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Quality Management Program overview

The AmeriHealth Quality Management (QM) Program is organized around a vision of supporting optimal health outcomes and satisfaction with care for our Members, as well as meeting all applicable regulatory and accreditation requirements. A philosophy of promoting the Academy of Medicine domains of quality (i.e., Safe, Timely, Effective, Efficient, Equitable, and Patient-Centered [STEEEP] care) for our Members informs all QM activities, assessments, and performance improvement projects.

The goals of the AmeriHealth QM Program include:

- Assess and improve the safety of medical and behavioral health care and services provided to Members.
- Evaluate the sufficiency of the plan networks for Members to access qualified Providers for timely and appropriate care.
- Ensure evidence-based, effective care is provided to members for their medical and behavioral health conditions.
- Promote efficient care and reduce health care waste through facilitating communication, continuity, and coordination of care among Providers and supporting a focus on prevention and appropriate level of service.
- Promote health equity among diverse populations by identifying and addressing social needs, including access to care that fits cultural and linguistic preferences.
- Assess and address the satisfaction of Members with their health care plan and services to support patient-centered system improvements.

Our relationships with our network Providers are essential in achieving our quality goals. Since our Providers deliver care to our Members, our role is to assist their efforts and to provide the tools and information they need to maintain the highest standards of care. Likewise, participating network practitioners have a role in supporting the QM Program. They contribute to the planning, design, implementation, and review of the QM Program, policies, and goals through the Clinical Quality Committee and other quality committees, which include network Providers as voting Members. All participating Providers are required to allow the Plan to use performance data for developing and implementing clinical and service quality improvement activities, public reporting to consumers, preferred status designation in the network, and cost sharing arrangements. All Providers are expected to cooperate with the QM Program, including requests for information and actions to support Member safety activities, complaint and occurrence inquiries, coordination of care, adherence to standards of care, non-discrimination, and other efforts to promote the health and wellbeing of our Members.

Information about our QM Program is available to our Providers and Members upon request, including a description of our QM Program goals and activities. This information is available online at www.amerihealth.com or Providers may contact Customer Service at 1-888-YOUR-AH1.
Quality Management activities

The QM Program supports an ongoing comprehensive program of continuous quality improvement throughout the organization. We monitor, evaluate, and act to improve the quality and safety of clinical care and the quality of service provided to Members by participating practitioners and Providers, as well as Plan delegates, across all our product lines. We identify opportunities and establish initiatives to improve meaningful clinical outcomes and service quality by monitoring and analyzing:

- claims, pharmacy, and other data to identify high-volume, high-risk, and problem-prone services and acute and chronic conditions;
- data from internal performance monitoring activities and satisfaction survey results;
- data from complaints and Member appeals and direct input from Members, practitioners/Providers, and AmeriHealth staff.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Qualified Health Plan Enrollee Experience Survey (QHP EES) Member survey data relating to primary and specialty care;
- Healthcare Effectiveness Data and Information Set (HEDIS®) data for management of certain conditions and medications.

Member safety activities

Nothing is more important than the safety of our Members when receiving clinical care. The QM Program investigates all quality of care concerns. There are a variety of ways QM staff is alerted to potentially suboptimal care or medical errors that could impact the safety of our Members: Member and Provider complaints and grievances, patient safety claim codes and never event reports, care management and coordination team reviews, records audits, appeals, and other sources. The QM team assesses all reported occurrences for quality issues.

In addition, the Member Safety program is committed to promoting an environment that fosters safe clinical practice and minimizes medical and medication errors by:

- Monitoring and assessing reported safety concerns related to health care delivery to our Members;
- Close monitoring of quality, claim, and safety data sources to identify and respond to trends;
- Alerting Providers to potential safety concerns and gaps in care for individual Members in their care;
- Monitoring the coordination of care of our Members, including between medical and specialty care and medical and behavioral healthcare;
- Identifying processes and practices that have potential to contribute to the reduction of medical and medication errors within our network;
- Developing and disseminating information to Providers to promote safe clinical and prescribing practices and optimal outcomes;
- Educating Members about patient safety and their role in reducing medical and medication error;
- Evaluating the impact of Member safety interventions on our Members’ health outcomes;
- Close collaboration with health care Providers, hospitals, consumers, and other stakeholders through our partnerships.
Member complaint process

The QM department investigates all quality-of-care and service concerns/complaints and occurrences, ensuring appropriate clinical review and follow-up, as well as forwarding documentation of any quality related actions to the Credentialing department for inclusion in the Provider’s Plan record. Members or their representatives may file a concern/complaint by calling Customer Service at the number listed on their ID card or sending their complaint in writing to us by mail or email. Quality complaints are expressions of dissatisfaction with or criticism of the quality of care or service received from an in-network Provider or the quality of a practitioner’s office site. Quality complaints are typically forwarded to the QM department by Member Services or Appeals and may also be directed from other internal departments. Member safety occurrences are defined as adverse events that occur during inpatient or outpatient treatment that may present a Member safety concern.

If an AmeriHealth New Jersey Member or the Member’s designee is dissatisfied with the AmeriHealth process for managing Member concerns, he or she has the right to complain to the Department of Banking and Insurance using the following contact information:

- Office of Managed Care
- Consumer Protection Services
- Department of Banking and Insurance
- P.O. Box 475
- Trenton, NJ 08625-0475
- Main phone: 1-888-393-1062
- Fax: 609-777-0508 or 609-292-2431

A complaint form is available for complaints to the Department of Banking and Insurance online at www.state.nj.us/dobi/mcfaqs.htm.

On receipt of a complaint, QM Complaint Coordinators assess and document the nature of the complaint, categorize it, and initiate an investigation involving review by a Medical Director. Occurrences are assessed by Clinical QM Specialists, who document the nature of the occurrence, categorize it, and initiate an investigation involving review by a Medical Director. Complaint and occurrence investigations include correspondence with the Provider and/or facility involved and may include requests for records. Failure to respond to inquiries regarding complaints and occurrences will result in an escalation of the assigned severity of the complaint or occurrence. Providers are notified of any review of potential quality issues and the determination of any investigation in writing. If the Medical Director determines that there was an actual significant adverse effect on the Member, a corrective action plan addressing the quality issue identified will be requested.

As part of the resolution process, QM staff maintain a tracking database to facilitate the review, investigation, resolution, and trending of Member complaints and occurrences. Resolved complaints are monitored and analyzed to facilitate the identification of individual outliers and plan-wide trends. Outliers with multiple complaints or occurrences assigned escalated severity levels are subject to further peer review and corrective action, as appropriate. Improvement initiatives may also be implemented in response to identified adverse plan-wide trends, as necessary.

Monitoring of continuity and coordination of care

Effective continuity and coordination of care promotes both Member safety and the efficient use of healthcare resources. Care transitions refer to Members moving between health care practitioners and across settings as their conditions and care needs change during the course of a chronic or acute illness. This may include transitions between practitioners (e.g., primary care and specialists, behavioral health practitioner and primary care), and movement across settings.
of care. Care coordination is the facilitation, across transitions and settings of care, of patients getting the care or services they need and Providers getting the necessary information to provide the highest quality care.

Our goal is for Members to receive seamless, continuous, and appropriate care. On an annual basis, we collect and analyze data about the coordination of care across settings or transitions in care in our network to identify opportunities to improve. Examples of the type of data collected to improve coordination of care and promote collaboration between Providers, including medical and behavioral health care practitioners, include:

- appropriate documentation of exchange of information and coordination between Providers;
- appropriate follow through on Referrals and studies;
- appropriate diagnosis, treatment, and Referral of behavioral health disorders commonly seen in primary care;
- appropriate prescribing and monitoring use of psychopharmacological medications;
- primary or secondary preventive behavioral healthcare program implementation;
- management of treatment access and follow-up for Members with co-existing medical and behavioral health disorders, including Members with severe or persistent mental illness.

QM also works with the Clinical Services and Utilization Management departments to monitor the coordination of care when Members move from one setting to another, such as when they are discharged from a hospital. The Transition of Care program provides telephonic support to eligible Members and their caregivers as they transition from inpatient care to home. Members are made aware of how they become eligible to participate, how to use program services, and how to opt-in or out of the program. Health Coaches provide education and coordinate care services so members/caregivers learn self-management skills that will ensure their needs are met during the transition and avoid unplanned readmissions or other transitions in care. The program uses an evidence-based model that focuses on four conceptual areas: medication self-management, understanding and use of the personal health record, primary care and/or specialist follow-up and member/caregiver knowledge on identification and management of signs and symptoms. Members who require additional support are transitioned into case management or disease management. Without coordination, such transitions often result in poor quality care and risks to patient safety. Analysis of discharge planning and care management data and surveys of practitioners regarding communication and coordination informs the design and implementation of these improvement initiatives.

Rights and responsibilities

Member rights

A Member has the right to:

- receive information about the health plan, its benefits, services included or excluded from coverage policies and procedures, participating practitioners/Providers, and Members’ rights and responsibilities. Written and Web-based information provided to Members will be readable and easily understood.
- be treated with courtesy, consideration, respect, and be recognized for his or her dignity and right to privacy;
• participate in decision-making with practitioners regarding his or her health care, including the right to candid discussions of appropriate or Medically Necessary treatment options for his or her condition, regardless of cost or benefits coverage.

• voice complaints or appeals about the health plan or the care it provides and receive a timely response. The Member has a right to be notified of the disposition of appeals/complaints and the right to further appeal, as appropriate.

• make recommendations regarding our Member rights and responsibilities policy by contacting Customer Service in writing;

• choose practitioners within the limits of covered benefits, availability, and participation within the AmeriHealth network;

• have confidential treatment of personally identifiable health/medical information. Members also have the right to have access to their medical record in accordance with applicable federal and State laws.

• be given reasonable access to medical services;

• receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, health status, genetic information, color, religion, gender, sexual orientation, national origin, source of payment, utilization of medical or mental health services or supplies, or other unlawful basis including, without limitation, the filing by such Member of any complaint, grievance, appeal or legal action against Professional Provider, a Group Practice Provider (if applicable) or AmeriHealth;

• formulate and have advance directives implemented. AmeriHealth will provide information concerning advance directives to Members and practitioners and will support Members through our medical record-keeping policies;

• obtain a current directory of participating practitioners in the plan’s network, upon request. The directory includes addresses, telephone numbers, and a listing of Providers who speak languages other than English.

• file a complaint or appeal about the health plan or care provided with the applicable regulatory agency and to receive an answer to those complaints within a reasonable period of time. To be notified of the disposition of an appeal or complaint and further appeal, as appropriate.

• appeal a decision to deny or limit coverage, first within the plan and then through an independent organization for a filing fee, as applicable. Members also have the right to know that their doctor cannot be penalized for filing a complaint or appeal on a Member’s behalf.

• for members with chronic disabilities, the right to obtain assistance and Referrals to Providers who are experienced in treating their disabilities.

• have candid discussions of appropriate or Medically Necessary treatment options for his or her condition, regardless of cost or benefits coverage, in terms that the Member understands, including an explanation of their medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the Member is unable to easily understand this information, he or she has the right to have an explanation provided to his or her next of kin or guardian and documented in his or her medical record. AmeriHealth does not direct practitioners to restrict information regarding treatment options.

• have available and accessible services when Medically Necessary, including availability of care 24 hours a day, 7 days a week, for urgent and Emergency conditions;
call 911 in a potentially life-threatening situation without prior approval from AmeriHealth and the right to have AmeriHealth pay per contract for a medical screening evaluation in the emergency room to determine whether an Emergency medical condition exists;

continue receiving services from a Provider who has been terminated from the AmeriHealth network (without cause) in the time frames as defined by applicable State requirements. This continuation of care does not apply if the Provider is terminated for reasons that would endanger the Member, public health or safety, breach of contract, or fraud.

have the rights afforded to Members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Member understands;

be free from balance billing by Participating Providers for Medically Necessary services that were authorized or covered except as permitted for copayments, coinsurance, and deductibles by contract;

be free from lifetime or yearly dollar limits on coverage of essential health benefits;

be free from unreasonable rate increases and to receive an explanation of rate increases of 15% or more before the Member’s premium is raised;

receive prompt notification of terminations or changes in benefits, services, or Provider network;

have a choice of specialists among Participating Providers following an authorized Referral, as applicable, subject to their availability to accept new patients;

choose an individual On-Exchange health plan rather than the one the Member’s employer offers and to be protected from employer retaliation.

Member responsibilities
A Member has the responsibility to:

communicate, to the extent possible, information that AmeriHealth and Participating Providers need in order to provide care;

follow the plans and instructions for care that he or she has agreed on with his or her practitioners. This includes consideration of the possible consequences of failure to comply with recommended treatment.

understand his or her health problems and participate in developing mutually agreed upon treatment goals to the degree possible;

review all benefits and Membership materials carefully and to follow the rules pertaining to the health plan;

ask questions to assure understanding of the explanations and instructions given;

treat others with the same respect and courtesy expected for him or herself;

keep scheduled appointments or give adequate notice of delay or cancellation;

pay deductibles, coinsurance, or copayments, as appropriate, according to the Member’s contract;

pay for charges incurred that are not covered under, or authorized under, the Member’s benefit policy or contract;
• pay for charges that exceed what AmeriHealth determines as customary and reasonable (usual and customary, or usual, customary and reasonable, as appropriate) for services that are covered under the out-of-network component of the Member’s benefit contract with respect to point of service contracts.

Hospital responsibilities
Hospitals contracted with AmeriHealth are required to comply with the AmeriHealth QM Program and quality improvement activities, including allowing the Plan to use their performance data. Hospitals have the responsibility to:

• ensure that all necessary authorizations are obtained prior to rendering services;
• be available and accessible 24 hours per day, 7 days per week;
• notify the Primary Care Physician (PCP)/family practitioner of follow-up care for services performed in the Emergency department;
• notify the PCP/family practitioner of follow-up care for services performed after a hospital stay;
• maintain Member confidentiality and comply with HIPAA† regulations;
• respect Member rights and responsibilities;
• comply with QM Program initiatives and any related policies and procedures;
• comply with QM requirements, including, but not limited to:
  – cooperate with the onsite medical review process and provide medical records when requested for clinical and/or service outcome measures;
  – respond to investigations of Member complaints regarding quality of care and services;
  – cooperate with the development of corrective action plans when measurements identify opportunities for improvement or as a result of a quality of care inquiry.

†HIPAA, the Health Insurance Portability and Accountability Act, was enacted by the U.S. Congress in 1996, and became effective July 1, 1997. This act is a grouping of regulations that work to combat waste, fraud, and abuse in health care delivery and health insurance. The intention of HIPAA is also to improve the effectiveness and efficiency of the health care system; portability and continuity of health insurance coverage in the group and individual markets; and the ability to provide consequences to those that do not apply with the regulations explicitly stated within the Act.

Medical record keeping standards
A medical record documents a Member’s medical treatment, past and current health status, and treatment plans for future health care and is an integral component in the delivery of quality health care. As such, we established medical records standards in 1996 and routinely distribute these standards to PCPs and specialists.

We regularly assess compliance with these standards and monitor the processes and procedures that Physician offices use to facilitate the delivery of continuous and coordinated medical care. We have established a performance goal of 90 percent compliance with our medical record standards.

The standards are as follows:
Medical record content
Medical records should include the following content:

- medical history and physicals;
- significant illnesses and medical conditions indicated on the problem list;
- documentation of medications – current and updated;
- prominent documentation of medication allergies and adverse reactions. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- food and other allergies, such as shellfish or latex, which may affect medical management;
- past medical and surgical histories (for patients seen three or more times) easily identified, including serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- for patients 12 years and older, appropriate notations concerning use of cigarettes, alcohol, and substance abuse (for patients seen three or more times);
- the history and physical documents appropriate subjective and objective information for presenting complaints;
- working diagnoses consistent with findings;
- treatment or action plans consistent with diagnoses;
- unresolved problems from previous office visits addressed in subsequent visits;
- documentation of clinical evaluation and findings for each visit;
- appropriate notations regarding the use of consultants;
- no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure;
- an immunization record for children that is up to date or an appropriate history in the medical record for adults;
- evidence that preventive screening and services are offered.

Medical record organization
Medical records should be organized as follows:

- Each page in the record contains the patient's name or ID number.
- The record containing the patients personal/biographical data, including his or her address, employer, home and work telephone numbers, and marital status.
- All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, a unique electronic identifier, or initials.
- All entries are dated.
- The record is legible to someone other than the author.
Information filed in medical records

Ensure that the following information is filed in medical records:

- all services provided directly by a practitioner who provides primary care services;
- all ancillary services and diagnostic tests ordered by a practitioner;
- all diagnostic and therapeutic services for which a member was referred by a practitioner, such as:
  - home health nursing reports
  - specialty physician reports
  - hospital discharge reports
  - physical therapy reports;
- laboratory and other studies ordered, as appropriate;
- encounter forms or notes that have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or on a schedule deemed necessary.
- if a consultation is requested, a note from the consultant is in the record;
- specialty Physician, other consultation, laboratory, and imaging reports filed in the chart and initialed by the practitioner who ordered them to signify review. Review and signature by professionals other than the ordering practitioner do not meet this requirement.
- if the reports are presented electronically, or by some other method, there is also representation of review by the ordering practitioner;
- consultation and abnormal laboratory and imaging study results include an explicit notation in the record of follow-up plans;
- the existence of an advance directive is prominently documented in each adult (18 and older) Member’s medical record. Information as to whether the advance directive has been executed is also noted.
- records of hospital discharge summaries and emergency department visits maintained in the Member’s record.

Ease of retrieving medical records

- Medical records are to be made available to AmeriHealth in accordance with the terms of the Hospital, Ancillary Facility, or Ancillary Provider Agreement (Agreement).
- Medical records are to be organized and stored in a manner that allows easy retrieval.

Confidentiality of information

Hospitals contracted with AmeriHealth are required to ensure that:

- Protected Health Information (PHI) is protected against unauthorized or inadvertent disclosure.
- Medical records are safeguarded against loss or destruction and are maintained according to State requirements. At a minimum, medical records must be maintained for at least 10 years or until the Member reaches age 23 years, whichever is longer.
• Medical records are stored in a secure manner that allows access by authorized personnel only.

• Staff receives periodic training in Member information confidentiality.

For complete information on AmeriHealth standards for Providers, including privacy, records standards, and Member rights, please visit [www.amerihealth.com](http://www.amerihealth.com).

### Maintenance of records and audits

#### Medical and other records

Providers must maintain all medical and other records in accordance with the terms of their Agreement with AmeriHealth HMO, Inc. and its Affiliates (collectively, “AmeriHealth”) and this Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers. Subject to applicable State or federal confidentiality or privacy laws, AmeriHealth or its designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over AmeriHealth, shall have access to Provider records, on request, at Provider’s place of business during normal business hours, to inspect, review, and make copies of such records.

When requested by AmeriHealth or its designated representatives, or designated representatives of local, State, or federal regulatory agencies, the Provider shall produce copies of any such records and will permit access to the original medical records for comparison purposes within the requested timeframes and, if requested, shall submit to examination under oath regarding the same.

If a Provider fails or refuses to produce copies and/or permit access to the original medical records within 30 days as requested, AmeriHealth reserves the right to require Selective Medical Review before claims are processed for payment to verify that claims submissions are eligible for coverage under the benefits plan.