) the components and activities of the QAPIP, including those as required below; 3) the role for recipients of service in the QAPIP; and 4) the mechanisms or procedures to be used for adopting and communicating process and outcome improvements.
- II The QAPIP must be accountable to the Governing Body - Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:
 - A. Oversight of QAPIP - There is documentation that the Governing Body has approved the overall QAPIP and an annual QI plan.
 - B. QAPIP progress reports - The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions.
 - C. Annual QAPIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.
- III There is a designated senior official responsible for the QAPIP implementation.
- IV There is active participation of providers and consumers in the QAPIP.
- V The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.
 - A. PIHP must utilize performance measures established by the department in the

areas of access, efficiency and outcome and report data to the state as established in contract.

- B. The PIHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.
- VI The PIHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in the contract and analyzes the causes of negative statistical outliers when they occur.
- VII The PIHP's QAPIP includes affiliation-wide performance improvement projects that achieve through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction.
- A. Performance improvement projects must address clinical and non-clinical aspects of care.
 - 1. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.
 - 1. Non-clinical areas would include, but not be limited to, appeals, grievances and complaints; and access to, and availability of, services.
 - B. Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's consumers; consumer demographic characteristics and health risks; and the interest of consumers in the aspect of service to be addressed.
 - C. Performance improvement projects may be directed at state or PIHP-established aspects of care. **The statewide project for FY'09 is improving the access to services for children who are Medicaid beneficiaries and adult beneficiaries with substance use disorders as measured by the performance targets individually negotiated between MDCH and each PIHP.** Future state-directed projects will be selected by MDCH with consultation from the Mental Health Quality Improvement Council and will address performance issues identified through the external quality review, the Medicaid site reviews, or the performance indicator system.
 - D. PIHPs may collaborate with other PIHPs on projects, subject to the approval of the department.
 - E. The PIHP must engage in at least two projects during the waiver renewal period.
- VIII The QAPIP describes the process of the review and follow-up of sentinel events.
- A. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate, **with root cause analyses to commence within two business days of the sentinel event.**

B. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

IX. **The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management has been used in an emergency situation. Only techniques that have been approved during person-centered planning by the beneficiary or his/her guardian, and are supported by current peer-reviewed psychological and psychiatric literature may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.**

X. The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.

A. The assessments must address the issues of the quality, availability, and accessibility of care.

C. As a result of the assessments, the organization:

1. Takes specific action on individual cases as appropriate;
2. Identifies and investigates sources of dissatisfaction;
3. Outlines systemic action steps to follow-up on the findings; and
4. Informs practitioners, providers, recipients of service and the governing body of assessment results.

C. The organization evaluates the effects of the above activities.

D. The organization insures the incorporation of consumers receiving long-term supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

XI. The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (**by MDCH and the PIHPs**) clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the persons served.

XII. The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified

to perform their jobs.

The PIHP must have written policies and procedures for the credentialing process which are in compliance with MDCH’s Credentialing and Re-credentialing Processes, January 2007 , Attachment P.6.4.3.1, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, re-certifying and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP are incorporated into this re-credentialing process.

The PIHP must also insure, regardless of funding mechanism (e.g., voucher):

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:
 - a. Educational background
 - b. Relevant work experience
 - c. Cultural competence
 - d. Certification, registration, and licensure as required by law
 2. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.
 3. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.
- XIII. The written description of the PIHP’s QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by affiliates (as applicable), providers and subcontractors.
- A. The PIHP must submit to the state for approval its methodology for verification.
 - B. The PIHP must submit its findings from this process and provide any follow up actions that were taken as a result of the findings.
- XIV. The organization operates a utilization management program.
- A. Written Plan - Written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.
 - B. Scope - The program has mechanisms to identify and correct under utilization as well as over utilization.
 - C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:
 1. Review decisions are supervised by qualified medical professionals.

- Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.
2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.
 3. The reasons for decisions are clearly documented and available to the member.
 4. There are well-publicized and readily-available appeals mechanisms for both providers and patients. Notification of denial is sent to both the beneficiary and the provider. Notification of a denial includes a description of how to file an appeal.
 5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
 6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.
 7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.