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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 care) for our Members informs all QM activities.

The goals of the QM Program include:

- Assess and improve the **safety** of medical and behavioral health care and services our Members receive.
- Evaluate the sufficiency of the plan networks for Members to be able to access qualified Providers for **timely** and appropriate care.
- Ensure evidence-based, **effective** care and services are 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, and supporting Plan staff cultural humility and awareness of disparities.
- 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 needed 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.

For more information about our QM Program, including our goals and activities, please visit *www.amerihealth.com* or call Customer Service at 1-888-YOUR-AH1. Members should call the Customer Service telephone number listed on their ID card if they have a concern or complaint about the quality of care or service that they have received.

Provider obligation to cooperate with the QM program

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 well-being of our Members. AmeriHealth requires access to Member medical records at times for a variety of purposes. Providers are responsible for providing Member medical records for any Member they treat, upon request, and coordinating with any file management vendors. In general, medical records must be provided at no charge to AmeriHealth. Please refer to your Provider agreement for specific terms and exceptions.

Quality Management activities

The QM Program is an ongoing, comprehensive program that supports 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 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 complaints and occurrences for quality issues. There are a variety of ways the QM program is alerted to potentially suboptimal care or medical errors that could impact safety for 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. Through ongoing education and sharing of effective safety practices, close monitoring of quality data, and collaboration among health care Providers, hospitals, consumers, purchasers, and other stakeholders the QM Program is able to enhance and promote safety for our Members. Our Member safety activities include:

- 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.

Safety occurrence investigations

The QM department investigates all safety occurrences, ensuring appropriate clinical review and follow-up, as well as forwarding documentation of any quality related actions to the Credentialing team for inclusion in the Provider's Plan record. Member safety occurrences are defined as clinical quality or adverse events that occur during inpatient or outpatient treatment that may present a Member safety concern. Occurrences may be related to falls, injuries, hospital readmissions, adverse outcomes related to procedures, inappropriate treatment, etc. Occurrences may be identified by Plan staff, "never event" claims codes, Members, physicians, or Providers.

On receipt of an occurrence, Clinical QM Specialists assess and document the nature of the occurrence, categorize it, and initiate an investigation involving review by a Medical Director. Occurrence investigations include correspondence with the Provider and/or facility involved and may include requests for medical records. Requested records must be provided within 30 days. ***Failure to respond to inquiries regarding occurrences will result in an escalation of the assigned severity of the occurrence.*** Providers with occurrences assigned escalated severity levels may be subject to further peer review and corrective action, as appropriate. 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.

Occurrences are monitored, trended, and analyzed to facilitate the identification of individual outliers and plan-wide trends throughout the year. Outliers with multiple occurrences may be subject to further peer review and corrective action, as appropriate. Plan-wide improvement initiatives may also be implemented in response to identified adverse plan-wide trends, as necessary.

Member complaint process

The QM department investigates all quality of care and service concerns/complaints, ensuring appropriate review and follow-up, as well as forwarding documentation of any quality related actions to the Credentialing team for inclusion in the Provider's Plan record. This information may also be taken into consideration as part of a facility's organizational assessment. Members, or their representatives with the Member's consent, 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.

If an AmeriHealth Member or the Member's designee is dissatisfied with the 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:

Consumer Protection Services
Department of Banking and Insurance
20 West State St., 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
Attn: Sylvia Allen-Ware

Main phone: 609-292-7272
Fax: 609-633-0808

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

On receipt of a quality of care or service complaint, QM Complaint Coordinators and/or Clinical QM Specialists assess and document the nature of the complaint, categorize it, and initiate an investigation involving review by a Medical Director.

Complaint investigations include correspondence with the Provider and/or facility involved and may include requests for records. Requested records must be provided within 5 days. ***Failure to respond to inquiries regarding complaints will result in an escalation of the assigned severity of the complaint***. Providers with complaints assigned escalated severity levels may be subject to further peer review and corrective action, as appropriate. Providers are notified of any review of potential quality or service 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 or service issue identified will be requested.

Complaints are monitored, trended, and analyzed to facilitate the identification of individual outliers and plan-wide trends throughout the year. Outliers with multiple complaints may be 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.

A Medicare Advantage grievance is any complaint or dispute raised by a Medicare Advantage Member or the Member's representative, other than a dispute involving an organizational determination. Medicare Advantage grievances may include disputes regarding such issues as office waiting times, practitioner behavior, adequacy of facilities, involuntary disenrollment situations, or coverage decisions by AmeriHealth to process a Medicare appeal request under the standard 30-day time frame rather than as an expedited appeal. A resolution will be issued no later than 30 days after the grievance is received.

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.

The QM Program conducts an annual assessment of care continuity and coordination across the network to identify opportunities to better support care coordination and continuity between Providers and across settings. Selected HEDIS measures and internal data based on claims inform the assessment of efficiency of care transitions between practitioners or health care settings. Data is compiled on documentation of communication between PCPs and specialists, including behavioral health specialists via sample medical chart reviews. Analysis of quality complaints, occurrences, and Member feedback data also helps to identify opportunities to address care continuity. This assessment helps the Plan to set goals for improving care, on which the QM Program evaluates progress annually.

On an annual basis, we collect and analyze data about opportunities for collaboration between medical care and behavioral health care practitioners, in the following areas:

- exchange of information;
- appropriate diagnosis, treatment, and Referral of behavioral disorders commonly seen in primary care;
- appropriate use of psychotropic medications;

- primary or secondary preventive behavioral health care program implementation;
- management of treatment access and follow-up for Members with co-existing medical and behavioral disorders,
- special needs of Members with severe and persistent mental illness.

QM also works with the Case Management 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.

Health equity

AmeriHealth is committed to providing access to culturally and linguistically appropriate (CLAS) health care services in a competent manner. This means all reasonable accommodations are provided to ensure equal access to communication resources for our Members.

Providers are subject to a variety of federal and state laws and regulations regarding the provision of culturally competent and non-discriminatory health care services, including but not limited to Title VI of the Civil Rights Act of 1964, Title III of the Americans with Disabilities Act, and Executive Order 13166 (regarding access to services for persons with limited English proficiency).

Providers are prohibited from discriminating against AmeriHealth Members. Discriminatory action, including violation of the aforementioned regulations or identification of discrimination through quality investigations, may subject a Provider to corrective action and possible termination from the network.

Language assistance services

AmeriHealth makes interpretation services available to practitioners. Your AmeriHealth patients can call the Customer Service number on the back of their Member ID card to request telephone interpretation for a preferred spoken language or video interpretation for sign language. Free telephone relay services are also available at TTY/TDD: 711.

Your AmeriHealth patients can also call the Customer Service number on the back of their Member ID card to request additional language assistance services. Members may request that information about their plan be shared via audio recordings or via printed documents in other languages, large print, or Braille.

Note: According to the U.S. Department of Health and Human Services (HHS) the assistance of friends or family is not considered competent, quality interpretation. These persons should not be used for interpretation services except where a Member has been made aware of their right to receive free interpretation and continues to insist on using a friend or family member for assistance in their preferred language.

Cultural Competence

The National Standards for CLAS in Health and Health Care were developed by HHS. They are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for providing effective, equitable, understandable, respectful, and quality health care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Below are several of the CLAS standards which AmeriHealth encourages all Providers in our network to adopt in furtherance of providing culturally competent care:

- Provide effective, understandable, and respectful care to all patients in a manner compatible with the patient's cultural health beliefs and practices of preferred language/format.
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area.
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services.
- Establish written policies to provide translation and interpretive services for patients upon request.
- Routinely document patient preferred language or format, such as Braille, audio, or large type, in all medical records.

Rights and responsibilities

Member rights

A Member has the *right* to:

- receive information about AmeriHealth, its benefits, services included or excluded from coverage, policies and procedures, Participating Practitioners/Providers, and Members' rights and responsibilities. Information provided will be in a manner and format that is easily understood and readily accessible.
- obtain a current directory of Participating Providers in the plan's network, upon request. The directory includes addresses, telephone numbers, and a listing of Providers who speak languages other than English.
- prompt notification of terminations or changes in benefits, services, or Provider network;
- be treated with courtesy, consideration, respect, and recognition of their dignity and right to privacy;
- confidential treatment of personally identifiable health/medical information. Members also have the right to access their medical record and ask that it be amended or corrected, in accordance with applicable federal and State laws.
- 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 the filing by such Member of any complaint, grievance, appeal or legal action against Professional Provider, a Group Practice Provider (if applicable) or AmeriHealth;
- participate with practitioners in making decisions about their health care,
- formulate and have advance directives implemented.
- candid discussions of appropriate or Medically Necessary treatment options and alternatives for their conditions, regardless of cost or benefit coverage, in terms that the Member understands, including an explanation of their complete medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the

Member is not capable of understanding this information, an explanation shall be provided to his or her next of kin or guardian and documented in the Member's medical record.

- 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;
- voice and file complaints (sometimes called grievances) or appeals about AmeriHealth or the care it provides and receive a timely response about the disposition of the appeal/complaint and the right to further appeal through an independent organization for a filing fee or the applicable regulatory agency, as appropriate. A doctor cannot be penalized for filing a complaint or appeal on a Member's behalf.
- make recommendations regarding our Member rights and responsibilities policy by contacting Customer Service;
- choose practitioners/Providers within the limits of covered benefits, availability, and participation within the AmeriHealth network;
- a choice of specialists among Participating Providers following an authorized Referral, as applicable, subject to their availability to accept new patients;
- for Members with chronic disabilities, the right to obtain assistance and referrals to Providers with experience in treatment of their disabilities.
- continue receiving services from a Provider who has been terminated from the AmeriHealth network (without cause) in the timeframes defined by the applicable State requirements of the Member's benefit plan. This does not apply if the Provider is terminated for reasons which would endanger the Member, public health or safety, breach of contract, or fraud.
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation by contracted Providers of AmeriHealth.
- available and accessible services when Medically Necessary, including availability of care 24 hours a day, 7 days a week, for urgent and emergent conditions;
- call 911 in a potentially life-threatening situation without prior approval and have AmeriHealth pay per contract for a medical screening evaluation in the emergency room to determine whether an Emergency medical condition exists;
- be free from balance billing by 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;
- choose an individual On-Exchange health plan rather than the one offered by an employer and to be protected from employer retaliation

Member responsibilities

A Member has the *responsibility* to:

- communicate, to the extent possible, information AmeriHealth and Participating Providers need in order to provide care;
- follow plans and instructions for care agreed to with their practitioners. This includes consideration of the possible consequences of failure to comply with recommended treatment.
- understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible;
- review benefits and Member materials carefully, follow the policies and procedures of the health plan, and advise AmeriHealth of any questions or concerns;

- be considerate and act in a way that helps the smooth running of Providers' offices and facilities;
- pay premiums and any cost-sharing owed (deductibles, coinsurance, or copayments, as appropriate) and meet other financial responsibilities described in the Member's contract/Evidence of Coverage;
- pay for charges incurred that are not covered under, or authorized under, the Member's benefit policy or contract;
- for point of service contracts, to 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.

Additional Medicare Advantage Member rights

A Medicare Advantage Member has additional rights, including the *right* to:

- get information in a way the Member understands from Medicare, health care Providers, and, under certain circumstances, contractors;
- get information in a way the Member understands about Medicare and get answers to questions to help him or her make health care decisions, including what is covered, how doctors are paid, what Medicare pays, and how much they have to pay;
- see AmeriHealth Providers and get covered health services and drugs within a reasonable period of time, in a language the Member can understand and in a culturally sensitive way;
- get a decision about health care payment, coverage of items or services, or prescription drug coverage before getting services. If you disagree with the decision of your claim, you have the right to file an appeal.

Additional Medicare Advantage Member responsibilities

A Medicare Advantage Member has additional responsibilities, including the *responsibility* to:

- notify Providers that they are enrolled in our health plan when seeking care (unless it is an Emergency);
- notify the health plan if they have additional health insurance or prescription drug coverage;
- notify the health plan if they move.

Hospital responsibilities (including Psychiatric Hospitals and Behavioral Health Facilities)

Hospitals contracted with AmeriHealth are required to comply with the 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;
- notify the PCP/family practitioner of an inpatient admission to a psychiatric facility, including crisis facilities and the psychiatric departments of acute care hospitals, for the purpose of evaluation or treatment, or both, whether voluntary or involuntary;
- 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, privacy and security of protected health information; 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 routinely distribute our established medical records standards.

Medical record content and documentation standards

History and physical – The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.

The history and physical should contain:

1. History of present illness.
2. Past medical history
   - A Past medical history (for patients seen three or more times) that is easily identified and includes 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.
3. Medications and allergies
   - Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
   - Documentation of medications that are current and updated.
   - Documentation of food and other allergies, such as shellfish or latex, that may affect medical management.
4. Family or social history
   - For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history).
5. Prevention screening
   - An immunization record (for children) that is up to date or a suitable history has been made in the medical record (for adults).
   - Preventative, and risk screening.
   - Evidence that preventive screening and these services are offered in accordance with the organization's practice guidelines.

6. Review of systems - physical exam
7. Data collection - tests
8. A problem list
   - Significant illnesses and medical conditions are indicated on the problem list.
   - Unresolved problems from previous office visits are addressed in subsequent visits.
9. Diagnoses
   - The documentation of clinical findings and evaluation for each visit is included.
10. Treatment plan
    - Working diagnoses are consistent with findings.
    - Treatment plans are consistent with diagnoses.
    - There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
    - Laboratory and other studies are ordered, as appropriate.

Medical record keeping system

Information filed:

1. All services provided directly by a practitioner who provides primary care services.
2. All ancillary services and diagnostic tests ordered by a practitioner.
3. 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
4. An advance directive that is prominently documented in each adult (18 and older) Member's medical record. Information as to whether the advance directive has been executed also noted.
5. Records of hospital discharge summaries and emergency room/department visits.
6. If a consultation is requested, there is a note from the consultant in the record.
7. Laboratory and other studies ordered.

Standards for availability and retrieval:

1. Medical records must be made available to the Plan as defined in the Professional Provider Agreement.
2. Medical records must be organized and stored in a manner which allows easy retrieval.

Organization:

1. Each page in the record contains the patient's name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status. Consider including race, ethnicity, primary language, sexual orientation, and gender identity.
3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier, or initials.
4. All entries are dated.
5. There is review for under- or over-utilization of consultants.

6. The record is legible to someone other than the writer.
7. 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.
8. Specialty physician, other consultation, laboratory, and imaging reports filed in the chart are 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 have an explicit notation in the record of follow-up plans.

Confidentiality

1. Protected Health Information (PHI) must be protected against unauthorized or inadvertent disclosure.
2. Medical records must be safeguarded against loss or destruction and maintained according to state requirements. At a minimum, medical records must be maintained, beginning on the date of the last medical service, for at least 11 years, or age of majority plus six years, whichever is longer.
3. Medical Records must be stored securely in a way that allows access by authorized personnel only.
4. Staff must receive periodic training on health information confidentiality.

Monitoring and performance goals

The Plan regularly assesses the quality of medical record keeping and compliance with these standards through medical record review; and monitors the processes and procedures used by physician offices to facilitate the delivery of continuous and coordinated medical care. Performance goals have been established to assess the quality of medical record keeping.

The Plan monitors compliance with the medical record standards outlined in this policy through mechanisms that include:

- Assessments completed for improvement of the medical record keeping practices of practitioners who provide care such as: PCPs, OB-GYNs, and high-volume behavioral health specialists.
- Assessments performed as part of the Plan's performance monitoring and improvement activities.

The Plan has established a minimum acceptable overall score of 90% for compliance with standards for medical records and plan-wide compliance rates in studies that assess performance across the practitioner network. Where actual performance falls below established goals, practice-specific or plan-wide improvement activities are initiated as appropriate.

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.