

Gold Choice
PCMPIIA

Quality Assurance Program

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I. Quality Assurance Program (QAP)

A. Gold Choice Background & Unique Characteristics

The Gold Choice (PCMPIIA) physician case management program was established in 1996 by the SUNYAB Department of Family Medicine in collaboration with the Erie County Departments of Social Services and Mental Health as a model program to integrate the Medicaid special needs population (mentally ill and substance abuse) into managed care. One key feature of the Gold Choice program is that all enrollees must currently be in treatment with an assigned counselor within a behavioral health agency. The Gold Choice program was designed to link these patients to the Medicaid Managed Care Program using a primary care partial capitation model. The behavioral health, hospital, diagnostic, drug, lab, and OB/GYN services are available fee-for-service (not part of the partially capitated services), which means that Gold Choice does not have access to these encounter records, constraining the scope of quality assurance measures that are compiled by the program.

B. QAP Mission & Strategic Objectives

Mission Statement:

The mission of the Gold Choice QAP is to work in partnership with the participating primary care providers and the associated behavioral health agencies to continually improve the quality of care and service delivered to Gold Choice members. The goal of the program is to encourage the delivery of optimal services at the appropriate time and in the most effective manner.

Strategic Objectives:

1. To facilitate patient empowerment by actively encouraging their self-management.
2. To support the continued development of proactive provider practices.
3. To improve evidence-based interventions and performance measures over time.
4. To expand collaboration and coordination with all community resources to meet the complex needs of the mentally ill/substance abuse enrollees, and foster care children.

C. QAP Oversight & Organizational Structure

The Gold Choice Quality Assurance Committee (QAC) governs the Quality Assurance Program. The Composition is as follows:

Medical Director
Behavioral Health Care Services Director
Program Director
Quality Assurance Coordinator
Provider Relations Representative
MIS Representative
Case Management Representative
Physician providers

THE ROLE OF THE MEDICAL DIRECTOR

The Medical Director will be responsible for supervising the Quality Assurance Program. The Medical Director's responsibilities include:

- Convene and chair the QAC
- Review all providers' applications for credentialing
- Monitor the quality assurance activities
- Provide oversight in the development and monitoring of provider corrective action plans
- Sanction non-compliant providers
- Oversee and direct the implementation of the annual QA Work Plan
- Reports all activities to Gold Choice Executive Committee

GOLD CHOICE EXECUTIVE COMMITTEE COMPOSITION AND RESPONSIBILITIES

The Gold Choice Executive Committee consists of:

- The Chairman of the Department of Family Medicine at the University at Buffalo
- The Executive Officer of the Department of Family Medicine
- The Medical Director of Gold Choice Program
- The Program Director of Gold Choice Program

The responsibilities of the Gold Choice Executive Committee are:

- Oversight of all aspects of the Gold Choice Program
- Assure the programs financial viability
- Review all quality issues
- Assure compliance with all aspects of the contract and the public health laws
- Address all patient and provider grievances
- Approve all aspects of improvement and innovation of the program
- Shall meet at least quarterly to perform these functions

GOLD CHOICE EXECUTIVE COMMITTEE STANDARD AGENDA

- Approval of minutes
- Program Director's Report
- Budget and Financials
- Personnel Issues
- Review of Administrative Policies and Procedures
- Medical Director's Report
- QA committee report (overview of all new QA related issues)
- Review of complaints and grievances
- Credentialing issues
- Review results of clinical studies that evaluate the quality of care

ROLE OF THE QUALITY ASSURANCE COMMITTEE

- Set the standards for care
- Assure that the standards of care are distributed to the provider network
- Review all sources of input(grievances, complaints, member satisfaction surveys, feedback from providers, member services staff, LDSS staff, etc.) to identify problems or potential problems for continuous quality improvement intervention
- Review the population-based data from the health risk assessment
- Review a summary of the encounter data
- Review chart audit data
- Work with Medical Director to develop new disease-state management projects
- Prepare feedback reports to the physicians regarding health risk and chart audit data
- Identify areas that require correction and develop appropriate plans for resolution and follow up on potential and actual problems for members

- Develop an annual Quality Assurance Work-plan
- The Quality Assurance Committee will meet quarterly
- Keep minutes that describe activities specific to Gold Choice

STANDARD AGENDA FOR THE QA COMMITTEE

- Approval of minutes
- Executive Committee Report
- Electronic Information Systems
- Quality Improvement Follow-Up Report
- Complaints and Grievances
- Credentialing issues
- Approval, review, and updating of policies and procedures
- Approval, review, and updating of practice standards
- Approval, review, and updating of practice guidelines
- Clinical Studies
- Review of Physician Self-Assessment/ Medical Record Audits
- Encounter Data Report

D. Provider Orientation

The Provider Relations Coordinator will provide each new PCP an orientation including an overview of the medical record standards of care, clinical studies, clinical guidelines for STD/HIV/Lead poisoning/CTHP, credentialing, contracts, and the case management protocols. Educational in-services are offered at any time as well.

E. Medical Record Standards

All medical records must contain the following patient information:

- If relevant, all information pertaining to C/THP, STD's and lead screening
- Date of Birth and Sex
- All levels and management of care must be noted, including initial physical and all mental health and chemical dependency diagnosis
- Current medications and problems identified
- All allergies and adverse reactions notes and prominently displayed
- A history of all labs ordered and results
- All patient referrals
- All Consultant summaries
- Plans of action consistent with findings and diagnosis
- All previous unresolved problems must be addresses including a follow-up plan
- A review of all ER visits and inpatient hospitalizations
- Entries must be dated, legible and signed

F. Maintenance of Contractor Records

A list of currently enrolled members who have had at least two PCP visits within the past 12 months is generated using encounter data. From this pool, selection is driven predominantly by provider site. In order to avoid multiple records from one provider or provider site, once a client is randomly selected from a given site, all other clients from that site in the pool of potential clients are deleted to ensure that multiple clients from any given site are not selected.

The providers of members who are randomly selected are sent a Physician Self-Assessment (PSA) tool with the Gold Choice medical record standards. They are asked to audit their own charts and return the PSA within 10 business days.

Standards and Performance Goals for Participating Providers -- Providers are rated on the Medical Record Review Standards with the following performance goals:

1. 100% compliance -- fully compliant with standards
2. 80% compliance -- significant compliance
3. Below 80% compliance requires a corrective action plan

Providers with non-compliant medical records are required to adhere to a Corrective Action Plan developed by the medical director within 30 days of notice. The results are reviewed by the Quality Assurance Committee and kept in the providers' files for future credentialing review consideration.

Gold Choice Process for Improving Medical Records, including any actions it has taken -- Any provider below 80% compliance with these Medical Records Standards will require corrective action. Corrective action includes but is not limited to:

1. Letters sent to providers that include specific deficiencies identifying the compliance issues and a suggested action plan for improvement.
2. Suggested models of records such as forms, problem lists or medication allergies documentation forms.
3. Re-education information highlights of best practices or blinded records that meet Gold Choice standards particularly well.

Subsequently, ten percent (10%) or 2 charts will be requested for an in-house audit to check the validity of the physician self-assessment (PSA). Gold Choice utilizes a medical record review staff to conduct onsite follow up reviews. Providers and their office staff receive verbal feedback and education, which includes, but is not limited to, the Plan's requirements, various Department of Health reporting requirements, medical record documentation and member education. Providers receive a written report card following the onsite review.

In order to assure provider compliance, those who have been deemed non-compliant will be audited again within 6 months of the original audit.

Confidentiality

Access to medical records is permitted only to those individuals who are part of the team providing healthcare to the individual. Such information contained in the medical record may be used by the Plan or its providers only for a purpose directly connected with the performance of the Plans' obligations under the Medicaid Managed Care Program.

Organization of the Medical Record and Filing of Information in the Medical Record:

- Medical records are stored in a secure location not accessible to patients.
- Record for each member, identified by a medical record identifier (either name or number) on each page.
- Medical records are organized with a filing system to ensure easy retrievability.

- Medical records must be retained for at least six (6)years for adults and six (6)years from the age of majority for children

Confidentiality of HIV-Related Information:

Providers must develop policies and procedures to assure confidentiality of HIV-related information. These policies must include:

Initial and annual in-service education of the providers' staff and/or contractors

- Identification of those staff members allowed access and the limits of their access to HIV-related information.
- A procedure to limit access to trained staff (including contractors).
- A protocol for secure storage (including electronic storage).
- Procedures for handling requests for HIV-related information.
- Protocols to protect persons with or suspected of having HIV infection from discrimination.

These policies must include:

- Initial and annual in-service education of the providers' staff and/or contractors.
- Identification of those staff members allowed access and the limits of their access to HIV-related information.
- A procedure to limit access to trained staff (including contractors).
- A protocol for secures storage (including electronic storage).
- Procedures for handling requests for HIV-related information.
- Protocols to protect persons with or suspected of having HIV infection from discrimination.

G. Yearly Clinical Studies

The purpose of these studies is to ensure that evidence-based treatments that reduce morbidity and mortality for a specific disease will be utilized in the care of our patients. These guidelines and survey tools will be distributed to help physicians in the care of their patients. The specific diseases to be studied are as follows but not limited to:

- 1) Asthma
- 2) Diabetes
- 3) Breast Cancer Screening and Mammography
- 4) Atrial Fibrillation
- 5) Congestive Heart Failure
- 6) Coronary Artery Disease

1) Asthma:

Goal of Treatment: To minimize attacks and to maintain pulmonary function and activities of daily living at normal levels.

Standard of Treatment: Anyone with mild intermittent asthma, defined as two or less attacks per week, can be maintained on an inhaled bronchodilator. Anyone who has had a hospital admission, an emergency room visit, or who has attacks more frequently than this, needs to be on an anti-inflammatory regimen. Acceptable anti-inflammatory regimens include:

- Inhaled corticosteroid (preferred agent)

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- Cromolyn sodium
- Leukotriene inhibitor

Asthma Care Guideline: (same as NYS DOH guideline)

2) Diabetes Mellitus:

Definition of Diabetes Mellitus (DM): The body has an inability to handle sugar properly resulting in consistently high blood sugars and complications in other organ systems. Complications of diabetes include heart attacks, strokes, amputations, kidney failure, blindness, and increased susceptibility to infectious diseases.

Goal of Treatment: To normalize the blood sugar and prevent the complications of Diabetes:

Standard of Treatment:

To counsel the patient on the following areas every 6 months:

- Diet
- Exercise
- Foot care

To measure the following:

- HbA1C every 6 months
- Improve control of HbA1C
- Blood pressure every 6 months
- Urine microalbumin yearly

To have the following examinations:

- Dilated retinal exam yearly
- Foot examination every 6 months
- To have the following immunizations:
- Flu shot yearly
- Pneumovax once in a lifetime
- Desired Measurement Outcomes
- HbA1C < 8.0
- BP < 130/85
- LDL Cholesterol < 100

3) Breast Cancer Screening and Mammography:

Goal of Treatment: Fifty percent of female members adhering to screening guidelines with an improvement goal of 10%.

Standard of Treatment: For normal risk members aged 20 or older but less than 40 years physical Breast Exam every 1-3 years, and breast Self Exam encouraged. For normal Risk members aged 40 year and older an annual physical exam, an annual mammogram, and breast self-exam encouraged.

4) Atrial Fibrillation:

Goal of Treatment: It has been shown that adequately anti-coagulating patients with atrial fibrillation can prevent stroke. Therefore, it is the goal of treatment to have all eligible patients with atrial fibrillation to be placed on Coumadin unless there is a contra-indication

Standard of Treatment: All patients with atrial fibrillation, except for patients younger than 65 who do not have structural heart disease, shall be anti-coagulated with Coumadin, unless there is

an absolute contra-indication to anti-coagulation. Those on Coumadin shall maintain an INR of 2.0-3.0

4) Congestive Heart Failure:

Definition of Congestive Heart Failure: (CHF) Congestive Heart Failure is defined as systolic dysfunction of the left ventricle as evidenced by an ejection fraction of less than 40% on either a 2D Echocardiogram or a MUGA scan.

Goal of Treatment: It has been shown that both angiotensin converting enzyme inhibitors (ACEI) reduce mortality in people with congestive heart failure. Therefore, it is the goal of treatment to have all patients with congestive heart failure on these medicines.

Standard of Treatment: All patients with CHF will be placed on an ACEI unless there is a contra-indication to use.

5) Coronary Artery Disease

Definition of Coronary Artery Disease (CAD): Any patient who has been diagnosed as having an MI or who has had Coronary Artery Bypass Surgery, an angioplasty or an abnormal coronary angiogram has coronary artery disease.

Goal of Treatment: To prevent future heart attacks and deaths.

Standard of Treatment: All patients with coronary artery disease will be on (ABC'S): **A**spirin, **B**eta-Blocker, **C**holesterol lowering drug (unless there is a contra-indication) and a **S**moking cessation regimen.

H. Sources of Data available to the QAP

Encounter Data

Member Satisfaction Surveys

Complaint and Grievances

Physician Self Assessment

Electronic Phone Log maintained by Member Services

Health Risk Assessment

As part of the quality assurance program evaluation, the quality assurance committee will analyze the above data to evaluate the member input, analyze the quality indicators, and report the findings to the medical director for the purpose of initiating quality improvement projects.

I. Policy for Monitoring Provider Compliance with Clinical Studies

A physician self-assessment program for disease state management has been developed.

- One disease state will be studied per year. With the above studies this will guide QA through a six-year plan.
- The provider will receive a list of Gold Choice members (via encounter data) who have been diagnosed with the disease and asked to audit the charts.

- 25% return rate of self-assessment forms will be considered an adequate sample size.
- Physicians who response rate and/or lack of will be tracked for quality assurance and credentialing purpose.
- If a physician consistently does not return the forms, the compliance auditor will be sent out to the sites to audit charts and/or cap payment is withheld until data is received.
- The number of charts to be reviewed will be directly correlated to the number of members on the providers' roster who have a diagnosis for the standard of care being studied in the given quarter.

FEEDBACK OF CLINICAL STUDIES INFORMATION:

The QA committee will analyze the results of all chart reviews and make recommendations for provider education and quality improvement projects. The data will be aggregated and fed back to individual practitioners for clinical use, comment, and suggestion.

J. Credentialing/Credential Review Procedures

In order to ensure, in accordance with Article 44 of the Public Health Law, that all persons providing care and services for GOLD CHOICE membership satisfy all applicable licensing, certification or qualification requirements under New York State law, providers are required to complete a written application process. This includes documentation to support the primary verification sources.

The process for credentialing is completed by the Gold Choice Credentialing Committee. The committee is comprised of the Provider Relations Associate, the Associate Director, and the Medical Director. The Provider Relations Associate collects all required documentation. Once all necessary information is compiled it is given to the Associate Director who reviews the information and for accuracy and completeness, and then in turn submits the information to the NYSDOH for placement of the Scope of Benefits File. The Medical Director reviews and approves all providers' applications. Gold Choice Program only credential primary care providers specializing in family practice, general practice, internal medicine, or pediatrics, and D.O's, Nurse Practitioners.

The following is the application/credentialing process for the Gold Choice Program:

Each provider who will be serving Gold Choice membership completes the Physician or Nurse Practitioner Application in full (copies of applications are attached), including the authorization for release of information.

Accompanying each application and included in the provider's file are copies of the following primary verification sources:

Physician

Valid Professional License

Valid DEA Certificate
Board Certification Certificate
Proof of Current Malpractice Insurance
Letters of Appointment to each hospital provider has admitting privileges
Graduation from Medical School – written documentation
Completed Residency Program – written documentation
Professional Claims History

Nurse Practitioner

Valid Professional License
Valid DEA Certificate
Proof of Current Malpractice Insurance

Also obtained and verified is the following information:

- Any sanctions imposed by Medicaid via the Health Provider Network
- Attestation of provider as to validity of information provided
- The National Practitioner Data Bank Profile (see attached disclaimer)
- Information from the NYS Department of Education

The provider must be a NYS Medicaid Provider (must have individual MMIS Number) – if s(he) does not have a MMIS number, a request will be submitted to the NYSDOH on behalf of the provider. A Physician or Nurse Practitioner cannot participate with Gold Choice Program until s(he) is an approved Medicaid Provider.

When the application process is completed and the provider is assigned a Medicaid Provider Number, the information is sent to the New York State Department of Health – Office of Managed Care, via email for placement on the Scope of Benefits File.

Once all the processing is completed the provider is informed of the decision within 90 days. We will respond informing the applicant whether they are accepted as credentialed to participate in the network or that more time is needed to review the application or complete the credentialing process due to info not forthcoming from a third party or other extenuating circumstances. We will make every reasonable effort to resolve the delay ASAP. If an incomplete application is received or we are not currently taking additional providers we will respond to the applicant with notice ASAP but no later than 90 days from the receipt of the application. If s(he) has concerns or dispute with the decision s(he) is instructed to contact the Quality Assurance Coordinator.

Each provider that is approved for the Gold Choice Program is assigned an electronic and paper file with copies of all the appropriate documents listed previously.

Credentials Review Process

To ensure that no licensing or certification falls out of date a date specific credentials database is used to generate reports of expiration on a monthly basis. All documentation is updated on a continual basis. Each provider's file is updated with current copies of the primary verification sources as listed on the previous page, except letters of appointment. An updated attestation must be submitted.

The credentials review process is completed every three years. The factors that are taken into consideration are: non-compliance with Quality Assurance requests, complaints or inquiries from

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members, or necessary Quality Improvement Follow-up (QIFU) regarding Gold Choice policy and procedure (e.g. PCP responsibilities), and member satisfaction surveys.

If it is determined at this time that the provider is deficient the Medical Director advises the provider of the standards not met and requires the provider to explain how the deficiency will be corrected. GOLD CHOICE works closely with the provider until all standards are met for participation in the program. The Gold Choice Program reserves the right not to recredential a provider if the decision is approved by the Credentialing Committee, the Quality Assurance Committee, and the Executive Committee. The provider will be notified in writing of the decision with specific rationale as outlined by the above.

In order to ensure compliance with these standards the provider will be re-evaluated every 6 months until the next re-credential period.

As an ongoing process for determining if Medicaid or the Office of Professional Medical Misconduct had disciplined any providers two resources are monitored on a monthly basis: The New York State Department of Health's PRV292, and The Physician Discipline Monthly report. If it is revealed at this time that a network provider has been sanctioned or suspended the provider is deactivated from the Client Management System and any members assigned to that provider are notified and reassigned to another provider. In addition, the Medical Director, Quality Assurance Committee and Executive Committee are notified, and the provider is omitted from the network until the sanction or suspension has been removed.

K. Enrollee Satisfaction

Member satisfaction will be measured by the following procedures:

- Consumer Advisory Board-All members are invited and encouraged to participate. The board will attempt to meet every four months based on interest and potential attendance.
- Review of Complaint Logs-All Complaints and Grievances are reviewed by Quality Assurance Committee to determine if there is a trend or particular area of dissatisfaction as reported by membership. Reports are submitted quarterly to New York State Department of Health.
- Review of disenrollment data-Data that is provided by the ECDSS is reviewed to determine if there is a particular trend in reasons for disenrollment.
- Annual Member Satisfaction Survey-Membership is mailed and asked to complete a Member Satisfaction Survey annually. QAC reviews responses to determine if there is a particular trend in dissatisfaction.

II. Case Management

The purpose of the Gold Choice Case Management Program is to coordinate access to primary and specialty care for the membership and to link members with other needed support services available in the community. Our case management program is a collaborative effort with the primary care providers.

Supportive case management:

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These services are provided by phone by trained member services representatives that are available Monday – Friday between the hours of 8:30 am – 4:30 PM.

- Linkage with and change of PCP and other ancillary services
- Access to emergency services.
- Member and provider education.
- Trouble shooting access to services.
- Authorization for services.

Pre-comprehensive case management:

These services are provided by trained case management staff, e.g. registered nurses either by the phone or face to face at a PCP office or counseling site.

- Determine client need for extensive services
- Determine if service is needed in the community, e.g. meet a consumer at the PCP office to provide support during the medical visit.
- Provide client education, e.g. personal hygiene/health; reinforce prescribed medical treatment plan, program benefit, access to services, grievances.
- Social support, e.g. reconnect to family, friends, and community resources.
- Link to other health care providers.

Specialized Case management:

This offers a comprehensive approach for members who have multiple co-morbidities. The care coordinator works with the member, the PCP, and the special care agency as part of an integrated system of care. In addition the care coordinator works with the member trying to reach the goals and recommendations in a person centered manner. The care coordinator identifies what information should be shared with the other providers i.e. ER visits.

For individuals who have not received medical care according to the identified standard of practice as outlined in the Gold Choice Quality Assurance Plan, the care coordinator contacts the Care Coordination agency to work with the Case Manager to attempt to resolve the issue. The Case Manager works with Gold Choice and the member to assist in accessing medical care services.

We have been working to build partnerships with the case management agencies and case managers in order to take steps to improve the health status of individuals.

For those members that have a one or more chronic disease diagnoses a care coordinator is assigned to determine several factors:

- If there is an HRA on file (if not one is obtained)
- Date of last visit-to determine if a f/u is needed
- Specific diagnoses in encounter data-to determine recommendations
- ER Hx, Inpt Hx, Transport Hx-to determine if member is using healthcare services appropriately

The Gold Choice Medical Director directs the Case Management Program.

III. Child Care Case Management

A single case manager is assigned to coordinate all children services. Gold Choice uses a multi-step process to coordinate care:

- 1) Assess via telephone survey the health needs of the child
- 2) As issues are identified, follow up with the family to resolve all outstanding immediate concerns.
- 3) Coordinate and link to needed services

IV. Policy And Procedures For Children Enrolled

C4K Foster Care:

- ❑ DSS Foster care representative at the Child Advocacy Center fills out all applications.
- ❑ Applications will then be sent to Gold Choice for further processing.
- ❑ All applications received are stamped with the identifier, C4K and then given the coding specialist to enter into the CMS.
- ❑ After entering they are then sent to DSS for processing with the other apps.
- ❑ On a monthly basis reports are run to determine who is active with Gold Choice and those that are still apply or pending, based on the determination from DSS.
- ❑ When they become active they are sent the standard welcome package.
- ❑ The application is then sent to case management in its enrollment folder (yellow)
- ❑ Case management will follow up with the children using the child care telephone screening tool within the first three months of enrollment.
- ❑ After monitoring the encounter data, to determine PCP visit rate, case management will follow up with the member on a need basis.
- ❑ All phone calls that are received in member services regarding the foster care children are sent immediately to case management or the Program Director. The CMS identifies these members with a C4K and all members' identifying information is kept confidential. This screen is only accessible with a special password access given to case management and the director.
- ❑ Member services representatives are trained to allow the person calling tell them what they need. If they need a new card, the caller must give the address to send it to. If different then in the CMS, the caller is referred to the Foster Care division and then follow up with Carol Sobolewski at 858-6002 or Ted Swiatek at 716-858-8962
- ❑ Only Gold Choice related information is to be given out over the phone.
- ❑ All address changes and questions regarding identifying information, questions about foster care and all other non-Gold Choice related concerns must go through the foster care division or Carol S. at DSS phone number is 716-858-6002 or 716-858-6437 or 716-858-6438.
- ❑ No identifying information is to be given out to the caller, ie address, phone, cin number.

Case Management for the C4K Program:

- ❑ Coordination of services will be arranged with the PCP and if necessary the care coordinator through phone calls by the Gold Choice case manager to insure that there is no duplication of services and/or efforts.

Non foster care Children

- ❑ Applications are processed as any other potential member.
- ❑ When they become active they are sent the standard welcome package.
- ❑ The application is then sent to case management in its enrollment folder (yellow)
- ❑ Case management will follow up with the children using the child care telephone screening tool within the first three months of enrollment.
- ❑ After monitoring the encounter data, to determine PCP visit rate, case management will follow up with the member on a need basis.

V. Clinical Practice Guidelines for C/THP, Lead, HIV, and STD'S

These will be monitored on a yearly basis through education to our members and monitoring of our providers. In order to ensure compliance a Physicians Self-Assessment will be sent in order to determine if Providers are adhering to guidelines for C/THP, Lead, STD's, and HIV screening and treatment protocols. A 25% response rate will be expected and considered an adequate sample size. If the provider is not adhering (less than 80%of those surveyed) to the guidelines education will be provided in the area of deficiency. These guidelines and protocols are reviewed and approved by the QA committee

VI. Complaints and Grievances

Definitions:

The complaint process is for the receipt and resolution of Enrollee complaints pursuant to section 4408-a of PHL and applicable Federal Regulations. Gold Choice does not have a formal utilization review or service authorization process. Decisions about access to services are made by the PCP based on his or her medical expertise. The complaint process serves as the mechanism through which an enrollee makes a formal request to the contractor to review a decision of a PCP to deny a request for a referral, or to deny or reduce a benefit or service, or to authorize a service for less than requested.

Complaint means Enrollee's expression of dissatisfaction with any aspect of his or her care including the decision of a PCP to deny a request for a referral, or to deny or reduce a benefit or service.

A complaint appeal means a request for a review of a complaint determination

An inquiry means a written or verbal question or request for information posed tot he contractor with regard to such issues as benefits, contracts, and organization rules. Neither enrollee complaints nor disagreements with contractor determinations are inquires.

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- I. The Call or letter of complaint is received and documented by member services in the Client Management System (CMS) and report is generated for *immediate* review
- a) Gold Choice accepts written Complaints either by letter or the supplied form.
 - b) Gold Choice does not require an Enrollee to file a Complaint in writing.
 - c) Gold Choice provides Enrollees with reasonable assistance in completing forms and other procedural steps for filing a Complaint or Complaint Appeal including, but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.
 - d) The Enrollee may designate a representative to file Complaints and Complaint Appeals on his/her behalf.
 - e) Gold Choice will not retaliate or take any discriminatory action against the Enrollee because he/she filed a Complaint or Complaint Appeal.
 - f) The Gold Choice procedures for accepting Complaints and Complaint Appeals includes:
 - 1) The toll-free telephone number: 1-888-419-1722
 - 2) Member Services staff to receive calls;
 - 3) "live" phone coverage from 8am –4 p.m. Mon.-Fri
 - 4) a telephone system available to take calls and member services staff to respond to all such calls no later than on the next business day after the calls were recorded
- II. Quality Assurance Coordinator will review and assign all complaints to appropriate staff members. For complaints clinical in nature the RN case manager is responsible under the supervision of the medical director. For complaints administrative in nature the Quality Assurance coordinator is responsible under the supervision of the Program Director.
- a) Complaints are reviewed by one or more qualified personnel including but not limited to Medical Director, RN Case Manager, Program Director, and Quality Assurance Coordinator.
 - b) Gold Choice ensures those personnel making determinations regarding Complaints, and Complaint Appeals were not involved in previous levels of review of decision-making.

- c) Complaints pertaining to clinical matters are reviewed by one or more licensed, certified or registered health care professionals in addition to whichever non-clinical personnel Gold Choice designates.

III. Acknowledgment

- a) Gold Choice provides written acknowledgment of any Complaint not immediately resolved, including the name, address and telephone number of the individual or department handling the Complaint, within fifteen (15) business days of receipt of the Complaint. The acknowledgement identifies any additional information required by Gold Choice from any source to make a determination. If a Complaint determination is made before the written acknowledgement is sent, Gold Choice may include the acknowledgement with the notice of the determination (one notice).

IV. Review/Timeframes

- a) For Complaints about the decision of a PCP to deny a request for a referral or to determine that a requested benefit is not covered pursuant to the terms of the contract, Gold Choice's Complaint process shall indicate the following specific timeframes regarding Complaint resolution:
 1. Whenever a delay would significantly increase the risk to an Enrollee's health, Complaints shall be resolved within forty-eight (48) hours after receipt of all necessary information. When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
 2. Complaints about denials of a request for a service; or a request for a referral; or a request about whether a service is included in the Benefit Package that are not Expedited must be resolved within fourteen (14) days after the receipt of the request with a possible fourteen (14) day extension.
 3. Fourteen (14) day extensions may be requested by an Enrollee or provider on the Enrollee's behalf (written or verbal).
 4. Gold Choice may also initiate an extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension must be well documented. If the extension is initiated by the Enrollee or provider, Gold Choice must provide written acknowledgement. If the extension is initiated by Gold Choice, Gold Choice must notify the Enrollee in writing, of the reason for the extension, how the delay is in the best interest of the Enrollee and any additional information that the plan requires to make its determination.
- b) When a Complaint is not about a denial by the PCP of an Enrollee's request for a referral or for a determination that a requested benefit is not covered pursuant to

the terms of this Agreement, the Gold Choice's Complaint process shall indicate the following specific timeframes regarding resolution:

1. All other non-service related Complaints shall be resolved within forty-five (45) days after the receipt of all necessary information and no more than sixty (60) days from receipt of the Complaint. Gold Choice shall maintain reports of Complaints unresolved after forty-five (45) days.

V. Determination

- a) If Gold Choice immediately resolves an oral Complaint to the Enrollee's satisfaction that Complaint may be considered resolved without any additional written notification to the Enrollee. Such Complaints must be logged by Gold Choice and included in Gold Choice's quarterly HPN Complaint report submitted to SDOH.
- b) Complaint Determinations by Gold Choice shall be made in writing to the Enrollee or his/her designee and include:
 1. the detailed reasons for the determination;
 2. in cases where the determination has a clinical basis, the clinical rationale for the determination;
 3. the procedures for the filing of an appeal of the determination, including a form, if used by Gold Choice, for the filing of such a Complaint Appeal; and notice of the right of the Enrollee to contact the State Department of Health
 4. SDOH's toll-free number for Complaints.
- c) If the Complaint was about the denial by a PCP of a request for a service and the determination was not in favor of the Enrollee, the Complaint Determination notice and the notice entitled "Managed Care Action Taken" containing the Enrollee's fair hearing and aid continuing rights must be sent.
- d) If Gold Choice was unable to make a Complaint determination about a non service related issue because insufficient information was presented or available to reach a determination, Gold Choice will send a written statement that a determination could not be made to the Enrollee on the date the allowable time to resolve the Complaint has expired.
- e) If Gold Choice was unable to make a Complaint determination about a service related issue within the fourteen day timeframe, it is considered a negative determination and a determination notice pursuant to (ii)

above and the "Managed Care Action Taken" notice containing fair hearing and aid continuing rights must be sent.

Complaint Appeals

- I. The Call or letter to appeal a complaint determination is received and documented by member services in the Client Management System (CMS) and report is generated for *immediate* review
 - a) The Enrollee or designee has no less than sixty (60) business days after receipt of the notice of the Complaint determination to file a written Complaint Appeal. Complaint Appeals may be submitted by letter or by a form provided by Gold Choice.

- II. Program Director will review and assign complaint appeal to appropriate staff member; For complaint appeals of a clinical nature Dr. Thomas Rosenthal, the Gold Choice CEO and for administrative, Kathy Duttge, COO.

- III. Acknowledgment
 - a) Complaint Appeal, Gold Choice shall provide written acknowledgment of the Complaint Appeal, including the name, address and telephone number of the individual designated to respond to the Appeal. Gold Choice shall indicate what additional information, if any, must be provided for Gold Choice to render a determination.
- IV. Review/Timeframes
 - a) Complaint Appeals of clinical matters are decided by personnel qualified to review the Appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer (i.e. Dr Thomas Rosenthal)
 - b) Qualified personnel at a higher level than the personnel who made the original Complaint determination shall determine complaint Appeals of non-clinical matters (i.e. Kathy Duttge).
 - c) Complaint Appeals shall be decided and notification provided to the Enrollee no more than:
 - 1) two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to an Enrollee's health; or
 - 2) thirty (30) business days after the receipt of all necessary information in all other instances.

- V. Determination

a) The notice of Gold Choice's Complaint Appeal determination shall include:

1. the detailed reasons for the determination;
2. the clinical rationale for the determination in cases where the determination has a clinical basis;
3. the notice shall also inform the Enrollee of his/her option to also contact the State Department of Health with his/her Complaint, including the SDOH's toll-free number for Complaints;
4. instructions for any further Appeal, if applicable.

Quality Assurance coordinator maintains a file on each Complaint and Complaint Appeal. These records shall be readily available for review by the SDOH, upon request. The file shall include:

- date the Complaint was filed;
- copy of the Complaint, if written;
- date of receipt of and copy of the Enrollee's written confirmation, if any;
- log of Complaint determinations including the date of the determination and the titles of the personnel and credentials of clinical personnel who reviewed the Complaint;
- date and copy of the Enrollee's Complaint Appeal;
- Enrollee or provider requests for expedited Complaint Appeals and Gold Choice's determination;
- necessary documentation to support any extensions;
- determination and date of determination of the Complaint Appeals;
- the titles and credentials of clinical staff who reviewed the Complaint Appeals; and
- Complaints unresolved for greater than forty-five (45) days.