Oklahoma Health Care Authority

EXTERNAL QUALITY REVIEW REPORT

SoonerCare

Report for Contract: State Fiscal Year 2010

Data Reviewed: State Fiscal Year 2009

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APS HEALTHCARE

OKLAHOMA HEALTH CARE AUTHORITY
EXTERNAL QUALITY REVIEW REPORT
SOONERCARE
SFY 2009 (July 1, 2008 – June 30, 2009)

Introduction

The purpose of this report is to document the results of the external quality review of the SoonerCare program for State Fiscal Year (SFY) 2009, July 1, 2008– June 30, 2009. The report consists of five parts. The first four parts present a review of compliance with four domains of measures and the fifth part highlights selected findings. The report concludes with a short bibliography crediting the many sources cited and reviewed. The table of measures is included as Appendix A.

In 1996, under the 1115(a) and 1915(b) federal waivers, Oklahoma implemented a Primary Care Case Management (PCCM) program for Temporary Aid to Needy Families (TANF) recipients residing in rural Oklahoma. In 2004, the PCCM program expanded into a statewide program for Oklahoma's Medicaid recipients called SoonerCare Choice. The ultimate goal of the Oklahoma SoonerCare PCCM program is to enhance the quality, continuity, and access to care available to its members. During the first half of SFY 2009, SoonerCare operated under a partially capitated case management system. The Oklahoma Health Care Authority (OHCA) implemented a patient-centered medical home model (PCMH) on January 1, 2009. The primary care provider (PCP) provides the medical home through which all care is coordinated.

During SFY 2009, SoonerCare provided services to 809,251 Oklahomans, an increase of 4.9 percent from SFY 2008. The majority of Oklahoma SoonerCare enrollees (61%) are children age 18 and under. The OHCA's SFY 2009Annual Report includes details regarding the SoonerCare program, its services, and operation. The report is available at the OHCA's web site at: www.okhca.org.

Prior to 2007, the Oklahoma Health Care Authority used the Quality Improvement System for Managed Care (QISMC) developed by the Centers for

Medicare and Medicaid Services (CMS) as a means to assess the quality of the infrastructure, operations, and strengths and weaknesses of the SoonerCare program. In SFY 2007, a new framework of assessment that excludes the QISMC measures not applicable to the SoonerCare program was developed. The framework consists of 122 measures used to review SoonerCare over SFY 2009. The 122 measures fall into four domains:

- Domain 1 focuses on the Quality Assurance (QA) program, the policy-making bodies in place to administer the program, its projects, and the data system maintained to ensure accurate, timely, and complete data collection.
- Domain 2 confirms that the agency articulates members' rights, promotes the exercise of those rights, and ensures that the OHCA staff and affiliated providers are familiar with enrollee rights.
- Domain 3 covers several aspects of health care service delivery, including availability; accessibility; continuity and coordination of care; service authorization; practice guidelines and new technology; provider qualifications and selection; member health records, and communication of clinical information.
- Domain 4 reviews how the OHCA oversees and is accountable for any functions or responsibilities delegated to other entities.

APS Healthcare serves as the External Quality Review Organization (EQRO) for the SoonerCare program. APS Healthcare is a leading national specialty healthcare company recognized nationwide for its collaborative customized approach, quality care management and behavioral health programs, advanced data analysis, and commitment to an integrated mind-body approach to analysis and review. In its role as the SoonerCare EQRO, it is the responsibility of APS Healthcare to evaluate the performance and progression of the program toward full compliance with the measures in the four domains.

In order to determine the SoonerCare program's compliance for this report, APS Healthcare conducted interviews with Quality Assurance management and reviewed

multiple sources of documentation as outlined in the "References" section of this report. The documentation included, but was not limited to, the OHCA rules, OHCA service efforts and accomplishments reports, OHCA annual reports, performance and quality reports, performance improvement project reports, the OHCA member handbook, provider contracts, and audit and tracking tools.

DOMAIN 1: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM (MEASURES QI 01 – QI 31)

Domain 1 consists of 31 measures divided into three parts. The first set of measures assesses the performance improvement projects selected by the SoonerCare program and confirms if they are outcome oriented and achieve demonstrable and sustained improvement in care and services. The second set assesses the health information system that collects, integrates, analyzes, and reports the data necessary to implement the Quality Assurance program. The third set reviews the administrative bodies and personnel in place to administer the Quality Assurance program.

Quality Studies (QI 01 – QI 15)

The SoonerCare program implemented a wide range of projects characterized by collaboration with stakeholders in other agencies and communities throughout Oklahoma, strategic relevancy to the needs of the SoonerCare population, and advancement of the findings of previous projects and programs. The OHCA SFY 2009 quality report provides detailed information regarding these projects. The Performance and Quality Report, "*Minding Our P's and Q's*", along with individual project reports and discussions with SoonerCare staff and management, are the primary references for the comments below and the source of information for individual project details.

Updates on Quality Initiatives

- In SFY 2009, the OHCA continued to provide educational outreach to the families of all newborns covered by SoonerCare. The telephone and letter contact informed parents about child health checkups, helped them navigate the health

care system, and aligned parents and their children with an accessible and appropriate PCP. The SFY 2009 outreach efforts resulted in a contact rate of 17.6%.

- The Perinatal Dental Access program, which offers basic dental care to pregnant members, provided dental care services to an average of 945 pregnant SoonerCare members per month during SFY 2009.
- Reducing emergency room (ER) utilization continues to be a priority for the OHCA. SFY 2009 marked the OHCA's fifth year of tracking emergency room (ER) services. To reduce inappropriate use of the ER and help align members with a PCP or medical home for routine health care needs, the OHCA expanded its outreach and educational efforts, contacting 4,996 members identified with high ER use.
- The OHCA held the third annual SoonerCare Tribal Consultation meeting in July 2009. Over 189 tribal leaders attended, representing over 19 tribes. This collaborative effort focused on SoonerCare issues such as program development, strategic planning, and legislation.
- The Child Health Advisory Task Force made several recommendations to the OHCA and OSDH during SFY 2009 including: online enrollment, childhood obesity, increasing the breast-feeding rates, updating the child health checkup schedule, and monitoring the impact of the patient-centered medical home model of care on children.
- The Medical Advisory Task Force (MAT), a collaborative group consisting of 12 physician members, worked to develop and improve SoonerCare programs and focused on developing the patient-centered medical home primary care delivery system during SFY 2009. MAT efforts included incorporating feedback from providers statewide, developing a transitional plan of action, developing incentives for providers, and reviewing the OHCA external review process. The PCMH was implemented mid SFY 2009.

- The Electronic Newborn-1 (NB-1) program completed its first full year of operation during SFY 2009 and doubled the number of participating hospitals. NB-1 is a user-friendly web-based application process for enrolling SoonerCare newborns, streamlining the application process, and eliminating wait time. It also ensures that the baby has program eligibility and assignment to a medical home provider prior to discharge from the hospital.
- During SFY 2008, the OHCA entered into an agreement with the Oklahoma State Department of Health (OSDH) to share information related to maternal and child health. This data-matching agreement allows both agencies to benefit from sharing information to fill in the gaps while maintaining the security and privacy of protected health information (PHI). The focus for SFY 2009 was to compare the timeliness of initiating prenatal care of SoonerCare mothers to non-SoonerCare mothers through the compilation of data collected by each agency.
- During its first full fiscal year, "Soon-to-be-Sooners" (STBS) provided pregnancy related services to 6,855 women who would not otherwise qualify for benefits due to citizenship status. The OHCA seeks to contribute to better outcomes for babies by providing appropriate prenatal care for expectant mothers.
- OHCA continued to produce four provider profiles during SFY 2009: Child Health Checkups, Breast Cancer Screening, Cervical Cancer Screening, and Emergency Room Utilization. PCPs who met the criteria received profiles designed to assist them with monitoring preventive health compliance rates for their members.

New Quality Initiatives

- The OHCA implemented a patient-centered medical home model on January 1, 2009. It incorporates a managed care component with traditional fee-for-service and provider incentive payments.
- The OHCA's Pregnancy Outreach Program, implemented in SFY 2009, involved identifying pregnant members and offering assistance with the SoonerCare

benefits. Each pregnant mother received an outreach letter asking the member to contact member services regarding their health benefits. Member service personnel evaluated each member to determine if the member might have a high-risk pregnancy and could benefit from follow up by a care management nurse. The program had a high member return call rate of 39.4% during its first year.

- In SFY 2009, the OHCA SoonerCare Health Management Program (HMP) began a three-year partnership with the Center for Health Care Strategies (CHCS) and the Robert Wood Johnson Foundation. The partnership seeks to assist small practices that serve a high proportion of SoonerCare members in reducing racial and ethnic disparities and improving overall outcomes. During initial year of the partnership, OHCA worked with 10 small primary care practices to provide practice facilitation and to implement process improvements.

SoonerCare Program Updates

- The SoonerCare Health Management Program (HMP) completed its first full year of operation in SFY 2009. The HMP helped over 3,800 SoonerCare members with high-risk health problems manage their chronic conditions. It included member assistance through face-to-face nurse care management and monthly calls to members by nurse care managers. The HMP also includes a practice facilitation component for providers and provided services to 60 practices.
- The "Oklahoma Cares" Breast and Cervical Center Treatment Program, an interagency collaboration of the OHCA, OSDH, Department of Human Services (DHS), the Kaw Nation of Oklahoma and the Cherokee Nation, identified and treated these two types of cancer. Since the program began in 2005, more than 20,000 women have qualified for the program. On average, 320 women were added to the program each month in SFY 2009.
- The OHCA's Insure Oklahoma program expanded the eligibility criteria and the employee staffing limits during SFY 2009, increasing enrollment by 71%. The program helped reduce the number of uninsured Oklahomans by assisting small

businesses in obtaining health insurance for their employees through two methods. One method, Employer-Sponsored Insurance (ESI), provided health insurance premium assistance to employees of small businesses. The other method, Individual Plan (IP), provided health coverage to individuals who did not have access to ESI through their employer. The enrollment for the IP program doubled from SFY 2008 to SFY 2009.

- The OHCA continued the success of "Focus on Excellence," a program centered on increasing quality and accountability for nursing facilities by having employees and consumers rate the performance on a transparent website. The system financially rewarded nursing homes that demonstrated improvement in the quality of life, care, and services provided to members. In addition to the performance-based reimbursement system, the program provided consumers with frequently updated information assisting in the selection and comparison of nursing homes. During SFY 2009, the Pacific Health Policy Group (PHPG) performed an audit of "Focus on Excellence" and commended the high level of participation in this program.
- SoonerPlan completed its fourth full fiscal year of operation, with more than 68,000 Oklahomans qualifying for services since the program began in April 2005. The program helped provide family planning services to adults who were otherwise ineligible for SoonerCare.

Study Results, Tracking Change, and Ongoing Quality Reviews

- Information gathered through the conduction of research studies impacted policy and procedure decisions of the projects and programs listed above. These studies carefully examined trends and provided insight into future possibilities. During SFY 2009, the OHCA conducted studies on Attention Deficit Hyperactivity Disorder, Emergency Room Utilization, Early Preterm Birth Outcomes, Child Health Checkups, Breast and Cervical Cancer Program, SoonerPlan, and Comprehensive Diabetes Care. The quality studies are available on the OHCA

web site, www.okhca.org.

- The research studies outlined above are complemented by analyses that track HEDIS® measures over time. In SFY 2009, trend data analysis determined whether apparent changes were statistically significant. The different analyses were complicated by the eligibility requirements and changing specifications of some of the HEDIS® measures. Trends were analyzed for the following HEDIS® measures:
  - Annual Dental Visit (ADV)
  - Breast Cancer Screening (BCS)
  - Cervical Cancer Screening (CCS)
  - Well-Child Visits in the First 15 Months of Life (W15)
  - Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
  - Adolescent Well-Care Visits (AWC)
  - Children and Adolescents' Access to Primary Care Practitioners (CAP)
  - Adults' Access to Preventive/Ambulatory Health Services (AAP)
  - Comprehensive Diabetes Care (CDC)
  - Use of Appropriate Medications for People With Asthma (ASM)
  - Appropriate Treatment for Children With Upper Respiratory Infection (URI)
  - Appropriate Testing for Children With Pharyngitis (CWP)
  - Lead Screening in Children (LSC)
  - Cholesterol Management for Patients With Cardiovascular Conditions (CMC)
- CAHPS® and ECHO® consumer satisfaction surveys allowed the OHCA to track changes and measure its performance. In SFY 2009, the CAHPS survey was administered to a random sample of parents and guardians to gauge their level of satisfaction with medical services and treatment provided to their children. The CAHPS survey asked questions related to consumers' experiences with providers and the SoonerCare system. The CAHPS survey results indicated a significant increase with members overall rating of SoonerCare and member satisfaction with

getting care quickly. The ECHO survey contains similar questions to CAHPS with SoonerCare adults about experiences with his/her behavioral health medical treatment. The SFY 2009 ECHO survey ratings showed a high level of satisfaction, holding steady compared to SFY 2007 survey results, as well as a significant increase of members who indicated receiving information of alternative treatment options.

- Two additional surveys were conducted during SFY 2009; one related to member satisfaction with the SoonerPlan program and the other related to member satisfaction with Oklahoma Cares (Breast and Cervical Cancer Treatment Program). Both surveys showed positive ratings and high levels of member satisfaction.
- The OHCA performed on-site provider reviews, dental provider audits, medical record reviews, and ongoing quality of care reviews to monitor service quality and investigate reports of problems. In SFY 2009, Quality Assurance/Quality Improvement (QA/QI) staff members completed 277 on-site provider reviews. QA/QI staff trained providers on policies and procedures to ensure that each provider understood compliance criteria. Noncompliance resulted in a provider corrective action plan, which OHCA then periodically monitors for correction and progress. The dental unit reviewed 118 practices during SFY 2009 to ensure the provision of quality services to members and to improve communication with dental providers. The OHCA's contracted EQRO retrospectively reviewed thousands of inpatient hospital admissions.
- PCP provider profiles in SFY 2009 focused on child health checkups, cervical cancer screenings, breast cancer screenings, and emergency room utilization. Providers who had enough data for a valid statistical analysis received a letter and a profile explaining how their rate of actual exams compared with the expected number of screenings. The profiles also showed how providers ranked among their peers statewide.

Health Information System (QI 16 – QI 20)

None of these studies would have been possible without a robust health information system to collect, integrate, analyze, and report the data necessary to implement the QA program. An APS Healthcare review of SoonerCare claims and encounters found that, apart from a few inconsistencies found in various fields in a very small percentage of claims, the administrative data for Oklahoma's SoonerCare clients appeared to be sound, reliable, and valid. This analysis also revealed greater stability in the population, with more people remaining in the program for longer periods, resulting in improved access to care.

Administration of Quality Assurance Program (QI 21 – QI 31)

These measures ensure there is a policy-making body to oversee the Quality Assurance program, and formal and ongoing communication and collaboration among the policy-making body and other functional areas of the organization. The SoonerCare program met each of these requirements.

Compliance Results – Domain 1

The SoonerCare program met the requirements of each of the 31 measures of Domain 1 during SFY 2009. Thus, the SoonerCare program achieved full compliance with Domain 1 measures during this review year.

DOMAIN 2: ENROLLEE RIGHTS (MEASURES QR 01-QR 37)

The organization must articulate enrollees' rights, promote the exercise of those rights, and ensure that its staff and affiliated providers are familiar with enrollee rights. Enrollees' interactions with the organization and its providers may have an important impact on their willingness and ability to understand and comply with recommended treatments, outcomes, and costs. The measures in Domain 2 reflect these requirements.

The SoonerCare program ensures compliance with federal and state laws affecting the rights of enrollees in areas such as discrimination, confidentiality, right to privacy, and accessibility through rules documented by the OHCA. These rules are available to

providers and are accessible to enrollees. The Oklahoma Secretary of State Office of Administrative Rules publishes the official rules as Title 317 of the Oklahoma Administrative Code. The text of the official rules is available on the OHCA website.

A review of the SoonerCare Choice member handbook demonstrated that OHCA successfully met many of the remaining Domain 2 measures. This document is updated annually and is distributed to enrollees upon enrollment and then annually thereafter. This document is readable at a 6th grade level and is available in both English and Spanish.

The SoonerCare Choice member handbook, the enrollment guide, and the provider directory detail the process for enrollee PCP selection. Together these documents ensure each enrollee the option to select a PCP from among those accepting new members. The OHCA performs periodic phone surveys to monitor member access to a PCP. The OHCA QA/QI staff conducts on-site audits of SoonerCare Choice providers to assess program compliance. A component of those audits assesses member access to his/her assigned PCP. In addition, the OHCA staff monitors the availability of specialty services across all geographic locations through ongoing communication with those providers.

The SoonerCare Choice member handbook also provides enrollees with the information they may need to file a complaint or grievance against the SoonerCare program or its providers. OHCA rules 317:2-1-1, 2 and 5 confirm the complaint and grievance documentation process, the appeals and hearing processes, and reference all timeframes for complaint or grievance resolution. According to the SFY 2009 OHCA annual report, the OHCA received and investigated 4,289 member complaints, which represents less than 1% of all SoonerCare enrollees.

Compliance Results – Domain 2

The SoonerCare program met the requirements of each of the 37 measures of Domain 2 during SFY 2009. Thus, the SoonerCare program achieved full compliance with Domain 2 measures during this review year.

DOMAIN 3: HEALTH SERVICES DELIVERY (MEASURES QH 01 – QH 49)

Domain 3 measures cover six distinct areas including:

- Availability and accessibility
- Continuity and coordination of care
- Service authorization
- Practice guidelines and new technology
- Provider qualifications and selection
- Enrollee health records and communication of clinical information

Availability and Accessibility (QH 01 – QH 12)

Twelve measures of Domain 3 fall under the area of availability and accessibility. These measures seek to confirm that enrollees have access to an adequate selection of PCPs and a comprehensive network of providers, including specialists. Measures cover the convenience of provider hours and locations, timeliness of care, and round-the-clock accessibility when warranted. These measures also attempt to verify that the organization has procedures in place to identify individuals with complex health care needs and ensure adequate coordination of care.

The OHCA monitored access to an adequate selection of PCPs each month, through encounter reports and on-site or phone-based provider audits. The Member Services department tracks and maintains records on the availability of appointment slots at specialty providers, so monthly data is available regarding which specialists have appointment openings when members call for referrals. On-site and phone audits confirmed that providers are maintaining convenient hours, timely access to services, and adequate after-hours access. The OHCA codes physician locations geographically and updates this file monthly to monitor provider office accessibility to members. The member handbook refers members to a Nurse Advice Line (i.e., Patient Advice Line) for use when an enrollee cannot reach a PCP, thus ensuring access to services 24 hours a day, seven days a week.

The SoonerCare Choice program achieved full compliance with the requirements of each of the 12 measures of this part of Domain 3 for SFY 2009.

Continuity and Coordination of Care (QH 13 – QH 18)

Six measures of Domain 3, Health Services Delivery, fall under the area of continuity and coordination of care. Measures in this area aim to verify that enrollees have access to an ongoing source of primary care, that all care received is coordinated and the maintenance of continuity of care.

The nature of the SoonerCare Choice program as a PCMH program ensures that a specific person, persons, or agency will be responsible for locating, coordinating, and monitoring all care on behalf of a client. This includes primary care, other medical care, and rehabilitative services. This is required through the OHCA rules.

Provider contracts ensure one provider will coordinate all care for a member, even when a member accesses other sources of care such as community or social services. Care management and its applicable OHCA rules also ensure continuity of care for enrolled members and allow for information dissemination to members as appropriate.

The SoonerCare Choice program is in full compliance with each of the six measures of this area of Domain 3 for SFY 2009.

Service Authorization (QH 19 – QH 27)

Nine measures of Domain 3 fall under the area of service authorization. Measures in this area aim to confirm the organization has procedures and policies in place related to authorization of services, or requests for continuation of services for its members.

The OHCA maintains a staff of two full-time and two part-time physicians to review and process each request for initial authorization of services or continuation of services for SoonerCare enrollees. Each physician focuses on a content/review area. Weekly meetings that include physicians, review nurses, and other quality team members provide a forum to discuss and confirm decisions made by individual reviewers. The OHCA generates an automatic written notice of the decision from the service authorization system for provision to the member, and providers receive an electronic notice. The provider billing and procedure manual outline the agency's approved service authorization procedures.

The SoonerCare program providers receive frequent updates concerning enrollee benefits through web portals, provider newsletters, automatic fax message updates, and provider rules, contracts, and manuals.

The SoonerCare program is in full compliance with each of the nine measures of this area of Domain 3 for SFY 2009.

Practice Guidelines and New Technology (QH 28 – QH 33)

Six measures of Domain 3 fall under the area of practice guidelines and new technology. Measures in this area aim to verify the organization has evidence-based practice guidelines in place and implements written policies and procedures for the evaluation of new medical technologies.

Multiple entities review practice guidelines including other Medicaid agencies and commercial insurance plans. The OHCA also has a contract with Oregon Health and Science University, which acts as a consultant to provide to conduct research on utilization of resources and offer guidance and interpretation for new guidelines. The OHCA disseminates practice guidelines through its website for use by SoonerCare providers, although legal constraints prevent public dissemination of all of the guidelines.

New medical technologies or new uses of existing technologies receive reviews and evaluations when requested. Research is automatically conducted on any new code that relates to a new technology. The Oregon Health and Science University also provides research and advice to evaluate new technologies.

The SoonerCare program is in full compliance with the requirements of each of the six measures of this area of Domain 3 for SFY 2009.

Provider Qualifications and Selection (QH 34 – QH 36)

Three measures of Domain 3 fall under the area of provider qualifications and selection. The purpose of these measures is to confirm that the organization has policies or procedures in place to handle provider terminations and is compliant with federal requirements on provider contracts.

Processes are in place for provider termination. The OHCA rules and the provider contract each document the provider termination process. The provider contract also details the appeals process. SoonerCare providers can be, and have been, terminated for quality-related issues. The appropriate licensure board receives termination documentation for its review. Additionally, the program monitors the licensure board weekly for providers who the OHCA should exclude from participation in SoonerCare.

The SoonerCare program is in full compliance with the requirements of each of the three measures of this area in Domain 3 for SFY 2009.

Enrollee Health Records and Communication of Clinical Information (QH 37–QH 49)

Thirteen measures of Domain 3 fall under the area of enrollee health records and communication of clinical information. The purpose of these measures is to verify that the organization enforces standards for enrollee health records and has policies or procedures in place for sharing enrollee health information.

The provider contracts and manuals for the SoonerCare program designate the standards providers must meet when completing and maintaining enrollee health records. The OHCA uses an onsite audit tool to confirm provider compliance with the standards set for record keeping.

The provider contract stipulates the process by which providers should exchange confidential enrollee health records and how to obtain proper consent and transfer member records in the event the member has a referral to a specialist or changes medical homes.

The SoonerCare program is in full compliance with the requirements of each of the 13 measures of this area in Domain 3 for SFY 2009.

Compliance Results – Domain 3

The SoonerCare program met the requirements of each of the 49 measures of Domain 3 during SFY 2009. Thus, the SoonerCare program achieved full compliance with Domain 3 measures during this review year.

DOMAIN 4: DELEGATION (QD 01 – QD 05)

The SoonerCare program oversees and is accountable for any functions or responsibilities that are described in the measures of Domains 1 through 3 that are delegated to other entities.

The SoonerCare program currently does not delegate services to other organizations. The OHCA only delegates operational functions. The OHCA monitors these operational functions, such as transportation or call center services, through weekly reports and annual audits. Written contracts are in place with the organizations to which OHCA delegated services, allowing for the revocation of the delegation or other remedies if inadequate performance is identified.

Domain 4 includes five measures. However, one element, the delegation of provider selection to another entity, is again not currently applicable to the SoonerCare program. Nevertheless, the list of measures retains this element so it is available in the future, if the program decides to pursue this option.

Compliance Results – Domain 4

The SoonerCare program met the requirements of the four remaining measures of Domain 4 during SFY 2009. Thus, the SoonerCare program achieved full compliance with Domain 4 measures during this review year.

SFY 2009 ACHIEVEMENTS OF NOTE

APS Healthcare would like to recognize the following achievements of note:

- The OHCA continued its collaboration with stakeholders in other agencies and communities throughout Oklahoma. A wide range of project benefited from this approach, including the "Oklahoma Cares" Breast and Cervical Center Treatment Program, the Family Planning Program, and the perinatal, child health, and medical advisory task forces.
- The OHCA's Insure Oklahoma program, which provides health insurance coverage to Oklahomans who would not otherwise have coverage, exhibits the agency's responsiveness.
- The OHCA's outreach programs provided its members with exemplary services.
- The OHCA continued its outreach and collaboration with Oklahoma's Native American tribes.
- The OHCA received positive audit results for the tiered reimbursement system for nursing facilities, "Focus on Excellence."
- The OHCA continued to provide profiles to its contracted providers, including profiles related to child health checkups, cervical cancer screenings, and breast cancer screenings.
- The OHCA makes available an array of clear, comprehensive and useful documents on its website for public review and use. The SFY 2009 Performance and Quality Report, "Minding our P's and Q's," provides a particularly useful review of the agency's initiatives and accomplishments.

APS Healthcare thanks the OHCA and SoonerCare management and staff, particularly Crystal Carel, MPH, Quality Assurance/Improvement Project Manager, Lise DeShea, Ph.D., Quality Assurance/Improvement Statistician and Patricia Johnson, R.N., B.S., Quality Assurance/Improvement Director for sharing their program knowledge and expertise with such graciousness, and for providing ready access to the many documents reviewed for this report.

References

1. **OHCA website**: http://www.okhca.org/
2. **OHCA rules:** http://www.okhca.org/xPolicy.aspx?id=734
3. **Other relevant codes and manuals**:
   http://okhca.org/providers.aspx?id=45&parts=7437_7439_7443_7455
4. **SFY 2009 OHCA Annual Report:** http://www.okhca.org/research/reports
5. **Performance and Quality Report, Minding Our P's and Q's**, for SFY 2009:
   http://www.okhca.org/research/reports
6. **Member and Provider Forms and Instructions:**
   http://www.okhca.org/individuals.aspx?id=116&menu=52
   http://www.okhca.org/providers.aspx?id=120
7. **Member Handbook:**
   http://www.okhca.org/publications/pdflib/SC_handbook.pdf
8. **SoonerCare Enrollment Guide and Provider Directory**
   http://www.okhca.org/client/pdf/providers.pdf
9. **Provider contract documents**:
   http://www.okhca.org/providers.aspx?id=105&menu=56&parts=7551_7553_7555
   Provider Billing and Procedure Manual:
   http://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=9340
10. **Medical Review Guidelines:**
    http://www.okhca.org/providers.aspx?id=634
11. **Care Management Information:**
    http://www.okhca.org/providers.aspx?id=2044&parts=7499_7501

Appendix A

SOONERCARE SFY 2010 ASSESSMENT FINAL REPORT	
CODE	**DOMAIN**
CODE	**DOMAIN 1 - QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT**
QI 01	The organization conducts performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. 42 CFR 422.152(b)(2) **[X] MET [ ] NOT MET [ ] NOTE**
QI 02	The organization measures its performance, using standard measures established or adopted by the State (Medicaid program). 42 CFR 422.152(c)(1) **[X] MET [ ] NOT MET [ ] NOTE**
QI 03	The organization corrects significant problems that come to its attention through internal surveillance, complaints, or other mechanisms. 42 CFR 422.152(d)(9) **[X] MET [ ] NOT MET [ ] NOTE**
QI 04	The organization demonstrates that the topics are identified through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services. 42 CFR 422.152(d)(1) **[X] MET [ ] NOT MET [ ] NOTE**
QI 05	The organization demonstrates that selection of topics takes into account: the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed. OPL 98-72
	[X] MET [ ] NOT MET [ ] NOTE
QI 06	The project topics include both physical health and mental health/substance abuse, abuse, unless, in the case of an organization contracting with the State, the organization's benefit structure doesn't permit this breadth. **[X] MET [ ] NOT MET [ ] NOTE**
QI 07	The organization performs an assessment of the organization's performance for each selected topic and is measured using one or more quality indicators. 42 CFR 422.152(d)(7) **[X] MET [ ] NOT MET [ ] NOTE**
QI 08	The organization demonstrates that the indicators selected for a topic in a clinical focus area include at least some measure of change in health status or functional status or process of care proxies for these outcomes. Indicators may also include measures of the enrollee's experience of and satisfaction with care. 42 CFR 422.152(d)(7)(ii) **[X] MET [ ] NOT MET [ ] NOTE**

QI 09	The organization selects some indicators for which data are available that allow comparison of the organization's performance to that of similar organizations or to local, state or national benchmarks. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QI 10	The organization establishes a baseline measure of its performance on each indicator, measures changes in performance, and continues measurement for at least one year after a desired level of performance is achieved. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QI 11	The organization demonstrates that its interventions result in significant demonstrable improvement in its performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project undertaken by the organization. 42 CFR 422.152(b)(2), 422.152(d)(9) **[X] MET [ ] NOT MET [ ] NOTE**
QI 12	When sampling is used, sampling methodology for assessment of the organization's performance shall be such as to ensure that the data collected validly reflect: the performance of all practitioners and providers who serve Medicare or the State enrollees and whose activities are the subject of the indicator. **[X] MET [ ] NOT MET [ ] NOTE**
QI 13	When sampling is used, sampling methodology for assessment of the organization's performance shall be such as to ensure that the data collected validly reflect: the care given to the entire population (including populations with special health care needs and populations with serious and complex health care needs) to which the indicator is relevant. **[X] MET [ ] NOT MET [ ] NOTE**
QI 14	The organization demonstrates that the sample or subset of the study population is obtained through random sampling and/or other State-approved sampling methods. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QI 15	The organization demonstrates that the samples used for the baseline and repeat measurements of the performance indicators are chosen using the same sampling frame and methodology. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QI 16	The organization demonstrates sustained improvements in performance or at least one year after the improvement in performance is first achieved. Sustained improvement is documented through the continued measurement of quality indicators for at least one year after the performance improvement project is completed. 42 CFR 422.152(d)(9) **[X] MET [ ] NOT MET [ ] NOTE**
QI 17	The organization monitors its members' satisfaction with the Plan and its PCPs in such areas as: 1. Customer Service 2. Getting needed care 3. Getting care quickly 4. Quality of care **[X] MET [ ] NOT MET [ ] NOTE**

QI 18	The organization monitors its contracted primary care providers for quality using provider profiling on target areas such as: 1. Children's Health 2. Women's Health 3. Chronic Conditions 4. Utilization of Services 5. Behavioral Health **[X] MET [ ] NOT MET [ ] NOTE**
QI 19	The organization will meet any goals for performance improvement on specific measures as required by the State (Medicaid program). 42 CFR 422.15 (c) **[X] MET [ ] NOT MET [ ] NOTE**
QI 20	The organization will measure and report to the State its performance, using standard measures (HEDIS or HEDIS-like) required by the State (Medicaid program). **[X] MET [ ] NOT MET [ ] NOTE**
QI 21	Assessment of the organization's performance on the selected indicators is based on systematic, ongoing collection and analysis of valid and reliable data. Assessment of compliance with this standard will be coordinated with review of the organization's information systems. 42 CFR 422.152(d)(8) **[X] MET [ ] NOT MET [ ] NOTE**
QI 22	The organization maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement its QA program. 42 CFR 422.152(d)(8) **[X] MET [ ] NOT MET [ ] NOTE**
QI 23	The organization's information system is be capable of collecting the following types of data: enrollee and provider characteristics, services furnished to enrollees, data as needed to guide the selection of performance improvement project topics (standard 1.4.1) and to meet the data collection requirements for performance improvement projects.42 CFR 422.152(d)(8) **[X] MET [ ] NOT MET [ ] NOTE**
QI 24	The organization ensures that information and data received from providers are accurate, timely and complete to best knowledge, information and belief. The organization has an ongoing process for assuring the accuracy and completeness of the data, whether compiled in its own facilities or reported by outside contractors. 42 CFR 422.152(d)(8) **[X] MET [ ] NOT MET [ ] NOTE**
QI 25	The organization reviews reported data for accuracy, completeness, logic, and consistency. 42 CFR 422.152(d)(8) **[X] MET [ ] NOT MET [ ] NOTE**
QI 26	The organization ensures that service data are collected in standardized formats to the extent feasible and appropriate. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QI 27	The organization's QA program is administered through clear and appropriate administrative arrangements. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**

QI 28	The organization establishes a policy-making body that oversees and is accountable for the QA program. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QI 29	The organization maintains a designated senior official who is responsible for QA program administration. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QI 30	The organization ensures that employed or affiliated providers and consumers actively participate in the QA program. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QI 31	The organization ensures that there is formal and ongoing communication and collaboration among the policy-making body that oversees the QA program and the other functional areas of the organization, e.g., health services management and member services. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
CODE	**DOMAIN 2 - ENROLLEE RIGHTS**
ER 01	The organization implements written policies with respect to the enrollee rights. [42 CFR 422.118 and 422.128] Policies are communicated to enrollees, and to the organization's staff and affiliated providers, at the time of initial employment or affiliation, and annually thereafter. 42 CFR 422.111 **[X] MET [ ] NOT MET [ ] NOTE**
ER 02	The organization monitors and promotes compliance with the policies by the organization's staff and affiliated providers. 42 CFR 422.152(f)(2) **[X] MET [ ] NOT MET [ ] NOTE**
ER 03	The organization ensures compliance with Federal and State laws affecting the rights of enrollees *(The focus of these requirements is on the enrollee).* *42 CFR 422.118(d) and 422.128(a)(1)(ii)(G)* Applicable Federal laws include, but are not limited to: 1. Title VI of the Civil Rights Act; Federal contracting ***SoonerCare*** Organizations are required under the laws administered by the Equal Employment Opportunity Commission (EEOC) to prevent discrimination in federally assisted programs. Under the rules governing grants, loans, and contracts no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. Each Federal department and agency, which is empowered to extend Federal financial assistance to any program or activity by way of grant, loan, or contract other than a contract of insurance or guaranty is empowered to administer this legal requirement. Public Law 88-352, July 2, 1964; Sections 602 & 603 of the Civil Rights Act of 1964. 2. Section 504 of the Rehabilitation Act of 1973; Pursuant to Section 504 of the Rehabilitation Act of 1973 which prohibits discrimination against any individual because of disability, Federal contractors are required to adhere to the prohibition against disability-based discrimination. Public Law 93-112, section 504.

	3. The Age Discrimination Act of 1975; 4. Titles II and III of the Americans with Disabilities Act; 5. Section 542 of the Public Health Service Act (pertaining to nondiscrimination against substance abusers); and 6. Title 45, Part 46 of the Code of Federal Regulations, pertaining to research involving human subjects. **[X] MET [ ] NOT MET [ ] NOTE**
ER 04	Each enrollee has a right to be treated with respect, dignity, and consideration for enrollee privacy. [42 CFR 422.118(a)] The organization implements procedures to ensure the confidentiality of health and medical records and of other information about enrollees. [42 CFR 422.118(a)] **[X] MET [ ] NOT MET [ ] NOTE**
CODE	**DOMAIN 2 - ENROLLEE RIGHTS**
ER 05	The right to privacy includes protection of any information that identifies a particular enrollee. Information from, or copies of, records may be released only to authorized individuals, and the organization must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only only in accordance with Federal or State laws, court orders, or subpoenas. 42 CFR 422.118(a) **[X] MET [ ] NOT MET [ ] NOTE**
ER 06	The organization implements procedures to ensure that enrollees are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. [42 CFR 422.112(a)(8)(I) and (10)(I)] [42 CFR 422.112(a)(8)(I) and (10)(I)] The organization ensures that it does not promote discrimination, discourage enrollment, or inhibit access to services. 42 CFR 422.100(g) **[X] MET [ ] NOT MET [ ] NOTE**
ER 07	Each enrollee has a right to accessible services. The organization ensures that all services, both clinical and nonclinical, are accessible to all enrollees, including those those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities. 42 CFR 422.112(a)(10)(I) **[X] MET [ ] NOT MET [ ] NOTE**
ER 08	The organization instructs enrollees that they have the right to access emergency health care services without prior authorization, consistent with the enrollee's determination of the need for such services as a prudent layperson. 42 CFR 422.112(a)(10)(ii) and 422.112(c) **[X] MET [ ] NOT MET [ ] NOTE**
ER 09	Each enrollee has a right to choose providers from among those affiliated with the organization. 42 CFR 422.112(a) **[X] MET [ ] NOT MET [ ] NOTE**

ER 10	The organization ensures that each enrollee may select his or her primary care provider from among those accepting new members. 42 CFR 422.112(a)(2) **[X] MET [ ] NOT MET [ ] NOTE**
ER 11	Each enrollee has a right to participate in decision-making regarding his or her health care. [42 CFR 422.112(a)(8)(iii)] The organization provides for the enrollee's representative to facilitate care or treatment decisions when the enrollee is unable to do so. [42 CFR 422.128(a) and (b)] The organization provides for enrollee or representative involvement in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment, and complies with requirements of Federal and State law with respect to advance directives. 42 CFR 422.128 and 422.206(b) and (c) **[X] MET [ ] NOT MET [ ] NOTE**
ER 12	Each enrollee has a right to receive information on available treatment options (including the option of no treatment) or alternative courses of care; health care professionals must provide information regarding treatment options in a language that the enrollee understands. **[X] MET [ ] NOT MET [ ] NOTE**
ER 13	Each enrollee has a right to have access to his or her medical records in accordance with applicable Federal and State laws. 42 CFR 422.118(c) **[X] MET [ ] NOT MET [ ] NOTE**
ER 14	Each enrollee receives, at the time of enrollment and at least annually thereafter, a written statement including information on: 1. Enrollee rights; 2. Enrollee responsibilities; 3. The names and locations of network providers, including information on which providers are accepting new Medicare/the State patients and any restrictions on enrollees ability to select from among network providers; 4. Amount, duration and scope of all benefits and services included and excluded as a condition of enrollment, including a description of how the organization evaluates new technology for inclusion as a covered benefit; 5. Procedures for obtaining services, including authorization requirements, any special procedures for obtaining mental health and substance abuse services, procedures for obtaining out-of-area coverage and, in the case of enrollees eligible for a point-of-service benefit, procedures for obtaining services through the benefit, including special conditions or charges that may apply; 6. In the case of the State enrollees, procedures for obtaining services covered under the state plan and not covered by the organization, and notice of the right to obtain family planning services from any State-participating provider (unless otherwise restricted); 7. Provisions for after-hours and emergency coverage. Materials must instruct enrollees that enrollees have the right to access emergency health care services from contracting or non-contracting providers without prior authorization, consistent with the enrollee's determination of the need for such services as a prudent layperson; 8. Policies on referrals for specialty care and other services not furnished by the enrollee's primary care provider; 9. Charges to enrollees, if applicable;

	10. Procedures established under standard 2.4 for resolving enrollee issues, including complaints or grievances and issues relating to authorization of, coverage of, or payment for services; 11. Procedures for changing primary care providers; 12. Procedures for recommending changes in policies or services; 13. Information on service area; and 14. Notice of the right to obtain the following information: 14a. In addition to the information in standards 1 through 13, the following information is available, upon request: 14b. The procedures the organization uses to control utilization of services and expenditures. 14c. The number of grievances and appeals and their disposition in the aggregate, in a manner and form specified by CMS or the State. 14d. A summary description of the method of compensation for physicians. 14e. The financial condition of the organization, including the most recently audited information regarding its condition. 42 CFR 422.111(b) and (c) **[X] MET [ ] NOT MET [ ] NOTE**
ER 15	The organization notifies enrollees affected by termination of or changes in benefits, services, service sites, or affiliated providers. To the extent practical, enrollees are informed of such terminations or changes prior to their effective date. 42 CFR 422.111(e) **[X] MET [ ] NOT MET [ ] NOTE**
ER 16	Enrollee information is readable and easily understood. 42 CFR 422.111(a)(2) **[X] MET [ ] NOT MET [ ] NOTE**
ER 17	Enrollee information is available in the language(s) of the major population groups served and, as needed, in alternative formats for the visually impaired. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
ER 18	The organization evaluates the effectiveness of its communications with enrollees. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
ER 19	The organization has a system for resolving issues raised by enrollees, including: complaints or grievances; issues relating to authorization of, coverage of, or payment for services; and issues relating to discontinuation of a service. [NOTE: references to an enrollee in these standards include reference to an enrollee's representative.] 42 CFR 422.562(a)(1) **[X] MET [ ] NOT MET [ ] NOTE**
ER 20	The organization documents each issue raised by an enrollee. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
ER 21	The organization acknowledges receipt of the issue and explains to the enrollee the process to be followed in resolving his or her issue. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
ER 22	The organization informs the enrollee of any applicable mechanism for resolving the issue external to the organization's own processes. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
ER 23	The organization implements a procedure, with clearly explained steps and time limits

	for each step, for the resolution of a complaint or grievance. The grievance is transmitted in a timely manner to staff that have authority to take corrective action. A grievance relating to quality of care is transmitted to appropriately qualified personnel within the health plan. The organization investigates the grievance and notifies the concerned parties of the results of the investigation and the proposed resolution. (Note: Physician peer review findings are confidential and not releasable to the enrollee). 42 CFR 422.564(a)(2) **[X] MET [ ] NOT MET [ ] NOTE**
ER 24	The organization provides an opportunity for reconsideration of the proposed resolution. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
ER 25	The organization tracks each grievance until its final resolution. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
ER 26	The organization has an expedited grievance process for issues requiring immediate resolution. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
ER 27	Monitoring of Issue Resolution Processes. The organization maintains, aggregates and analyzes information on the nature of issues raised by enrollees and on their resolution. [42 CFR 422.111(c)(3)] The information is used to develop activities under the organization's QAPI program, both to improve the issue resolution process itself, and to make improvements that address other system issues raised in the issue resolution process. **[X] MET [ ] NOT MET [ ] NOTE**
ER 28	Information related to coverage and payment issues is maintained for at least six years following final resolution of the issue, and is made available to the enrollee on request. 42 CFR 422.502(d)(1)(I-iii) **[X] MET [ ] NOT MET [ ] NOTE**
ER 29	Each enrollee may refuse care from specific providers. **[X] MET [ ] NOT MET [ ] NOTE**
ER 30	Each enrollee has a right to obtain a prompt resolution, of issues raised by the enrollee, including complaints or grievances and issues relating to authorization, coverage, or payment of services. **[X] MET [ ] NOT MET [ ] NOTE**
ER 31	The organization follows written procedures for the receipt and initial processing of all issues raised by enrollee. **[X] MET [ ] NOT MET [ ] NOTE**
ER 32	The organization—promptly determines whether the issue is to be resolved through: (a) the grievance process, (b) the process for making initial determinations on coverage and payment issues, or (c) the process for resolution of disputed initial determinations. **[X] MET [ ] NOT MET [ ] NOTE**
ER 33	The organization assists the enrollee as needed in completing forms or taking other necessary steps to obtain resolution of the issue. **[X] MET [ ] NOT MET [ ] NOTE**

ER 34	The organization implements a procedure, with clearly explained steps and time limits for each step, for reviewing requests for reconsideration of initial decisions not to provide or pay for a service. **[X] MET [ ] NOT MET [ ] NOTE**
ER 35	The organization's notice to an enrollee and/or provider of its decision to deny, limit, or discontinue authorization of, or payment for, a service includes information about how to obtain a reconsideration of the decision. The notice to the enrollee must be in writing. **[X] MET [ ] NOT MET [ ] NOTE**
ER 36	The organization's process complies with procedural requirements and time limits established by CMS or the State, conforming to CMS requirements. **[X] MET [ ] NOT MET [ ] NOTE**
ER 37	Requests for reconsideration by the organization of a denial based on lack of medical medical necessity are reviewed by a health care professional, who is appropriately credentialed with respect to the treatment involved and who is not the individual who made the initial determination. **[X] MET [ ] NOT MET [ ] NOTE**
CODE	**DOMAIN 3 - HEALTH SERVICES DELIVERY**
AVAILABILITY AND ACCESSIBILITY	
QH 01	The organization ensures that all covered services, including additional or supplemental services contracted for, by, or on behalf of its enrollees, are available and accessible. 42 CFR 422.112 (a) **[X] MET [ ] NOT MET [ ] NOTE**
QH 02	The organization maintains and monitors a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services and to meet the needs of the population served. 42 CFR 422.112 (a)(1) **[X] MET [ ] NOT MET [ ] NOTE**
QH 03	The organization offers a panel of primary care providers from which the enrollee may select a personal primary care provider. 42 CFR 422.112 (a)(2) **[X] MET [ ] NOT MET [ ] NOTE**
QH 04	The organization provides or arranges for necessary specialty care, including women's health services. 42 CFR 422.112 (a)(3) **[X] MET [ ] NOT MET [ ] NOTE**
CODE	**DOMAIN 3 - HEALTH SERVICES DELIVERY**
QH 05	The organization has procedures for: the identification of individuals with complex or serious medical conditions: an assessment of those conditions; the identification of medical procedures to address and/or monitor the conditions; and a treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan, and that is time-specific, and updated periodically. The organization must also have procedures for ensuring adequate coordination of care among providers. 42 CFR 422.112 (a)(4) **[X] MET [ ] NOT MET [ ] NOTE**

QH 06	The organization must make a good faith effort to provide written notice of a termination of a contracted provider within a reasonable time of receipt or issuance of a notice of termination to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must also be notified. 42 CFR 422.111(e) and 422.204(c)(4) **[X] MET [ ] NOT MET [ ] NOTE**
QH 07	When medically necessary, the organization makes services available 24 hours a day, 7 days a week. 42 CFR 422.112(a)(8) **[X] MET [ ] NOT MET [ ] NOTE**
QH 08	The organization ensures that the hours of operation of its providers are convenient to and do not discriminate against enrollees. 42 CFR 422.112(a)(8) **[X] MET [ ] NOT MET [ ] NOTE**
QH 09	The organization ensures that services are provided in a culturally competent manner to all enrollees, including: those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds.42 CFR 422.112(a)(9) **[X] MET [ ] NOT MET [ ] NOTE**
QH 10	Standards for timeliness of access to care and member services that meet or exceed such standards as may be established by CMS or the State, continuously monitors its provider network's compliance with these standards, and takes corrective action as necessary. 42 CFR 422.112(a)(7)(i) **[X] MET [ ] NOT MET [ ] NOTE**
QH 11	Policies and procedures, including coverage rules, practice guidelines, payment policies and utilization management that allow for individual medical necessity determinations. 42 CFR 422.112(a)(7)(ii) **[X] MET [ ] NOT MET [ ] NOTE**
QH 12	The organization must develop a policy encouraging provider consideration of beneficiary input in the provider's proposed treatment plan. 42 CFR 422.112(a)(7)(iii) **[X] MET [ ] NOT MET [ ] NOTE**
CONTINUITY AND COORDINATION OF CARE	
QH 13	The organization ensures continuity of care and integration of services through arrangements that include, but are not limited to the following: For Medicaid, MCOs should make use of a health care professional who is formally designated as having primary responsibility for coordinating the enrollee's overall health care; for Medicare, MCOs should develop policies that specify under what circumstances services are coordinated and the methods of coordination. 42 CFR 422.112(b) **[X] MET [ ] NOT MET [ ] NOTE**
QH 14	The organization's policies specify whether services are coordinated by the enrollee's primary care provider or through some other means. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**

QH 15	Regardless of the mechanism adopted for coordination of services, the organization either ensures that each enrollee has an ongoing source of primary care; or offers to provide each enrollee with an ongoing source of primary care and provides a primary care source to each enrollee who accepts the offer. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 16	The organization must ensure that programs for coordination of care that include coordination of services with community and social services are generally available through contracting or noncontracting providers in the area served by the organization. 42 CFR 422.112 (b)(3) **[X] MET [ ] NOT MET [ ] NOTE**
QH 17	The organization must ensure continuity and coordination of care through procedures for timely communication of clinical information among providers. 42 CFR 422.112(b)(4) **[X] MET [ ] NOT MET [ ] NOTE**
QH 18	The organization ensures continuity and coordination of care through measures to ensure that enrollees are informed of specific health care needs that require follow-up; receive, as appropriate, training in self-care and other measures they may take to promote their own health; and comply with prescribed treatments or regimens. 42 CFR 422.112(b)(5)&(6) **[X] MET [ ] NOT MET [ ] NOTE**
SERVICE AUTHORIZATION	
QH 19	The organization implements written policies and procedures, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services. 42 CFR 422.202(b) **[X] MET [ ] NOT MET [ ] NOTE**
QH 20	Criteria for decisions on coverage and medical necessity are clearly documented, are based on reasonable medical evidence or a consensus of relevant health care professionals, and are regularly updated. 42 CFR 422.202(b)(1) **[X] MET [ ] NOT MET [ ] NOTE**
QH 21	Mechanisms are in place to ensure consistent application of review criteria and compatible decisions. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 22	A clinical peer reviews decisions to deny authorization are determined on grounds of medical appropriateness. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 23	The requesting provider and the enrollee are promptly notified of any decision to deny, limit, or discontinue authorization of services if the enrollee objects. The notice specifies the criteria used in denying or limiting authorization and includes information on how to request reconsideration of the decision . The notice to the enrollee must be in writing. OPL 98-72, 42 CFR422.80(c)(1);(iii) 422.568 &(e) **[X] MET [ ] NOT MET [ ] NOTE**
QH 24	Compensation to persons or organizations conducting utilization management activities shall not be structured so as to provide inappropriate incentives for denial, limitation or discontinuation of authorization of services. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**

QH 25	The organization does not prohibit providers from advocating on behalf of enrollees within the utilization management process. 42 CFR 422.206(a)(1) **[X] MET [ ] NOT MET [ ] NOTE**
QH 26	Mechanisms are in effect to detect both underutilization and over utilization of services. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 27	The organization furnishes information to all affiliated providers about enrollee benefits. 42 CFR 422.202(b)(2) **[X] MET [ ] NOT MET [ ] NOTE**
CODE	**DOMAIN 3 - HEALTH SERVICES DELIVERY**
PRACTICE GUIDELINES AND NEW TECHNOLOGY	
QH 28	The organization adopts and disseminates practice guidelines. 42 CFR 422.202(b)(2) **[X] MET [ ] NOT MET [ ] NOTE** **NOTE**: Though not all practice guidelines are equally distributed due to legal issues, this measure is considered met.
QH 29	Practice guidelines are based on reasonable medical evidence or a consensus of physicians in the particular field, consider the needs of the enrolled population, are developed in consultation with physicians, and are reviewed and updated periodically. 42 CFR 422.202(b) **[X] MET [ ] NOT MET [ ] NOTE**
QH 30	Practice guidelines, including any admission, continued stay, and discharge criteria used by the organization, are communicated to all providers and enrollees when appropriate, and to individual enrollees when requested. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 31	Decisions with respect to utilization management, enrollee education, coverage of services, and other areas to which the practice guidelines are applicable are consistent with the guidelines. 42 CFR 422.202(b)(3) **[X] MET [ ] NOT MET [ ] NOTE**
QH 32	The organization implements written policies and procedures for evaluating new medical technologies and new uses of existing technologies. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE** **NOTE**: Policies and procedures are implemented for new technologies as requested.
PROVIDER QUALIFICATIONS AND SELECTION	
QH 33	The evaluations take into account coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and federal and state coverage decisions, as appropriate to the evaluation. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 34	The organization establishes written policies and procedures for suspending or terminating affiliation with a contracting health care professional (for Medicaid) or physician (for Medicare), including an appeals process. 422.204(c)(1) **[X] MET [ ] NOT MET [ ] NOTE**

QH 35	The organization notifies licensing and/or disciplinary bodies or other appropriate authorities when a health care professional's or institutional provider or supplier's affiliation is suspended or terminated because of quality deficiencies. 42 CFR 422.204 (3) **[X] MET [ ] NOT MET [ ] NOTE**
QH 36	The organization ensures compliance with Federal requirements prohibiting employment or contracts with individuals excluded from participation under either Medicare or the State. 42 CFR 422.752 (a)(8) **[X] MET [ ] NOT MET [ ] NOTE**
ENROLLEE HEALTH RECORDS AND COMMUNICATION OF CLINICAL INFORMATION	
QH 37	The organization implements appropriate policies and procedures to ensure that the organization and its providers have the information required for effective and continuous patient care and for quality review, and conducts an ongoing program to monitor compliance with those policies and procedures. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 38	The organization makes a best-effort attempt to conduct an initial assessment of each enrollee's health care needs, including following up on unsuccessful attempts to contact the enrollee, within 90 days of the effective date of enrollment. 42 CFR 422.112(a)(1)(v)(A) **[X] MET [ ] NOT MET [ ] NOTE**
QH 39	The organization ensures that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that takes into account professional standards. 42 CFR 422.112(b)(4)(ii) **[X] MET [ ] NOT MET [ ] NOTE**
QH 40	The organization enforces standards for health record content and organization, including specifications of basic information to be included in each health record. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 41	The organization implements a process to assess and improve the content, legibility, organization, and completeness of enrollee health records. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 42	Enrollee health records are available and accessible to the organization and to appropriate state and federal authorities, or their delegates, involved in assessing the quality of care or investigating enrollee grievances or complaints. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 43	The organization ensures appropriate and confidential exchange of information among providers. 42 CFR 422.118 **[X] MET [ ] NOT MET [ ] NOTE**
QH 44	The organization maintains policies and procedures requiring that a provider making a referral transmit necessary information to the provider receiving the referral. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**

QH 45	The organization maintains policies and procedures requiring that a provider furnishing a referral service report the appropriate information to the referring provider. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 46	The organization maintains policies and procedures that require providers to request information from other treating providers as necessary to provide care. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 47	If the organization offers a point-of-service benefit or other benefit providing coverage of services by non-network providers, the organization transmits information about services used by an enrollee under the benefit to the enrollee's primary care provider, if one has been selected by the enrollee. OPL 98-72 **[X] MET [ ] NOT MET [ ] NOTE**
QH 48	The organization has policies and procedures for sharing enrollee information with any other organization or provider with which the enrollee may subsequently enroll or from whom the enrollee may seek care. 42 CFR 422.11(c) **[X] MET [ ] NOT MET [ ] NOTE**
QH 49	The organization determines that all providers are qualified through a defined process. **[X] MET [ ] NOT MET [ ] NOTE**
CODE	**DOMAIN 4 - DELEGATION**
QD 01	The organization oversees and is accountable for any functions or responsibilities that are described in the standards of Domains 1 through 3 that are delegated to other entities. The following requirements apply to all delegated functions. 42 CFR 422.502(I)(4) **[X] MET [ ] NOT MET [ ] NOTE**
QD 02	A written agreement specifies the delegated activities and reporting responsibilities of the entity and provides for revocation of the delegation or other remedies for inadequate performance. 42 CFR 422.502(I)(4)(ii) **[X] MET [ ] NOT MET [ ] NOTE**
QD 03	The organization evaluates the entity's ability to perform the delegated activities prior to delegation. 42 CFR 422.502(I)(4)(iii) **[X] MET [ ] NOT MET [ ] NOTE**
CODE	**DOMAIN 4 - DELEGATION**
QD 04	The performance of the entity is monitored on an ongoing basis and formally reviewed by the organization at least annually. 42 CFR 422.502(I)(4)(iii)] **[X] MET [ ] NOT MET [ ] NOTE**
QD 05	If the organization delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity. 42 CFR 422.502(I)(5) **[X] MET [ ] NOT MET [ ] NOTE** **NOTE**: Measure is currently not applicable to the organization, but may apply in the future.