	JOHNS HOPKINS HEALTH PLANS	**Policy Number: PNM.014** Effective Date: 12/1/2010 Review Date : 12/10/15 Revision Date: 12/22/16
	Subject: Primary Care Quality & Efficiency Standards for HealthCare Quality Improvement **Department: Provider Relations** **Lines-of-Business: Priority Partners**	**Page 1 of 7**

ACTION

☐ New Policy

☐ Repealed Policy Date: ____________________

☐ Superseded Policy Number: ____________________

POLICY:

It is the policy of Johns Hopkins Health Plans to promote quality, cost-effective healthcare for its Priority Partners members within the primary care setting.

SCOPE:

This policy applies to promoting quality of care and service efficiency among Priority Partners' primary care providers and their patient panels.

DEFINITIONS (if applicable or reference departmental glossary if one is available):

Provider: A Provider is defined, for the purposes of this policy, as a primary care physician (PCP), or any type of primary care provider, including but not limited to FQHC's, Nurse Practitioners (NP), and any practitioner, practice group, or practice site that is contracted with PPMCO to provide primary care services to Priority Partners members.

Somatic Care: defined as the medical care that addresses an individual's physical health care needs, including substance abuse treatment.

RESPONSIBILITIES:

PURPOSE:

Priority Partners is committed to promoting quality, cost-effective health care for its members. With these goals in mind, Priority Partners has developed a Quality Improvement Program, as outlined within the HealthChoice Provider Manual. Part of the mission of that Program is to evaluate services and care delivery with respect to outcomes (e.g. member satisfaction); analyze outcomes as compared to national industry benchmarks; and evaluate the overall effectiveness of the program. The ultimate goal of establishing these Provider Quality and Efficiency Standards is to assist Providers with aligning their practices with Quality Improvement Program Initiatives that enable them to deliver high quality cost-effective evidence-based care to Priority Partners' members.

QUALITY AND EFFICIENCY STANDARDS:

Priority Partners will employ the following performance measures to evaluate and compare the quality and efficiency of Providers. Depending on the size of the Provider panel, Priority Partners will work with individual providers or through the organization's designated leadership to conduct such evaluation. Understanding that the development and application of performance measures are intended for continuous improvement, Priority Partners can revise the measures and establish specific metrics as needed.

Clinical Quality Metrics: Providers are expected to comply with the following clinical quality metrics (See Appendix A for Provider Accountability and Access Metrics):

- All HEDIS and/or Value Based Purchasing (VBP) measures applicable to physician practices.
- Medically necessary Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to enrollees younger than 21 years old in accordance with COMAR 10.09.67.20 and accessible online.
- Clinical Practice Guidelines and Preventive Health Guidelines as outlined in the Preventive Health Guidelines Policy (CMS11.02) and the Clinical Practice Guideline Policy (CMS11.01) and accessible online.
- Priority Partners' Medical Policies supplied by Priority Partners and accessible on-line.
- All mandated federal or state legislation or regulations that establish provider quality standards per COMAR 10.09.66.07

Cost Effectiveness: As a Maryland MCO, Priority Partners is specifically tasked with the promotion of cost effectiveness for the Maryland health care system. Maryland law requires that "the Maryland Medical Assistance Program use its leverage as a high volume purchaser to promote the cost effectiveness of Maryland's health care system." Md. Code Ann. §15-103.1. In furtherance of this statutory requirement, "MCOs [may] establish measures that are designed to maintain quality of services and control costs, consistent with its responsibilities to enrollees." See COMAR §10.09.65.02(O).
In keeping with this responsibility, Priority Partners includes cost effectiveness, as a performance measure, to ensure each Provider's alignment with their expected cost associated to the morbidity ratio of their patient population. Individual and categories of providers will be benchmarked against their peers and the rest of the Priority Partners network of providers along the following performance measures.

- Provider Profiling Reports generated by the Priority Partners' Profiling Tool.
- Provider financial efficiency information will be benchmarked against the Priority Partner's network.

Providers are expected to work with Priority Partners to: 1) stay within network parameters and targets of the Profiling Reports, including such metrics as the resource use ratios and efficiency ratios; and 2) work on key opportunities identified within the Provider's annual provider profile report.

Appropriateness of Referrals: A key objective of the Quality Improvement Program is to improve the quality of care consistent with the Comprehensive Quality Management Program through the Johns Hopkins Health Plans Quality of Care Referral and review process. In order to accomplish this objective, Providers will comply with the following:

- The Referral/Authorization Process Requirements set forth within the HealthChoice Provider Manual;
- The Referral Procedures set forth within the HealthChoice Provider Manual;
- The Pre-Authorization Process set forth within the HealthChoice Provider Manual;
- Outpatient Referral and Pre-Authorization Guidelines;
- Referrals must be made to in-network physicians, based on DHMH standards and individual patient need and approval from Care Management.
- As information becomes available Provider and PPMCO will collaborate to ensure referrals are consistently made to providers within the most cost-efficient setting;

Provider Compliance with Policies:

- Providers will comply with all Access Standards, set forth within PNM.002 Monitoring Network Access Policy and the HealthChoice Provider Manual.
- Providers will meet all Medical Record Standards, set forth within the HealthChoice Provider Manual, and within the Medical Record Standards Guidelines.

DATA COLLECTION AND ANALYSIS:

Priority Partners utilizes profiling reports and quality data to give Providers time sensitive, meaningful and useful information for comparing the efficiency of Providers' utilization, taking into account the health status of their patients. Priority Partners recognizes that to be successful, performance profiling must address important differences in case-mix and thus Priority Partners' process identifies practices that have healthier versus sicker patient population using the Johns Hopkins ACG (Adjusted Clinical Groups) methodology. The ACG methodology also allows Priority Partners to describe the morbidity burden of a Provider's population, describe the healthcare use of a population and predict future healthcare utilization. It is the goal of Priority Partners to utilize risk adjustment methodology in provider profiling applications as it improves the credibility of results by minimizing bias associated with patient mix. Additional information on the ACG methodology can be accessed at http://acg.jhsph.org/

Data will be collected from multiple sources. These sources may include, but are not limited to the following: electronic medical records (EMR), medical record review, administrative claims data; pharmacy claims data, financial efficiency information, member and provider surveys, customer service reports, complaints and grievance data, and clinical data as submitted by Care Coordinators. The security, integrity, and confidentiality of all patient information will be maintained according to Johns Hopkins Health Plans' policies and procedures as well as state and federal regulations.

Priority Partners will ensure a high level of data integrity, and may use an independent vendor to conduct surveys or to conduct compliance audits, as it deems necessary. This will provide performance data suitable for comparison on national, regional and local levels.

REMEDIATION:

Priority Partners will collaborate with the Provider towards achieving the applicable standard and if Provider should fail to demonstrate collaborative engagement, Priority Partners, upon its discretion, may elect to employ any of the following strategies to remedy the non-compliance, commensurate with the severity of the performance deficiency with thirty (30) days prior written notice.

Increased Review: Provider may be required to report additional information about their practice or submit reports more frequently. Priority Partners may conduct on-site inspections. Priority Partners may also engage Provider in processes to improve metrics.

Suspension of Automatic Enrollment: New members will no longer be automatically assigned to the Provider’s panel.

Temporarily Close Panel to New Members: Provider’s panel will be closed to new members and members requesting a change of primary care provider (PCP), until such time the Provider demonstrates achieving the standards identified herein.

Close Panel: Provider’s panel will be closed to new members or members requesting a change of PCP.

Reassignment of Members: Provider’s panel may be closed indefinitely or reprioritized, to acceptance of new members via auto assignment and members requesting a change of PCP. Priority Partners may also reassign any existing panel members to another PCP in the network upon their discretion. Once a Provider’s panel is closed or reprioritized, members can no longer be assigned to that Provider’s panel, until such time the Provider demonstrates achieving the standards identified herein.

Termination: Provider’s contract may be terminated in accordance to the Provider Agreement, subject to Provider’s continuation of care requirements. Members of the terminated Provider shall receive notice of the termination as applicable.

CROSS REFERENCE (with other relevant policies, procedures, and/or workflows):

COMAR §10.09.65.02(O).
COMAR 10.09.67.20.
Md. Code Ann. §15-103.1
PNM.011 Practitioner Termination
PNM.018 Provider Initiated Member Reassignment
CMS11.01 Clinical Practice Guidelines
CMS11.01 Preventive Health Guidelines

Approvals:

________________________________ __________________________
Dina Goldberg, Sr. Director, Provider Relations Date

________________________________ __________________________
N. Flaherty, Director, Quality Improvement Date

________________________________ __________________________
Tina Magrowsky, Director, Enrollment Date

Quality Committee:

________________________________ __________________________
Process Management Team Chair Date

________________________________ __________________________
Priority Partners Network Development Committee Chair Date

Review/Revision Dates: 11/9/11, 12/11/12, 12/24/12, 5/16/13, 7/18/14, 12/10/15, 12/22/16

Appendix A

PROVIDER ACCOUNTABILITY & ACCESS METRICS

- Work with Priority Partners on improving upon those HEDIS/VBP measure opportunities presented to Providers. Providers need to achieve the neutral zone for eighty-percent (80%) of the measures identified on their practice specific Progress Reports by the end of the calendar year.

- PCP groups with an MLR in excess of 85%, adjusted for outliers, should work collaboratively with PPMCO in order to achieve the targeted MLR.

- Work collaboratively with Priority Partners to ensure newly assigned plan members are seen within ninety (90) days of assignment to the practice, per COMAR.

ACCESS & AVAILABILITY STANDARDS

- **Initial Appointment:** Members must be scheduled for an initial health appointment within 90 days of enrollment, unless one of the exceptions set forth in the HealthChoice Provider Manual applies.

- **Appointment Scheduling:** Priority Partners requires its Providers to meet or exceed the Appointment Wait Time Access Standards listed within the chart below in order to meet its responsibilities under the Code of Maryland Regulations.

Service	Appointment Wait Time (not more than):
Initial prenatal appointments	Ten (10) days from request, or from the date the MCO receives a Health Risk Assessment (HRA) for the new enrollee (unless enrollee continues care with established provider and established provider concludes that no initial appointment is necessary).
Family Planning appointments	Ten (10) days from the date enrollee requests appointment
High Risk enrollee appointments	Fifteen (15) days from request
Urgent Care appointments	Forty-eight (48) hours from the request
Routine, Preventative Care, or Specialty Care appointments	Thirty (30) days from initial request or, where applicable, from authorization from PCP.
Initial newborn visits	Fourteen (14) days from discharge from hospital
Initial newborn visits if a home visit has been provided	Within thirty (30) days from date of discharge from hospital

Regular optometry, lab, or x-ray appointments	Thirty (30) days from date of request
Urgent lab or x-ray appointments	Forty-eight (48) hours from date of request
Wait for enrollee inquiries on whether or not to use an emergency facility	Thirty (30) minutes

- **Office Wait Times**:
  - Office waiting times should not exceed one hour, unless the PCP is unavailable due to an emergency. Member should be given the choice of waiting or rescheduling the appointment.
  - Members should be seen at the rate of six (6) or less per hour.
  - A PCP office may not leave an enrollee call on hold for more than ten (10) minutes.

- **Hours of Operation & Availability**:
  - PCP will maintain reasonable hours of operation including 24 hours weekly per solo practice and 32 hours weekly per group practice.
  - PCP will provide direct access to enrollees through an answering service/paging mechanism or an answering machine with specific instructions on how the member can reach the practitioner directly and how to access emergency services for coverage twenty-four hours a day, seven days a week (24/7). Automatic referral to the hospital emergency department does not qualify.
  - PCP will inform enrollees that in the event of a non-emergency illness or condition, their first point of contact should be the PCP.

For individual primary care practices without on-call coverage, the Provider Relations Department must be notified of all planned and unplanned absences greater than four days from the practice.