960 TRACKING AND TRENDING OF MEMBER AND PROVIDER ISSUES

REVISION DATES: 10/01/15, 10/01/13, 04/01/12, 02/01/11, 10/01/09, 10/01/08, 02/01/07, 06/01/05, 04/01/05, 08/13/03, 10/01/01, 10/01/97

INITIAL EFFECTIVE DATE: 10/01/1994

A. OVERVIEW

Each Contractor must develop and implement policies and procedures to review, evaluate and resolve quality of care and service issues raised by enrolled members, contracted providers and stakeholders. The issues may be received from anywhere within the organization or externally from anywhere in the community. All issues must be addressed regardless of source (external or internal).

NOTE: References to a member in this Policy also include reference to a member's guardian and/or representative.

B. DOCUMENTATION RELATED TO QUALITY OF CARE CONCERNS

As a part of the Contractor's process for reviewing and evaluating member and provider issues, there must be written policies and procedures regarding the receipt, initial and ongoing processing of these matters that include the following:

1. Document each issue raised, when and from whom it was received, and the projected time frame for resolution.

2. Determine promptly whether the issue is to be resolved through the Contractor's established:

    a. Quality management process.

    b. Grievance and appeals process,

    c. Process for making initial determinations on coverage and payment issues, or

    d. Process for resolving disputed initial determinations.

3. Acknowledge receipt of the issue and explain to the member or provider the process that will be followed to resolve his or her issue through written correspondence.

4. Assist the member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.

5. Ensure confidentiality of all member information.

6. Inform the member or provider of all applicable mechanisms for resolving the issue external to the Contractor processes.

7. Document all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each complaint, grievance or appeal, including but not limited to:

    a. Corrective action plan(s) or action(s) taken to resolve the concern.

    b. Documentation that education/training was completed. This may include, but is not limited to, in-service attendance sheets and training objectives.

    c. New policies and/or procedures.

    d. Follow-up with the member that includes, but is not limited to:

        i. Assistance as needed to ensure that the immediate health care needs are met, and
        ii. Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns.

    e. Referral to the Contractor's compliance department and/or AHCCCS Office of the Inspector General.

(Refer to 9 A.A.C. 34 and the AHCCCS contract for information regarding requirements for the grievance system for members and providers.)

C. PROCESS OF EVALUATION AND RESOLUTION OF QUALITY OF CARE AND SERVICE CONCERNS

The quality of care concern process must include documentation of identification, research, evaluation, intervention, resolution and trending of member and provider issues. Resolution must include both member and system interventions when appropriate. The quality of care/service concern process must be a stand alone process completed through the quality management unit. The process shall not be combined with other agency meetings or processes. Work units outside of the quality

management unit will not have the authority to conduct quality of care investigations but may provide subject matter expertise throughout the investigative process.

1. The Contractor must develop and implement policies and procedures that address analysis of the quality of care issues through:

    a. Identification of the quality of care issues.

    b. Initial assessment of the severity of the quality of care issue.

    c. Prioritization of action(s) needed to resolve immediate care needs when appropriate.

    d. Review of trend reports obtained from the Contractor's quality of care data system to determine possible trends related to the provider(s), including organizational providers, involved in the allegation(s) including: type(s) of allegation(s), severity and substantiation, etc.

    e. Research, including, but not limited to: a review of the log of events, documentation of conversations, and medical records review, mortality review, etc.

    f. Quantitative and qualitative analysis of the research, which may include root cause analysis.

    g. Direct interviews of members, direct care staff, and witness to a reportable event; when applicable and appropriate.

2. Onsite visits must be conducted by the Contractor's Quality Management staff when there are identified health and safety concerns, immediate jeopardy or serious incident situations, or at the direction of AHCCCS. Subject matter experts outside the Quality Management unit may participate in the onsite visit but may not take the place of Quality Management staff during reviews.

3. Member health, welfare and safety is an important tenet in a program providing Long Term Services and Supports (LTSS). Contractors are required to participate in efforts to prevent, detect, and remediate all critical incidents including those that are self-identified, or when notified by AHCCCS of incidents or concerns identified by ADHS Licensure or by AHCCCS. (§ 438.330(b)(6).

4. Contractors may not delegate quality of care investigation processes or onsite quality of care visits.

5. The Contractor must develop a process to assure that action is taken when needed by:

    a. Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring,

    b. Determining, implementing and documenting appropriate interventions,

    c. Monitoring and documenting the success of the interventions,

    d. Incorporating interventions into the organization's Quality Management (QM) program if successful, or

    e. Implementing new interventions/approaches when necessary.

6. The Contractor must develop a process to ensure resolution of the issue. Member and system resolutions may occur independently from one another.

7. The Contractor must develop a process to determine the level of severity of the quality of care issue.

8. The Contractor must develop a process to refer/report the issue to the appropriate regulatory agency including the Department of Child Safety or Adult Protective Services, Arizona Department of Health Services (ADHS), the Attorney General's Office, law enforcement and AHCCCS for further research/review or action. Initial reporting may be made verbally, but must be followed by a written report within one business day.

9. The Contractor must have a process to refer the issue to the Contractor's Peer Review Committee when appropriate. Referral to the Peer Review Committee is not a substitute for implementing interventions aimed at individual and systemic quality improvement.

10. If an adverse action is taken with a provider for any reason including those related to quality of care concern, the Contractor must report the adverse action to the AHCCCS Clinical Quality Management Unit within 24 hours of the determination to take an adverse action as well as to the National Practitioner Data Bank.

11. The Contractor must have a process to determine the level of substantiation of the quality of care or service issue.

12. The Contractor must have a process to provide written notification to the appropriate regulatory/licensing Board or Agency and AHCCCS when a health care professional's organizational provider or other provider's affiliation with its network is suspended or terminated for any reason, including those related to quality of care issues, and

13. The Contractor must have a process to document the criteria and process for closure of the review or investigation including, but not limited to the following:

    a. A description of the problems, including new allegations identified during the investigation/review process, and the substantiation and severity level for each allegation as well as the case overall.

    b. Written response from or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or Medical Examiner.

14. Investigations that identify an adverse outcome, including mortalities, due to prescribing issues or failure of the provider to check the CSPMP, to coordinate care with other prescribers, refer for substance use treatment or pain management, the Contractor shall notify AHCCCS CQM, take appropriate action with the provider including suspension or corrective action plans and referrals to appropriate regulatory Boards including the Pharmacy Board. The case findings shall be taken to the Contractor's Peer Review Committee for discussion and review.

Requests for Copies of Death Certificates:

As part of the quality of care investigation process, AHCCCS Contractors may request copies of member death certificates from the ADHS Office of Vital Statistics The following process must be followed:

- AHCCCS Contractors must send a letter, on Contractor letterhead, providing one or two names of employees who are authorized to make a request for a copy of the death certificate. The request should be someone at a manager or supervisory level position with the Contractor.

- The letter must be sent to:

  Arizona Department of Health Services
  Office of Vital Records
  Office Chief
  P.O Box 3887
  Phoenix, Arizona 85030

- The letter will be kept on file with the Office of Vital Records. Only those individual(s) listed on the letter are eligible to apply/request a copy of the death certificate.

- The following information will be needed from the Contractor, submitted on Contractor letterhead, when making the request for a copy of the death certificate:

    - The decedent's (member's) name
    - Date of death
    - Purpose of request (i.e. quality of care investigation process)
    - Signature of the authorized employee
    - Requests must be mailed with original ink signatures
    - Documentation showing that decedent was a member of the Contractor making the request (copy of an eligibility screen with the Contractor's name, member's name and date of eligibility is acceptable)

- A fee of $5.00 for each copy requested in the form of a business check, money order or credit card.

- All requests should be sent to:

  Office of Vital Records
  Attention: Office Chief
  P.O. Box 3887
  Phoenix, Arizona 85030

Contractors must notify the ADHS Office of Vital Statistics in writing of any termination of employment of those listed on the original letter. Included in the notification should be the name of the replacement managerial or supervisory staff person. These changes should be mailed to:

Operations Section Manager
Arizona Department of Health Services
Office of Vital Records
Operations Section Manager
P.O Box 3887
Phoenix, Arizona 85030

D. TRACKING AND TRENDING OF QUALITY OF CARE ISSUES

Tracking and trending of member and provider issues is crucial to quality assurance and quality improvement.

1. The Contractor must develop and implement a system to document, track, trend and evaluate complaints and allegations received from members and providers or as directed by AHCCCS, inclusive of quality of care, quality of service, and immediate care need issues.

    a. The data from the quality of care data system must be analyzed and evaluated to determine any trends related to the quality of care or service in the Contractor's service delivery system or provider network. Contractors are responsible for incorporating trending of quality of care issues in determining systemic interventions for quality improvement.

    b. The Contractor must document quality tracking and trending information as well as documentation that the information was submitted, reviewed, and considered for action by the Contractor's local Quality Committee and local Medical Director, as Chairman of the Quality Management Committee.

    c. Quality tracking and trending information from all closed quality of care issues within the reporting quarter must be submitted to AHCCCS/Division of Health Care Management/Clinical Quality Management (AHCCCS/ DHCM/CQM) utilizing the Quarterly Quality Management Report (Exhibit 960-1). The report is due 45 days after the end of each quarter, reported separately by line of business and must include the following reporting elements:

        i. Types and numbers/percentages of substantiated quality of care issues,
        ii. Interventions implemented to resolve and prevent similar incidences, and
        iii. Resolution status of "substantiated", "unsubstantiated" and "unable to substantiate" quality of care issues.

        If significant negative trends are noted, the Contractor may consider developing performance improvement activities focused on the topic area to improve the issue resolution process itself, and to make improvements that address other system issues raised during the resolution process.

    d. The Contractor must submit to AHCCCS CQM all pertinent information regarding an incident of abuse, neglect, exploitation, serious incident and unexpected death (including all unexpected transplant deaths) as soon as the Contractor is aware of the incident, and no later than 24 hours. Pertinent information must not be limited to autopsy results, and must include a broad

review of all issues and possible areas of concern. Delays in receipt of autopsy results shall not result in a delay in the Contractor's investigation of a quality of care concern. Delayed autopsy results shall be used by the Contractor to confirm the Contractor's resolution of the quality of care concern.

2. The Contractor must ensure that member health records are available and accessible to authorized staff of its organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care/service or investigating member or provider quality of care concerns, complaints, allegations of abuse, neglect, exploitation, serious incidents, grievances, Provider Preventable Conditions and Healthcare Acquired Conditions (HCAC). Member record availability and accessibility must be in compliance with Federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. 431.300 *et seq*.

3. Information related to coverage and payment issues must be maintained for at least five years following final resolution of the issue, and must be made available to the member, provider and/or AHCCCS authorized staff upon request.

4. In addition to care coordination, as specified in its contract with AHCCCS, the Contractor must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program, also referred to as the Challenging Member Program. This includes, but is not limited to, members who do not meet the Contractor's criteria for case management as well as members who contact governmental entities, including AHCCCS, for assistance.

E. PROVIDER-PREVENTABLE CONDITIONS (EFFECTIVE 07/01/2012)

42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable conditions. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC).

If an HCAC or OPPC is identified, the Contractor must conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

The terms HCAC and OPPC are defined as follows:

Health Care Acquired Conditions (HCAC) – means a Hospital Acquired Condition (HAC) under the Medicare program which occurs in any inpatient hospital setting and

is not present on admission (Refer to the current CMS list of Hospital-Acquired Conditions).

Other Provider Preventable Conditions (OPPC) - means a condition occurring in the inpatient and outpatient health care setting which AHCCCCS has limited to the following:

1. Surgery on the wrong member,
2. Wrong surgery on a member, and
3. Wrong site surgery.