Part Three: Monitoring Services

Section 17: Quality Improvement

The Alliance has a quality improvement program in order to evaluate and improve services for members. All providers are expected to participate in this program. This section will help providers understand and meet the Alliance’s quality improvement goals.

Quality Improvement Program Overview

It has been said “You cannot manage what you do not measure.” The Alliance Quality Improvement Program enables us to measure, assess and improve important aspects of health care delivery and the health care outcomes of our members.

GOALS OF THE QUALITY IMPROVEMENT PROGRAM

The Alliance Quality Improvement Program adheres to the principles of the National Committee on Quality Assurance. The goals of the Alliance Quality Improvement Program are to:

- Implement an integrated performance measurement and assessment system to provide information of value to the health care plan, purchasers, providers, and consumers of health care services
- Develop a system for performance measurement that the Alliance, the State, and other purchasers of health care services can effectively utilize in promoting better understanding of health care services purchased and in improving those health care services provided
- Define and collect performance measures in a manner consistent with state and national parameters to allow comparison of information between health care plans and to define benchmarks for improvement purposes
- Consider existing information in order to contain costs and avoid duplication of effort
- Continue to evolve with the incorporation of new performance measures and the revision or elimination of old performance measures as new information is developed and defined
- Respect patient confidentiality with all data and information provided and used in the performance measurement and assessment system

PROVIDER INVOLVEMENT

The Quality Improvement Program will only realize its potential with provider involvement. All providers are encouraged to:

- Participate as a Health Care Quality Committee (HCQC) or other Alliance committee member
  - Attend trainings and meetings
  - Attend the open session of monthly HCQC meetings
  - Document services in medical records and on claims/encounter forms
  - Know the contents of this manual
  - Read the Provider Manual, Provider Bulletin and Provider Manual Updates

Providers may receive, upon request, the annual Quality Improvement Plan. Additionally, providers are invited to make comments and suggestions.
**Quality Improvement Program Structure**

As a public-private partnership, the Alliance has structured its Quality Improvement Program to allow participation at multiple levels by providers and members.

**BOARD OF GOVERNORS**

The Alliance Board of Governors:

- Approves the Quality Management Plan and reviews the Annual Report of the Quality Program
- Approves Provider credentialing, recredentialing, contracts and other payment formulas
- Reviews results of Quality Improvement Studies and recommendations for improvement of outcomes forwarded from the HCQC

**HEALTH CARE QUALITY COMMITTEE (HCQC)**

The HCQC is a standing subcommittee of the Board of Governors, that:

- Recommends annual goals for the Quality Improvement Program
- Reviews quality study results and makes recommendations for corrective action or improvement
- Ensures implementation of corrective action plans
- Reviews appealed grievances and credentialing decisions
- Oversees the Plan’s Utilization Management (UM) Program
- Approves Medical Necessity Criteria and Clinical Practice Guidelines and review compliance monitoring

**PEER REVIEW AND CREDENTIALING COMMITTEE (PRCC)**

The PRCC is a peer committee that:

- Reviews and makes recommendations on provider credentialing and recredentialing
- Reviews patient safety events, peer review issues and provider-related grievances and complaints

**PHARMACY & THERAPEUTICS (P&T) COMMITTEE**

The P&T Committee is another peer subcommittee. This subcommittee:

- Monitors the use of drugs
- Maintains the Alliance’s formulary
- Develops education programs for providers on appropriate use of drugs

**QUALITY MANAGEMENT STAFF**

The role of the Quality Management staff is to:

- Develop reports, analyses, summaries and graphical presentations of plan performance measures and provider profiles
- Design studies and develop methods of data collection
- Provide administrative support for HCQC and Peer Review Committees
- Serve as internal consultants/trainers on concept and methodology of Continuous Quality Improvement
- Ensure compliance of the Quality Improvement Program with regulatory requirements
OTHER DEPARTMENTS
Every department in the Alliance participates in quality improvement by formal self-evaluation, such as comparing their key processes to standards and by resolving problems for members and providers.

Alliance Measures of Provider Performance
Giving providers feedback about their performance in relationship to their peers has proven to be a powerful tool to move behavior toward the best practice.

Alliance providers allow the plan to use provider performance data in quality improvement activities and to conduct the Alliance Quality Improvement Program. The Alliance Quality Improvement Program includes systems to recognize providers on the basis of:
- Partnership behaviors that assist the plan in measurement and management of health
- Clinical practices that are linked to improved health outcomes for members

The data collected from the claims and encounter data are used to measure a provider’s clinical practice. The diagnoses and procedure codes documented on these forms are crucial to accurate profiling. Missing, inaccurate or non-specific codes significantly impact systems such as the reporting of annual HEDIS measures.

Accurate coding of diagnoses and procedures affects the quality profile.

PROVIDER QUALITY REPORT
As part of the Quality Improvement Program, the Alliance compiles a provider quality report for each PCP undergoing recredentialing. The report summarizes a range of provider statistics and activities available from the following areas:
- Member complaints
- Quality reviews
- Utilization management
- Member satisfaction surveys
- Site review score

The Medical Director reviews the quality report and shares its results with the Peer Review and Credentialing Committee to aid in their decision whether to recredential a provider.

Measuring and Improving Plan Performance (HEDIS)
PERFORMANCE STUDIES
Health Effectiveness Data Information Set (HEDIS) measures are developed by a national group of health care experts, issued annually and used as a standard across the country. Using HEDIS measures, the Alliance can compare its performance against other managed care plans. HEDIS study methodology and results are also validated and audited by an external agency.

HEDIS studies use data submitted by providers on their claims/encounter forms, and may be supplemented with data retrieved from providers’ medical records. The Alliance makes every effort to request records or schedule HEDIS data retrieval for all studies at the same time and only once each year.
MEDI-CAL QUALITY IMPROVEMENT ACTIVITIES
In addition to HEDIS measures, the Alliance has several monitoring responsibilities for its Medi-Cal members. The Quality Improvement Program examines data from internal studies in such areas as access (e.g., waiting times for appointments, adequacy of provider network), coordination and continuity of care, utilization, and members' rights.

The results of HEDIS and internal studies for the plan’s Medi-Cal members are the basis of planned quality improvement activities. Mandated by the Federal Balanced Budget Act for Medicaid and Medicare health plans, quality improvement activities are aimed at producing statistically significant and sustained improvement in an important aspect of health care delivery or clinical outcome.

An External Quality Review Organization (EQRO) contracted with the Department of Health Care Service validates the Alliance’s quality improvement activities. This external review process may also involve requests for member medical records from providers and/or site visits.

Patient Safety
Overuse, under use, and misuse of care threaten patient safety and are monitored to identify potential systems or process issues. An adverse event is defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as “unexpected occurrences involving death or serious physical or psychological injury or risk thereof.” Examples of adverse events in a hospital setting include cases of infant abduction, an infant discharged to the wrong family, rape by another patient or staff, hemolytic transfusion reaction, or surgery on the wrong patient or body part. An example of an adverse event in an office setting would be anaphylactic reaction to a medication given by the provider.

REPORTING
Providers must report adverse events that involve Alliance members to the Provider Services department immediately after the occurrence. Alliance staff may also become aware of adverse events through a member or provider complaint, concurrent utilization review, or facility site reviews. Hospital providers must follow the requirements of JCAHO.

ACTION
The Alliance Medical Director may request an analysis of cause, an action plan, or other response from the provider. In some cases, the Medical Director may suspend the provider's contract pending review by the Peer Review and Credentialing Committee. Providers may appeal suspension decisions. Final decisions regarding provider sanctions are made by the Alliance Board of Governors.

Immediately report adverse events to Provider Services at 510-747-4510

Reporting Provider-Preventable Conditions
BACKGROUND
Beginning July 1, 2012, federal law requires that all providers report provider-preventable conditions (PPCs) that occurred during treatment of Medi-Cal patients. Providers need to report all PPCs that
are associated with claims for Medi-Cal payment or with courses of treatment given to a Medi-Cal patient for which payment would otherwise be available. Providers do not need to report PPCs that existed prior to the provider initiating treatment for the beneficiary.

The federal Affordable Care Act section 2702 and Title 42 of the Code of Federal Regulations, sections 447, 434 and 438 also require that Medi-Cal and Medi-Cal Managed Care plans no longer reimburse providers for PPC’s that occur during treatment of Medi-Cal patients. The Alliance will investigate all reports of PPCs, including those it discovers through any means, to determine if payment adjustment is necessary.

Interested providers may read the State Plan Amendment for PPCs, which took effect July 1, 2012.

REPORTING REQUIREMENTS

For Alameda Alliance for Health Medi-Cal members, providers must report directly to the Alliance using the PPC reporting form within five (5) working days of discovery of the PPC and confirmation that the patient is a Medi-Cal beneficiary. The PPC reporting form is attached and instructions for completing the form are included. Forms should be faxed to the Compliance Department at 510-373-5999 or emailed to the Compliance Department at compliance@alamedaalliance.org.

Please note that reporting PPCs for a Medi-Cal beneficiary does not preclude the reporting of adverse events and healthcare-associated infections (HAI) to the California Department of Public Health pursuant to Health and Safety Code.

WHAT IS CONSIDERED A PPC?

Federal regulations define PPCs. They include health care-acquired conditions (HCAC) in acute inpatient hospital settings only and other provider-preventable conditions (OPPC). The three current OPPCs that CMS requires are to be reported in all health care settings. By law, providers must report any PPC that did not exist prior to the provider initiating treatment for that patient.

CMS added two new HCACs in August 2012 that need to be reported effective October 1, 2012. They are surgical site infection following cardiac implantable electronic device (CIED) procedures and iatrogenic pneumothorax with venous catheterization. CMS added them as hospital-acquired conditions (HACs) with the August 31, 2012 Federal Register (item (II)(F)(5(b)). By federal regulations, HACs automatically become Medicaid HCACs for PPCs. Providers must report these new HCACs that occur on or after October 1, 2012.

Health Care Acquired Conditions (HCACs) are defined as:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization (October 1, 2012)
- Manifestations of poor glycemic control
  - Diabetic ketoacidosis
  - Nonketotic hyperosmolar coma
  - Hypoglycemic coma
Secondary diabetes with ketoacidosis
- Secondary diabetes with hyperosmolarity
- Stage III and IV pressure ulcers
- Surgical site infection following:
  - Mediastinitis following coronary artery bypass graft (CABG)
  - Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery
  - Orthopedic procedures for spine, neck, shoulder, and elbow
  - Cardiac implantable electronic device (CIED) procedures (October 1, 2012)
- Vascular catheter-associated infection
- For non-pediatric/obstetric population, deep vein thrombosis (DVT)/pulmonary embolism (PE) resulting from:
  - Total knee replacement
  - Hip replacement

**Other Provider Preventable Conditions (OPPCs) are defined as:**
- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

**ATTACHMENTS & FORMS**
- PPC Reporting Form (DHCS 7107)

**Section 18: Complaints and Grievances**

Providers and members may encounter problems delivering and receiving health care. This section outlines the process to resolve these problems.

**Philosophy & Definitions**

The Alliance’s philosophy for complaints and grievances is founded on communication, problem-solving, and fairness. The Alliance does not differentiate between a grievance and a complaint. Our goal is to keep both members and providers satisfied. Member and provider concerns are taken seriously. The Alliance grievance policies ensure that grievances are addressed in a timely manner. This process is in accordance with state regulations and provides an opportunity for all sides to be heard and an opportunity for appeal.

**DEFINITIONS & ROLES**

- A **Grievance** is any written or oral expression of dissatisfaction made by a member or the member’s representative or a provider. Where the plan is unable to distinguish between grievances and inquiries, they shall be considered grievances.

- The **Member Services Representative** (MSR) is the Alliance staff person who receives and documents complaints received by phone.

- The **Grievance and Appeal Coordinator** is responsible for investigating and resolving member grievances.

- The **Provider Services Representative** (PSR) is the Alliance staff person responsible for intake,
investigation, and resolution of grievances filed by providers at the informal level. Certain Provider Services staff also track and monitor provider grievances for quality improvement purposes.

- The Medical Director and the Clinical Services staff are responsible for addressing grievances involving medical issues. These staff members work with MSRs and PSRs when these issues arise.

**Complaint/Grievance Procedures for Members**

A provider aware of a member with a problem or complaint about the Alliance, its policies, or its providers, should do the following:

- Have the member call the Member Services department at 510-747-4567, or
- Give the member a Complaint Form and a copy of the “Member Guide to the Grievance and Appeal Process.” See Attachments & Forms at the back of this section for these forms. Grievance forms in four languages (English, Spanish, Chinese, Vietnamese) may also be found in the Provider Services section of the Alliance website, under Health Ed and other Member Resources.

The Alliance will acknowledge receipt of the complaint within five (5) days and offer a resolution or status within thirty (30) days.

A member who files a complaint or grievance may not be discriminated against, and cannot be disenrolled from the Alliance plan solely on the basis of filing a complaint or grievance.

Copies of the Complaint Form and the “Member Guide to the Grievance and Appeal Process” are included at the end of this section.

**OTHER OPTIONS FOR MEMBERS**

Alliance members also have these other options if they have a complaint:

- **State Fair Hearing (Medi-Cal only)** State Fair Hearings are administered by the California Department of Social Services, State Hearings Division. The telephone number is 1-800-952-5253 (Voice) or 1-800-952-8349 (TDD). Medi-Cal beneficiaries may also request a state fair hearing through the Alameda County Social Services Agency. As long as the request for a hearing is made within 90 days of the action in question, members may exercise this option before, during or after the Alliance’s complaint process.

- **Medi-Cal Managed Care Division Office of the Ombudsman** can assist with enrollment and other problems. The office is open Monday - Friday, 8 a.m. - 5 p.m.; excluding holidays. The toll-free telephone number is 1-888-452-8609. Or email: MMCDOmbudsmanOffice@dhcs.ca.gov. Please note: email provides no mechanism for ensuring the confidentiality or privacy of information contained within a message in transit. Therefore, the sender of an email message assumes responsibility for including confidential or private data when utilizing this communication medium. Except in cases involving enrollment issues, members should contact the plan before using this option.

- **Department of Managed Health Care (DMHC)** This state agency regulates health plans like the Alliance. This option should be used after the plan’s grievance process, except where there
is an emergency, an unsatisfactory resolution by the plan, or the plan has not resolved a member’s complaint within 30 days. Members may also contact DMHC in emergency situations without going through the plan’s process.

- **DMHC HMO Help Center** Call 1-888-HMO-2219 (1-888-466-2219) or TDD: 1-877-688-9891. It is open 24 hours a day, 7 days a week. There is no charge for your call. The HMO Help Center can provide help in many languages. The department’s website (http://www.hmohelp.ca.gov) has complaint forms and instructions online.

- The HMO Help Center can also assist with a request for an **Independent Medical Review (IMR)**. This is an administrative procedure that allows a member to present evidence for independent medical review. The reviewers are certified by Department of Managed Health Care.

Alliance Medi-Cal members may request independent medical review if a State Fair Hearing has not been initiated and the member has completed the plan’s grievance process.

**Complaint/Grievance and Appeals Dispute Procedures for Providers**

**MEMBER COMPLAINTS ABOUT PROVIDERS**
A provider or office staff may be requested to respond in writing to a complaint filed against him or her by a member. Written responses are to be received within fourteen (14) days of the request.

**WHEN PROVIDERS HAVE COMPLAINTS**
Sometimes providers may have a complaint/grievance about the Alliance’s administration of the plan or about Alliance members.

Providers may present complaints/grievances to the Alliance by telephone, fax, email, in person, or in writing. If the complaint/grievance is regarding either the processing of a claim or the processing of an authorization, providers should follow the procedures set forth below under “Appeals/Dispute Procedures”.

Provider complaints involving quality of care delivery (for instance complaints against a vendor or another provider) may be directed to the Grievance and Appeals Unit of Medical Services. They can be reached at 510-747-4531.

The Provider Services department is the contact for all other complaints. Once a complaint is received by the Provider Services department, it will be acknowledged in writing within five (5) calendar days. The Alliance will propose a resolution in writing within thirty (30) days of receipt of the complaint/grievance.

Call the Provider Services Department for assistance at 510-747-4510 or fax 510-747-4508.

**APPEALS/DISPUTE PROCEDURES**
If a provider wishes to dispute a claim payment or denial (for reasons not related to a submission error or omission), an authorization request outcome, or the resolution to any other provider complaint/grievance, the provider may use the Alliance’s dispute resolution process to appeal the decision. The Alliance has created a dispute resolution process that complies with Title 28, Section 1300.71 of the California Code of Regulations related to the resolution of a provider dispute.
These disputes must be in writing and should be submitted to the appropriate department at one of the addresses listed below:

**Claims Disputes:**
NOPD Unit - Claims Department  
Alameda Alliance for Health  
P.O. Box 2460  
Alameda, CA 94501-0460  
Fax: 510-747-4506

**Authorization Disputes (UM Appeals):**
Grievance and Appeals  
Alameda Alliance for Health  
1240 South Loop Road  
Alameda, CA 94502  
Telephone: 510-747-4531  
Fax: 877-748-4522

**Other Provider Disputes:**
NOPD Unit - Provider Services Department  
Alameda Alliance for Health  
1240 South Loop Road  
Alameda, CA 94502  
Fax: 510-747-4508

1. The provider must send a Notice of Provider Dispute (NOPD) along with any relevant and supporting documentation within 365 days of the Alliance’s action or inaction that is the subject of the dispute.

2. The NOPD shall include all of the following:
   - Provider’s name and provider identification number
   - Provider’s contact information, including name, address, and telephone number of the provider’s contact person
   - Explanation of the issue, including any pertinent attachments, documentation, and supplemental information
   - If the dispute involves a patient, the name of the patient and patient identification number should be included

3. Within fifteen (15) working days of receipt of a NOPD, the Alliance will notify the provider of receipt of the NOPD. The provider will be advised of the Alliance’s contact person and telephone number for follow-up and status inquiries.

4. If the Alliance receives an incomplete NOPD from the provider, the Alliance will return it and require that the NOPD be completed as indicated above.

5. The provider has thirty (30) working days from the receipt of the returned NOPD to resubmit the completed notice.
6. When a provider resubmits the NOPD, the resubmission date shall be deemed to be the date of original submission.

7. The Alliance must resolve the provider dispute after receipt of a complete NOPD within forty-five (45) working days.

8. The appropriate department in consultation with other Alliance staff, as necessary, will determine the resolution and advise the provider of the decision.

9. The Alliance’s resolution of the dispute, including a statement of the pertinent facts and reasons upon which the Alliance is relying, shall be sent to the provider in writing within forty-five (45) working days.

PROCEDURE FOR PROVIDER APPEAL ON BEHALF OF THE MEDI-CAL MEMBER

A provider may submit an appeal for Medi-Cal benefits or services on behalf of a Medi-Cal member. When submitting an appeal please indicate if the member has been notified that you are submitting an appeal on his or her behalf.

Grievances and Appeals Unit
Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502
Telephone: 510-747-4531
Fax: 1-877-748-4522

1. Please fax to the Grievance and Appeals Unit a copy of the prior authorization, denial notice, and relevant supporting documentation within ninety (90) days of the Alliance’s action or inaction that is the subject of the dispute.

2. The appeal will be acknowledged in writing within five (5) calendar days and resolved within thirty (30) calendar days.

3. If you request an expedited appeal on behalf of the member you and the member will receive oral notice of the appeal resolution within seventy-two (72) hours, and written notice will be mailed within three (3) calendar days.

ATTACHMENTS & FORMS

- Member Guide to the Grievance and Appeal Process
  - Member Grievance Forms:
    - Chinese
    - English
    - Spanish
    - Vietnamese
- Member’s Guide to the Grievance Process - Your Rights Under Medi-Cal Managed Care
Section 19: Credentialing

All healthcare providers who contract with the Alliance must have credentials verified through the Alliance credentialing process. This section covers the credentialing and recredentialing requirements providers are expected to meet.

Credentialing Process

The Alliance utilizes a credentialing process in order to ensure the participation of quality network providers. The Alliance follows National Committee on Quality Assurance (NCQA) guidelines in conjunction with special credentialing guidelines required by State regulation and policy.

CONFIDENTIALITY

The information obtained during the credentialing process, whether directly from the provider, or from another source, will be treated as confidential information.

THE APPLICATION

Applicants must submit a signed application and supporting documentation to the Alliance. The Alliance then has 180 days from the signature date on the attestation form to work with the applicant and the Peer Review and Credentialing Committee, (PRCC) to complete the credentialing process.

As part of the application process, providers will be asked to attest to statements regarding:

• Reasons for any inability to perform the essential functions of the position, with or without accommodation
• Lack of present illegal drug use
• History of disciplinary actions taken against the license
• History of loss of license
• History of convictions
• History of loss or limitation of privileges or disciplinary activity at a facility
• History of professional liability judgments and/or claims that resulted in settlements or judgments paid by or on behalf of the applicant, or pending lawsuits
• Current malpractice insurance coverage

ADDITIONAL CREDENTIALING STEPS

Facility Site Review

All primary care providers and OB/GYN practice sites are reviewed by an Alliance Provider Services Representative and Quality Improvement Nurse Specialists prior to approval as an Alliance provider. (Please see Section 20 – Facility Site Reviews for detailed information on site reviews.)

Recommendation by the PRCC

The PRCC is a standing Alliance committee responsible for peer review and credentialing/credenetialing.

The PRCC recommends acceptance or denial of an applicant as follows:
If the recommendation is for DENIAL, the applicant receives written notification of the decision and supporting reasons. If the denial is due to medical quality of care, the appeal process is included.

If the recommendation is for APPROVAL, the applicant receives written notification of the decision and the name and specialty are forwarded to the Board of Governors in the credentialing summary.

**Board of Governors**
The Board of Governors reviews the recommendations of the PRCC and may take further action.

**PRACTITIONER RIGHTS**
Practitioners have the right to review information submitted to support their credentialing application, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request, and receive notification of these rights. Practitioners are notified of these rights in the application cover letter.

Right to review information: Practitioners are allowed access to their credentialing documentation the Alliance Credentialing Department has obtained to evaluate their credentialing application, attestation, or CV with the exception of National Practitioner Data Bank Reports, references, recommendations, or other peer-review protected information.

Right to correct erroneous information: Practitioners are notified when credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples of the type of information that would cause the Alliance to alert the practitioner, if there are substantial variations from the practitioner’s information include actions on a license, malpractice claims history, and/or board certification decisions. The Alliance Credentialing Department staff will contact the practitioner via written request (email or certified mail) of the discrepancy and the practitioner will be asked to submit corrections/explanations within 15 business days by mail or fax to the Alliance Credentialing Department staff contact.

Right to receive status: Practitioners may contact the Alliance Credentialing Department at any time regarding the status of their application for appointment or reappointment. All such requests will be responded to within four (4) business days and the practitioner will be notified of phase in the credentialing process.

**Credentialing Criteria and Basic Qualifications**
The following credentialing criteria are reviewed at initial credentialing and re-credentialing.

**LICENSE**
All providers must maintain a current license, which is applicable to the provider’s scope of practice in the state of California. If providers have, or had, out-of-state licenses, the status of these licenses shall also be verified for the same qualifications. All initial providers must have an unrestricted license. All provider Medical Board actions are reviewed by the PRCC.

**HOSPITAL ADMITTING PRIVILEGES**
All providers must maintain current hospital admitting privileges with unrestricted clinical privileges, at an Alliance-participating hospital. The Alliance may waive this requirement if the provider has admitting arrangements in writing through another Alliance-participating provider.
DEA CERTIFICATION
All providers must maintain a current Drug Enforcement Administration certification, if applicable to the provider’s scope of practice. The Alliance may waive this requirement if the provider’s DEA is pending and presents documented evidence that another participating provider will write all prescriptions that require a DEA.

SPECIALTY BOARD CERTIFICATION
Specialists applying to the network must be board-certified in the specialty and sub-specialty effective July 1, 2003 unless the provider was contracted with the Alliance prior to July 1, 2003. Specialists who have recently completed post graduate training may be credentialed and will be expected to complete their board certification within the timeframe as set forth by the American Board of Specialties.

NPDB and HIPDB
The National Practitioner Data Bank (NPDB) checks medical malpractice claims and license status for any state in which the physician has practiced. The Healthcare Integrity Protection Data Bank (HIPDB) collects information regarding licensure and certification actions, exclusion from federal and State health care programs, criminal convictions, and civil judgments related to health care.

PROFESSIONAL LIABILITY CLAIMS HISTORY
Information related to malpractice suits and settlements will be collected and reviewed.

CLEAR FROM SANCTIONS
The Alliance does not contract with providers who have elected to “Opt Out” of Medicare or are excluded or sanctioned from participation in Medicare/Medicaid programs.

PROFESSIONAL LIABILITY INSURANCE
All participating providers must maintain professional liability insurance with limits of liability of at least $1,000,000 per occurrence and $3,000,000 aggregate at all times.

WORK HISTORY
All providers will be reviewed for work history as obtained through their submitted application or Curriculum Vitae.

Recredentialing
Participating providers are recredentialed in accordance with Alliance policy. Currently, recredentialing occurs at least every three (3) years or more often as directed by the PRCC. The process is similar to the initial credentialing process as outlined earlier in this section.

The following performance areas will be reviewed for all providers, as applicable:
- Member complaints/grievances
- Results of quality reviews
- Facility site review results

DENIED RECREDENTIALING
If the PRCC determines that a provider does not meet recredentialing criteria, the provider’s participation will be terminated pursuant to the terms of the provider service agreement. From that
time onward, the provider may not submit claims to the Alliance for health services provided to Alliance members.

Section 20: Facility Site Review

All Alliance primary care and OB/GYN providers receive periodic facility site reviews. This section covers what to expect during a site review.

Facility Site Review Overview

The Department of Health Care Services (DHCS) mandates initial and periodic Facility Site Review (FSR) and Medical Record Review (MRR) Audits. The Alliance complies with the DHCS mandate and audits primary care and OB/GYN provider sites. The purpose of Facility Site Reviews (FSRs) is to ensure that all contracted primary care physician sites:

- Provide appropriate primary health care services to members
- Carry out processes that support continuity and coordination of care
- Maintain patient safety standards and practices
- Operate in compliance with all applicable local, State and federal laws and regulations

FSRs are conducted during the initial provider credentialing process. Additionally, site reviews will be conducted as part of the ongoing provider recredentialing process. This process ensures that each provider continues to meet the Alliance’s site review standards. The Quality Management department is responsible for conducting site reviews.

SITE REVIEW PREPARATION

The Alliance will help providers prepare for the review in several ways. Prior to a review, providers will receive a copy of the site review tool (please see Site Review Tool in the Attachments & Forms section). Providers should review it carefully so that nothing in the site review comes as a surprise. Facility Site Review Nurses offer on-site training prior to initial facility site reviews or upon provider’s request.

The Alliance has developed the Facility Site Review and Medical Record Review (MRR) Provider Toolkit to assist you in meeting the standards of the FSR. We distribute the Toolkit to newly contracted providers and upon request. The Toolkit contains many of the templates and resources needed for provider offices to successfully meet the FSR/MRR criteria.

For help preparing your practice for the FSR, contact:
- Provider Services at 510-747-4510, or
- FSR nurses at 510-747-6198 or 510-747-6218

PROBLEMS FOUND THROUGH FACILITY SITE REVIEWS AND MEDICAL RECORD REVIEWS

If a facility is found to be out of compliance with Alliance and/or State requirements, the provider is notified through the Corrective Action Plan (CAP). For Medical Record Review, a CAP is required for
any score below 90% or any section score below 80% regardless of total score. A total score under 80% will result in a hold on new member assignment.

Participation in the Alliance may be suspended until the facility meets compliance standards. If a provider’s non-compliance issues present a clear and immediate danger to patients, the provider’s members will be re-assigned to other providers. If problems are documented, providers are allowed time for correction. Problems must be corrected within forty-five (45) days of receipt of the CAP. Failure to provide a timely response results in a re-survey within 12 months and/or reporting the provider’s site review status to the Alliance’s Peer Review and Credentialing Committee (PRCC). The PRCC may suspend a provider from plan participation, or recommend termination due to non-compliance to the Alliance Board of Governors.

PROBLEMS FOUND THROUGH DHCS FACILITY REVIEWS
The California Department of Health Care Services (DHCS) conducts facility site reviews independently of the Alliance on a small sample of the Alliance’s provider network. DHCS does this to monitor both the Alliance’s compliance with the DHCS contract and to determine how well provider sites are able to implement and meet the standards. Should a DHCS inspector find a primary care site in substantial non-compliance, the Alliance may suspend that site from plan participation until the facility can meet compliance standards. If the provider’s non-compliance issues present a clear and immediate danger to Alliance members, they will be reassigned to another provider. A Medical Record Review with a score below 80% will result in a follow-up Medical Record Review in six (6) months and a hold placed on new membership assignment.

Facility Site Reviews
The Alliance’s Facility Site Review (FSR) and Medical Record Review (MRR) Provider Toolkit contains essential tools, templates, and guidance for meeting the standards of the survey. To request a Provider Toolkit, contact:
- Provider Services at 510-747-4510, or
- FSR nurses at 510-747-6198 or 510-747-6218

FACILITY SITE REVIEW TOOL
The Alliance utilizes a facility site review tool mandated by the California Department of Health Care Services (DHCS). A copy of the full Facility Site Review Tool is included in the FSR and MRR Provider Toolkit and the back of this section. For OB/GYN specialist, a modified FSR tool is used. The tool contains applicable State requirements. The site review tool mandates review in the broad areas listed below. Please see the full Facility Site Review Tool for a detailed explanation of the six criteria listed below:

1. Site Access/Safety
2. Site Personnel
3. Office Management
4. Clinical Services
   - Pharmaceuticals
   - Laboratory
   - Radiology
5. Preventive Services

6. Infection Control

Any deficiency found in the infection control and pharmaceutical services sections of the survey require a corrective action plan regardless of score.

CRITICAL ELEMENTS
Within the Facility Site Review, there are nine (9) critical survey elements related to the potential for adverse effects on patient health or safety. These critical elements have a weighted score of two points. All other survey elements are weighted at one point. Critical elements include:

1. Exit doors and aisles are unobstructed and egress accessible.

2. Airway management equipment (oxygen delivery system, oral airways, nasal cannula or mask, ambu bag) appropriate to practice and populations served are present on-site.

3. Only qualified/trained personnel retrieve, prepare, or administer medications. Medical assistants must be supervised by licensed personnel in retrieving and preparing medications prior to administration.

4. Office practice procedures utilized on site provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.

5. Only lawfully authorized persons dispense drugs to patients.

6. Personal protective equipment (PPE) is readily available for staff use.

7. Needle stick safety precautions are practiced on site.

8. Blood, other potentially infectious materials and regulated wastes are placed in appropriate leak-proof, labeled containers for collection, processing storage, transport or shipping.

9. Spore testing of autoclave/steam sterilizer is completed (at least monthly) with documented results.

CRITICAL ELEMENT DEFICIENCIES
All critical element deficiencies found during a full scope site survey, focused survey, or monitoring visit must be corrected by the provider within ten (10) business days of the survey date, and verified as corrected by the plan within thirty (30) calendar days of the survey date. Any critical element found deficient must be corrected to 100%.

HELPING PROVIDERS MEET STANDARDS
Sites that are non-compliant with Alliance and/or State requirements are given a forty-five (45) day period to correct identified deficiencies.

The Alliance wants providers to meet the standards. Provider Services staff and FSR nurses offer guidance and training, or refer providers to resources that can help them meet the established standards.

Medical Record Reviews
The Alliance’s Facility Site Review (FSR) and Medical Record Review (MRR) Provider Toolkit contains essential tools, templates, and guidance for meeting the standards of the survey.
To request a Provider Toolkit, contact:
- Provider Services at 510-747-4510, or
- FSR nurses at 510-747-6198 or 510-747-6218

MEDICAL RECORD REVIEW SURVEY
The Alliance utilizes a medical record review tool mandated by the California Department of Health Care Services (DHCS). The MRR Survey is a separate tool from the FSR Tool.

A copy of the full MRR Survey is included in the FSR and MRR Provider Toolkit and back of this section. For OB/GYN specialist, a modified MRR tool is used. The tool contains applicable State requirements, as well as some additional Alliance standards. The record review tool mandates review in the broad areas listed below. Please see the full MRR Survey for a detailed explanation of the six criteria listed below:

1. Format
2. Documentation
3. Coordination/Continuity of Care
4. Pediatric Preventive Health Care
5. Adult Preventive Health Care
6. Obstetric / Comprehensive Perinatal Services Program (OB/CPSP) Preventive Criteria

Alliance providers are required to have a medical record for each member. During an MRR, a minimum of ten (10) member records are audited per contracted provider. Reviewers may request additional records.

HELPING PROVIDERS MEET STANDARDS
The Alliance wants providers to meet the standards. Provider Services staff and FSR nurses offer guidance and training, or refer providers to resources that can help them meet the established standards. To request assistance, contact:
- Provider Services at 510-747-4510, or
- FSR nurses at 510-747-6198 or 510-747-6218

ATTACHMENTS & FORMS
- Full Scope Site Review Survey 2012
- Site Review Guidelines 2012
- Full Scope Medical Record Review Survey 2012
- Medical Record Review Guidelines 2012
- Specialty Services Facility Site Review Survey
- Specialty Services Site Review Guidelines
- Specialty Services Medical Record Review Survey
- Specialty Services Medical Record Review Guidelines
Section 21: Practice Guidelines

This section describes guidelines the Alliance has for providers to manage certain acute and chronic conditions and the process that is used to approve the guidelines and monitor adherence to them.

ABOUT CLINICAL PRACTICE GUIDELINES (CPGS)
Clinical Practice Guidelines are descriptive tools or standardized specifications for care developed to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.

SELECTION AND APPROVAL OF CLINICAL PRACTICE GUIDELINES
Guidelines selected by the Alliance are based upon clinical evidence known to be effective in improving health outcomes.

The Alliance chooses conditions for which to adopt guidelines based on:
- Prevalence in the member population
- Demonstrated variation in treatment or cost
- Focus of a clinical initiative or improvement activity

The Alliance's Health Care Quality Committee is responsible for approval of Clinical Practice Guidelines.

MONITORING OF CLINICAL PRACTICE GUIDELINES
The Alliance’s Quality Improvement Program measures use of practice guidelines annually through examination of one or more of the following : administrative data such as claims and encounters, pharmacy data, lab data, and Healthcare Effectiveness Data and Information Set (HEDIS) measure rates. In some circumstances, the Alliance may audit a sample of providers’ records to determine adherence to guidelines.

UPDATING CLINICAL PRACTICE GUIDELINES
Guidelines are reviewed by the Health Care Quality Committee at least every two years to ensure that new scientific evidence or national standards are incorporated. Reviews and updating of guidelines may be more frequent if national standards change. These reviews may be initiated due to information that is identified internally at Alliance or based on external input. The process of revision of the guidelines is managed through the Alliance Quality Department and the Chief Medical Officer with review and approval by the Health Care Quality Committee.

CLINICAL PRACTICE GUIDELINES FOR ACUTE AND CHRONIC MEDICAL CARE
Providers are encouraged to review the Alliance public website for current and updated guidelines for chronic medical conditions including; asthma, hypertension, and diabetes as well as, other medical conditions.

CLINICAL PRACTICE GUIDELINES FOR BEHAVIORAL HEALTH CARE
Providers are encouraged to review the Alliance public website for current and updated guidelines including depression and ADHD.
PREVENTIVE HEALTH GUIDELINES
Providers are encouraged to review the Alliance for Health website for current and updated guidelines including adult preventive guidelines for adults ages 20 – 64, adults ages 65 and over, children ages 0 – 24 months, children ages 2 – 19, and perinatal guidelines.

Provider Initial Review and Fair Hearing Process
Physicians, ancillary professionals, and other “Providers” shall be entitled to an Initial Review or Fair Hearing and Appeals proceedings when dissatisfied with certain adverse credentialing and/or participation decisions made by Alameda Alliance for Health (the “Plan”), including those based on a Medical Quality concerns.

The Initial Review and Fair Hearing process is divided into two phases:

- **Phase I- Initial Review:** An Initial Review before the PRCC to try to amicably resolve the matter; and
- **Phase II – Formal Hearing:** For Providers who are dissatisfied with the PRCC Initial Review decision and eligible for a Phase II hearing, a formal hearing in front of an impartial Judicial Review Committee.

PROCEDURES FOR INITIAL REVIEW
The Alliance offers providers an Initial Review when the provider is dissatisfied with an adverse credentialing and/or participation decision made by the PRCC. Decisions may include recommendations such as practice restrictions, denial of application, or participation in the Alliance network.

The provider will be notified in writing of the PRCC decision. Within thirty (30) days of receipt of the notice of action or proposed action by PRCC, the provider may request an Initial Review. A request for Initial Review must be in writing and must state the basis for the challenge, whether the provider would like to present evidence or oral testimony to the PRCC, or both, whether the provider needs special accommodations, and any preferred time or dates for the Initial Review within the next sixty (60) days.

The following procedures are followed for Initial Reviews:

- All credentialing and peer review issues shall be brought before the PRCC for review and recommendation
- Notice will be given to the provider stating the date of the initial review meeting and the provider shall have an opportunity to present his/her position
- The decision of the PRCC shall be binding and final if the decision was for any reason other than medical quality of care concern
- If a decision of the PRCC is based in whole or in part on medical quality of care concerns the provider shall have the right to appeal the PRCC decision to the Plan’s Judicial Review Committee through the Fair Hearing process.

FAIR HEARING PROCESS
Providers may request a Fair Hearing who are dissatisfied with the PRCC Initial Review decision and are eligible for a Phase II hearing, a formal hearing in front of an impartial Judicial Review Committee.
Grounds for a Fair Hearing
One or more of the following actions, or proposed actions, against a Provider by the PRCC after the Initial Review shall be grounds for a formal hearing before the Plan’s Judicial Review Committee:

1. Upholding the Plan’s reduction or failure to renew credentialing and/or participation based on Medical Quality Concerns;
2. Upholding the Plan’s suspension or imposition of restrictions on credentialing and/or participation for a cumulative total of thirty (30) calendar days or more in any 12 month period based on Medical Quality Concerns;
3. Upholding the Plan’s denial or termination of credentialing and/or participation based on Medical Quality Concerns.

Requesting an Appeal
If the PRCC recommends an adverse decision based on medical quality concerns of an initial application or recredentialing that results in a mandatory reportable action, the practitioner will be notified in writing of this decision. Within thirty (30) days of receipt of the PRCC notification, the practitioner has the right to request a hearing before a Judicial Review Committee (JRC). A provider who wishes, and is eligible, to file an appeal of an adverse credentialing or participation decision must deliver a written notice requesting a fair hearing before the Judicial Review Committee to the Chief Medical Officer of the Alliance within the time period specified.

The following procedures are followed for a Judicial Review process:
- Fair Hearings shall be brought before a JRC for review and recommendation
- Notice will be given to the provider stating the date of the JRC and the provider shall have an opportunity to present his/her position
- The decision of the JRC will be sent to the PRCC and the practitioner
- Within thirty (30) calendar days after final adjournment of the hearing, the JRC shall issue a written decision which shall include findings of fact and a conclusion.

Requirements for Mid-Level Clinicians
REQUIREMENTS FOR MID-LEVEL CLINICIANS
PCPs that employ or contract with Mid-Level Clinicians in their practices are responsible for making sure that the clinicians meet the standards set forth by the Clinician’s licensing authority. The PCP, as the clinician supervisor, is also responsible for developing the protocols under which the clinician will practice. (See Section 5 – PCP Roles & Responsibilities) They must meet certain qualifications and standards in order to be credentialed by the Alliance. This helps ensure quality care for members.

DEFINITIONS OF MID-LEVEL CLINICIANS
Mid-Level Clinicians are non-physician medical practitioners, including:

- Nurse Practitioners
- Physician Assistants
- Certified Nurse-Midwives

As defined in this section, “protocols” are practices and procedures developed by the supervising physician that meet the requirements of the Physician Assistant Practice Act and regulations of the Physician Assistant Examining Committee for Physician Assistants; and standardized procedures for Nurse Practitioners and Nurse Midwives.
CREDENTIALING
Any mid-level clinician that provides care to Alliance members must be credentialed by the Alliance.

LICENSING REQUIREMENTS
To provide services to Alliance members, mid-level clinicians must have a valid, current license issued by the state of California. Nurse-midwives must be certified by the ACNM Certification Council, Inc. Physician Assistants must be licensed in accordance with the requirements of the Physician Assistant Examiners Committee.

INSURANCE
The supervising physician must submit proof that his/her liability insurance covers the mid-level clinician, or that the clinician has individual coverage.

CPR AND ACLS CERTIFICATION
Mid-level clinicians must maintain CPR certification. They also are encouraged to obtain ACLS certification.

Physician/clinician Agreement
Each physician/mid-level clinician team must sign an agreement stating that the clinician will follow the practice protocols developed by the supervising physician. The agreements, called a Delegated Services Agreement and a Supervising Physician’s Responsibility document, must be submitted at the time of credentialing and recredentialing.

Protocols
Protocols must be reviewed and approved by the supervising physician annually. These protocols and any updates must be submitted to the Alliance at the time of credentialing and site reviews.

Organizational Providers
The Alliance is responsible for verification of the accreditation status, license, certification and standing with regulatory bodies of all directly contracted organizational providers. This includes, but is not limited to, acute care hospitals, free standing surgical centers, home health agencies, and skilled nursing homes that provide care to Alliance members, at the time of contracting and at a minimum every three (3) years thereafter.

Hospitals, facilities, and organizational providers must meet the following requirements to contract with the Alliance by submitting all licensing and specialty qualification documents to the Alliance for verification as part of the Alliance Credentialing and Recredentialing Process and demonstrating the ability to meet Alliance requirements as outlined in the Alliance Quality Improvement Plan, Assessment of Organizational Provider Policy, and contract provisions.

Requirements
- Completed Alliance Application including Attestations
- Valid, current and unrestricted healthcare/state and business licenses
- Valid and current Medicare/Medicaid certification
- Eligibility to participate in state and federal programs,
• Current malpractice/general professional liability insurance
• Accreditation or certification reviewed and approved by an accrediting body. If not accredited, the organization must submit copy of CMS or state site survey
• Clear of any sanctions, negative findings, or deficiencies
• CLIA certificate, if applicable