

PROPOSED PROGRAM REQUIREMENTS

QUALITY MANAGEMENT

Introduction

The Organization must operate an ongoing Quality Management program (QM) which includes quality assessment and performance improvement, in accordance with federal and State requirements. If the Organization chooses to become a PACE program, they must comply with the Quality Management Requirements of PACE. The requirements of this section explain the program requirements of the Organization if the decision is made to operate a Medicare Special Needs Plan (SNP) and/or contract with the Department of Disabilities, Aging and Independent Living (DAIL) to operate as Medicaid MyCare Vermont Provider.

The Organization must protect, maintain, and improve the quality of care provided to MyCare Vermont Participants. The vision of any quality improvement program is to insure the right care for every Participant every time. The Organization shall provide for the delivery of quality services to Participants with the primary goal of improving the health status and well-being of Participants. Where the Participant's condition is not stable, the Organization shall arrange for services that will seek to maintain the Participant's current health status and well-being, to the extent desired by the Participant, by implementing measures to prevent any further decline in condition or deterioration of health status or well-being.

The DAIL defines quality of services for MyCare Vermont as follows:

The degree to which services for individuals and populations:

- increase the likelihood of desired health outcomes;
- increase the likelihood of desired independence and quality of life;
- are Person-Centered; and
- are consistent with current professional knowledge about effective care.

The Organization shall have a Quality Management Program for:

- a) measuring the Organization's performance of its contractual responsibilities,
- b) identifying opportunities for improving performance,
- c) developing and implementing action steps to improve performance, and
- d) measuring whether the targeted improvements have been achieved.

If the Organization operates a SNP and contracts to be a MyCare Vermont provider, the DAIL will make every effort to coordinate program and reporting requirements with Medicare SNPs requirements. Below is a crosswalk of Medicare Requirements for SNPs and Medicaid regulatory requirements. Medicaid citations are noted. The Organization will be required to report all items listed below to the DAIL. Items 1-6, 8-10, 13-14 are required by both Medicare and Medicaid. Items 7, 12-13 are Medicare-only requirements.

1. Assess the quality and appropriateness of care and services furnished of all contracts and to individuals with special health care needs §438.204, §438.240(b)(4), §438.208(c)(2)
2. Identify the race, ethnicity and primary language spoken and submit to State §438.204(2)
3. Regularly monitor and evaluate the health plans for compliance §438.204(3)
4. Arrangements for annual, external independent reviews of the quality outcomes and timeliness of and access to the services covered under the contract §438.204(3)(d)
5. Appropriate use of intermediate sanctions §438.204(3)(e)
6. An information system that supports initial and ongoing operation and review of the State's quality strategy §438.204(3)(f)
7. Have a chronic care improvement program that includes methods for identifying the enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in a chronic care improvement program
8. Conduct quality improvement projects that can be expected to have a favorable effect on health outcomes and enrollee satisfaction that focus on specified clinical and non-clinical areas and that involve measurement of performance, system interventions including the establishment or alteration of practice guidelines, improving performance, systematic and periodic follow-up on the effect of the intervention §438.240(b)(1)
9. Follow written policies and procedures that reflect current standards of medical practice §438.236
10. Have in effect mechanisms to detect both under-utilization and over-utilization of services §438.240(b)(3)
11. Measure and report performance using the measurement tools required by CMS and report performance to CMS §438.350(e), §438.352
12. Make available to CMS information on quality and outcomes measures that will enable beneficiaries to compare health coverage options and select among them
13. PPO plans must have a provider network that has agreed to a contractually specified reimbursement for covered benefits regardless whether the benefits are provided within the network of providers
14. Annual review, at least, for a formal evaluation of the impact and effectiveness of the quality improvement program §438.240(d)
15. The Organization must correct all problems that come to its attention through internal surveillance, complaints or other mechanisms §438.364(a)(5)

Quality Management Program

The Organization shall have on file with the DAIL an approved written plan describing the QM Program, including how the Organization will accomplish the activities required by this section.

The Organization shall approach all clinical, functional, personal experience and administrative aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement and shall:

- rely heavily on Participant input;
- recognize that opportunities for improvement are unlimited;
- be data driven;
- rely heavily on input from all staff of the Organization and its subcontractors;
- require measurement of effectiveness, continuing development, and implementation of improvements as appropriate;
- evaluate Provider and Organization performance using objective quality indicators;
- support continuous ongoing measurement of clinical, functional, personal experience and administrative effectiveness and Participant satisfaction;
- support programmatic improvements of clinical, functional, personal experience and administrative processes based on findings from ongoing measurements; and
- support re-measurement of effectiveness and Participant satisfaction, and continued development and implementation of improvement interventions as appropriate.

The QM Program shall include annual goals for planned projects or activities, including clinical, functional, personal experience and administrative or initiatives and measurement activities. Each goal shall have associated timelines and quantitative measures for evaluation.

The Organization shall submit a semi-annual QM Program evaluation in a format and timeframe specified by the DAIL. The evaluation shall evaluate the effectiveness of clinical, functional, personal experience and administrative QM initiatives using, in whole or in part, the quality measures defined in the Quality Program Initiatives section.

The Organization shall include in subcontracts a requirement securing cooperation with the QM Program. The Organization shall keep participating physicians and other Network Providers informed about the QM Program and related activities.

QM Program Structure

The Organization shall maintain a well-defined QM structure that includes a planned systematic approach to improving clinical, functional, personal experience and administrative processes and outcomes. The Organization must ensure that sufficient skilled staff and resources are allocated to implement the quality management program. The Organization will require that Participants, ICT members, employees and contract providers are involved in the development and implementation of all quality management activities. The Organization shall designate:

Quality Management Director: an identified senior-level director who will oversee all quality management and performance-improvement activities. The quality management director must have expertise in the Integrated Care Model.

Medical Director: a medical director licensed by the State of Vermont with geriatric expertise and/or disability expertise and experience in community and institutional long

term care, who will be responsible for establishing medical protocols and practice guidelines to support the QM program described in this section.

Physician: a qualified physician, licensed by State of Vermont in Medicine and further board certified in family practice or internal Medicine, who will be responsible for establishing and monitoring the implementation and administration of geriatric and disability management protocols.

Behavioral Health Clinician: a qualified behavioral health clinician, with expertise in geriatric and disability service, who will be responsible for establishing behavioral health protocols and providing specialized support to the ICT.

The QM Program shall include a set of functions, roles, and responsibilities for the oversight of QM Program activities that are clearly defined and assigned to appropriate individuals, potentially including administrative staff, subcontractors, ICT members, other clinicians, and non-clinicians.

The QM Program shall include:

Participant Advisory Committee: The Organization must establish an advisory body that represents the interests of Participants and caregivers of MyCare Vermont. The Participant Advisory Committee guides key decision-making in the areas of Participant satisfaction and quality improvement. This committee provides quarterly reports to the Organization's Board of Trustees overseeing the operation of MyCare Vermont.

Ethics Committee: The Organization must establish an ethics committee, operating under written policies and procedures, to provide input to decision-making, including delivery of services, end-of-life issues and advance directives.

Professional Advisory Committee: The Organization must establish a Professional Advisory Committee to advise the Organization in the development and implementation of program policies and the ongoing review and evaluation of program performance in light of established goals and objectives. This committee provides quarterly reports to the Organization's Board of Trustees overseeing the operation of MyCare Vermont.

Clinical Practice Guidelines

The Organization shall adopt not fewer than six evidence-based clinical practice guidelines. The six evidence-based clinical practice guidelines must be distributed as follows: at least two specific quality goals in the acute/primary care¹, long-term care², and behavioral health³ areas. Such practice guidelines shall be based on valid and reliable clinical evidence, consider the needs

¹ Acute/primary care medical services include comprehensive care for routine, urgent and chronic medical needs.

² Long term care includes social, housekeeping and support services to improve or maintain function, health, and/or activities of daily living.

³ Behavioral health includes a continuum of services aimed at providing an array of mental health and substance abuse services, including prevention, treatment, and interventions that promote recovery and social well-being.

of Participants, be adopted in consultation with contracting health care professionals, and be reviewed and updated periodically, as appropriate, but not less than every other year.

The Organization shall develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QM Program.

The Organization shall coordinate the development of clinical practice guidelines with the DAIL to avoid providers receiving conflicting practice guidelines from the Organization and the DAIL.

The Organization shall disseminate the practice guidelines to all affected Providers, Participants and potential Participants. The Organization shall take steps to implement adoption of the guidelines, and to measure continuous Provider compliance with the guidelines.

Quality Measurement – Program Level

The Organization shall engage in the collection of quality measurement data. Quality measures are defined to include statistical assessments of the structure and process of medical, long-term care delivery and the personal experience of the Participant, as well as assessments of the impact or outcome of care on the health status and well-being of Participants.

Quality measures should be selected from nationally adopted or endorsed evidence-based measurement sets wherever possible. When such measures are not available, quality measure selection should be informed by a consensus process involving providers and Participant of services, in Vermont or elsewhere.

The Organization shall assess the quality of care delivered to Participants using measures and measurement methodologies, including:

- ♦ measurement of access to care and access to the ICT using a Participant survey;
- ♦ measurement of Participant involvement in the interdisciplinary care team;
- ♦ measurement of the provision of Person-Centered Care, of Participant goal attainment, and of care that is consistent with the Department’s “Desired Outcomes of Services” as defined in the Quality Management Plan;
- ♦ measurement of Participant experience and level of satisfaction using periodic telephone calls to Participants;
- ♦ measurement of program ICT performance through review of Individual Care Plans and minutes of ICT meetings, observation of ICT meetings and survey of ICT members;
- ♦ measurement of effective management of common chronic care conditions (e.g., asthma, depression) identified by the DAIL and other appropriate measures required by the DAIL;
- ♦ measurement of effective management of: dementia; alcohol and drug abuse prevention and treatment Initiative; abuse and neglect identification appropriate measures required by the DAIL;

- ♦ measurement of effective provision of preventive services (e.g., periodic recommended screenings, health promotion and wellness activities) using appropriate HEDIS measures identified by the DAIL and other appropriate measures required by the DAIL;
- ♦ measurement of incidence and appropriate use of ambulatory care-sensitive hospitalizations, hospital admissions and readmissions, nursing facility institutionalization and emergency room visits; and
- ♦ measurement of the effectiveness of Organization and ICT efforts to support Participants in managing chronic conditions using appropriate measures required by the DAIL.

The Organization shall use such quality measurement data in the development, assessment, and modification of its QM Program.

Annual Quality Program Initiatives

Using information obtained through the previous section, Quality Measurement - Program Level, the Organization shall annually define and develop at least two specific quality goals in the primary care, long-term care, and behavioral health areas. The Organization must provide documentation on each project, describing:

- a. the objective;
- b. the expected outcomes;
- c. a brief justification with background on each objective;
- d. how each quality goal will be measured;
- e. the target population;
- f. the method of evaluating change in the quality goals;
- g. communication processes; and
- h. documentation requirements.

Quality program initiatives shall be proposed to the DAIL for approval at least thirty (30) days prior to the start of each Contract Year and shall address identified opportunities for quality improvement for which a quality program initiative can positively impact care in a meaningful way for a significant percentage of Participants.

Quality initiative evaluations shall be included within the annual QM program evaluation submitted to the DAIL.

Quality Management Monitoring

The Organization shall develop written policies and procedures approved by the DAIL for selection and qualifications of clinical staff and contracted providers. Upon termination of any contracted providers the Organization must notify the DAIL concerning the reason for termination. The Organization will be required to perform competency reviews of all clinical staff and any network providers.

Collaboration with the Department of Disabilities, Aging and Independent Living (DAIL) Quality Management Plan

The DAIL maintains a Quality Management Plan to assure quality assurance and improvement. The DAIL Quality Management Unit performs ongoing assessment of the quality of certain long-term care services provided to Vermonters served by the DAIL, including services delivered by Home Health providers, Area Agencies on Aging, and Adult Day Services providers. The Organization as a MyCare Vermont provider will be subject to comply with the DAIL Quality Management Plan.

Collaboration with the External Quality Review Organization (EQRO)

The Organization will collaborate with the DAIL's external quality review organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to Participants and to identify opportunities for Organization improvement. The Organization shall work collaboratively with the DAIL and the EQRO to annually perform quality measurement activity.

Outcomes of the Quality Management Program

The DAIL will use the measures listed below to evaluate and measure the success of the QM program. The outcomes of a Quality Management Program are met when the Organization:

- a. Demonstrates that it has an internal quality improvement system described in an annual report to the DAIL;
- b. Provides documentation that it has reviewed and if appropriate, taken steps for improving the quality of services provided by subcontractors as reported in the annual delegation of authority report to the DAIL;
- c. Provides documentation that it has reviewed and if appropriate, taken steps for improving, access to health care in an annual report to the DAIL;
- d. Provides documentation of the results of physician credentialing in an annual report to the DAIL;
- e. Provides the results of member satisfaction survey indicating overall Satisfaction of at least eighty (80) percent in an annual report to the DAIL;
- f. Achieves demonstrable improvement in significant aspects of clinical, functional, personal experience areas that can be expected to have a favorable effect on health outcomes and Participant satisfaction, as evidenced in the two annual project reports to the DAIL; and
- g. Demonstrates improvement in the support provided to Participants in achieving their desired outcomes.