



Clinical Policy Guiding Document: Quality Improvement

BACKGROUND

The QI Program reflects a continuous quality improvement (CQI) philosophy and mode of action. This methodology involves a review of the complete range of health services provided to Members as categorized by all demographic groups, including those with special healthcare needs, clinically related groups, and service settings for clinical and non-clinical measures. The QI Program is based on the latest available research in the area of quality assurance and at a minimum includes a method of monitoring, analysis, evaluation and improvement in delivering quality care and service. The QI Program involves tracking and trending of quality indicators to ensure measures are reported, outcomes are analyzed, and goals are attained. Federal and state contractual standards, evidence-based practice guidelines, and other nationally recognized sources may be utilized to identify performance/metric indicators, standards, and benchmarks. Examples include:¹

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Health Outcomes Survey (HOS)
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- STAR Rating

Indicators are objective, measurable, and based on current knowledge and clinical experience (as applicable). The indicators may reflect, without limitation, the following parameters of quality:¹

- Structure, process, or outcome of care
- Administrative and care systems within clinical services which may include the following;
 - Acute and chronic condition management
 - Care management
 - Disease management
 - Utilization management
 - Credentialing
 - Member and Provider satisfaction
 - Medical record review
 - Member complaints and appeals
 - Practitioner availability and accessibility
 - Plan accessibility
 - Member safety
 - Preventive care
 - Disparities in care

HEDIS® measures and CAHPS® and HOS results are integrated in the QI Program. HEDIS® measures and methodology may be adopted as performance indicators for clinical improvement. The CAHPS® survey is utilized as one of the tools for assessing Member satisfaction. The HOS is used to assess the Member's physical and mental well-being at the beginning and end of a two-year cycle. Quality initiatives are developed and implemented as indicated by data analysis for process improvements. Initiatives are reassessed on an annual basis to evaluate intervention effectiveness and compare year-to-year performance.¹

WellCare utilizes the tools below to measure and maintain compliance – the following pages summarize each:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys
- Health Outcomes Survey (HOS)
- CMS Star Ratings
- Healthcare Effectiveness Data and Information Set (HEDIS)

Quality Improvement Program Objectives

- Facilitate the integration, support, and commitment to continuous quality improvement.
- Encourage and evaluate compliance to policies and procedures that standardize approaches to the completion of activities that reflect key program components.
- Develop and maintain a process through which clinical and operational performance is continuously measured, opportunities for improvement identified, meaningful interventions are initiated as appropriate, and the results of actions taken to improve outcomes are evaluated.
- Select and conduct meaningful and relevant (high-volume, high-risk, and/or problem prone) population-specific quality improvement initiatives that achieve, through ongoing measurement and intervention, sustained and significant improvement in aspects of clinical care and non-clinical services.
- Ensure availability of and access to qualified providers, adhering to established standards for credentialing and re-credentialing of network practitioners and providers.
- Adopt and disseminate evidence-based guidelines, thereby promoting the delivery of safe clinical practice.
- Facilitate integration of services to promote continuity and coordination of care, whether resulting from a change in setting or a transition of care, inclusive of both medical and behavioral health care delivery situations.
- Promote a supportive environment that assists associates and providers to render culturally-competent medical and behavioral health care and/or services, thereby promoting compliance with the WellCare Corporate Cultural Competency Plan.
- Encourage member participation in Plan programs and services through the dissemination of information that considers language and readability levels.
- Maintain established safeguards for member privacy, including confidentiality of member health information in accordance with the Health Insurance Portability and Accountability Act of 1996 and the regulations adopted there under (collectively, HIPAA).
- Engage members in managing, maintaining, and/or improving their current health status through preventive/wellness activities, disease management, case management, and other chronic care initiatives.
- Maintain a process for members, providers, various healthcare associations and community agencies to receive updates, and offer suggestions, concerns, and recommendation regarding the QI Program and activities.
- Ensure all aspects of the QI Program and activities are compliant with contractual, state, federal, and accreditation standards.
- Collaborate with various internal stakeholders to ensure the Plan's information system supports the collection, tracking, analysis, reporting and historical record keeping of relevant QI Program related data.
- Establish standards and conduct continuous, comprehensive oversight of all delegated entities.
- Establish standards and objectives for serving members with complex health needs.
- Health Plan Employer Data and Information Set ("HEDIS®"), Health Outcomes Survey ("HOS") and Consumer Assessment of Health Plans Study ("CAHPS") results that evidence improvements in Plan initiatives to improve member experience, satisfaction, health, and wellness.

- Conduct population specific quality improvement (“QI”) initiatives that achieve, through ongoing measurement and intervention, sustained and significant improvement in aspects of clinical care and non-clinical services.
- Annually, specific objectives to promote realization of select goals are identified and recorded in the Work Plan document.

Clinical Indicators and Initiatives

WellCare Health Plans participate in the collection and evaluation of data related to the member’s clinical outcome on selected measures (HEDIS®), the member’s perception of how their health has improved or not improved during a 2 year period (HOS), and the member’s perception of the quality of care and service rendered by the health plan and their provider(s) (CAHPS). Collectively, these three reports along with CMS’ Administrative data, which includes member complaints, appeals, and customer service data, provide an overview of the quality of care and service rendered by a health plan. Plans are graded on their performance and given 1-5 “stars”; one star indicates a low performance, whereas 5 stars indicate a high performance health plan. Each domain is also rated individually. The Star Results are reported to the Quality Improvement Committee (QIC) annually.⁷

CMS STAR RATINGS

One of the most important strategic goals that the CMS is involved in is improving the quality of care and general health status for Medicare beneficiaries. CMS publishes the Part C and D Star Ratings each year to: measure quality in Medicare Advantage (MA) and Prescription Drug Plans (PDPs or Part D plans), assist beneficiaries in finding the best plan for them, and determine MA Quality Bonus Payments. The ratings also support CMS efforts to improve the level of accountability for the care provided by physicians, hospitals, and other providers. Star Ratings are driving improvements in Medicare quality.⁵

Medicare Advantage with prescription drug coverage (MA-PD) contracts are rated on up to 44 unique quality and performance measures; MA-only contracts (without prescription drug coverage) are rated on up to 32 measures; and stand-alone PDP contracts are rated on up to 15 measures. Each year, CMS conducts a comprehensive review of the measures that make up the Star Ratings, considering the reliability of the measures, clinical recommendations, feedback received from stakeholders, and data issues. All measures transitioned from the Star Ratings are included in the display measures available on this page <http://go.cms.gov/partcanddstarratings>.

The Star Ratings measures span five broad categories: Outcomes, Intermediate Outcomes, Patient Experience, Access, and Process. For 2017, outcomes and intermediate outcomes continue to be weighted three times as much as process measures, and patient experience and access measures are weighted 1.5 times as much as process measures. A weight of 1 is assigned to all new measures. The Part C and D quality improvement measures receive a weight of 5 to further reward contracts for the strides they made to improve the care provided to Medicare enrollees.⁵ For additional information, click [here](#).

HEALTH OUTCOMES SURVEY (HOS)

Health Outcomes Survey (HOS) results assess the maintenance or improvement of the members’ health over time. The members report their perception of their physical and mental status as being better, the same or worse than expected. WellCare contracts with an NCQA-certified survey vendor to conduct the Health Outcomes Survey (HOS) on an annual basis dependent upon the cohort of each health plan. HOS data are evaluated to determine areas of needed improvement and the needs of the population served under the Medicare Advantage program. The HOS is used to assess the member’s physical and mental well-being at the beginning and end of a two-year cycle. HOS results are presented to the relevant quality committee to obtain input from the network participating providers. As data are evaluated, initiatives are identified to improve the health outcomes of our beneficiaries. These evaluations, initiatives, and data are presented to the relevant quality committee at least annually.⁷

The Health Outcomes Survey (HOS) is for Medicare Members and is a way to collect Member-reported health outcomes. The goal of the Medicare HOS program is to gather valid and reliable clinically meaningful data that have many uses, such as targeting quality improvement activities and resources; monitoring health plan

performance and rewarding top-performing health plans; helping beneficiaries make informed health care choices; and advancing the science of functional health outcomes measurement. Managed care plans with Medicare Advantage (MA) contracts must participate.⁴

The survey is administered for WellCare by an outside vendor. The survey is available from April through June for Members age 65 and older. Members are asked to report on the care and treatment they receive from their health care Providers. The survey includes questions that address behavioral and physical health; physical and social functioning; pain; energy; and quality of life. Members are surveyed once to collect a baseline and surveyed again two years later to measure the change in health over time.^x

A Member's annual wellness visit is a good time to discuss the following:

- Balance problems, falls, difficulty walking and other risk factors for falls
 - Suggest the use of a cane or a walker
 - Check blood pressure with patient standing, sitting and reclining
 - Suggest an exercise or physical therapy program
 - Suggest a vision or hearing test
 - Perform bone density screening, especially for high risk members
- Need for physical activity and ways to increase physical activity
 - Talk to the patient about the importance of exercise and physical activity
 - Discuss with the patient how to start, increase or maintain activity
- Bladder control and potential treatments for bladder control issues
 - Ask the patient if bladder control is a problem
 - If so, ask if it interferes with sleep or daily activities
 - Talk to the patient about treatment options
- Physical and behavioral health
 - Ask the patient about physical and behavioral health compared to two years ago
 - Discuss ways to improve status of both behavioral and physical
 - Suggest patient begin exercise programs or physical therapy if warranted

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS® is a tool utilized by 90% of the health plans to measure performance on important dimensions of care and service. Although HEDIS® includes 81 measures across 5 domains of care, the number of measures each health plan reports may vary according to contractual or federal standards. HEDIS® results are accessible to the public and widely accepted as a means to objectively compare the performance of health plans. WellCare integrates data from multiple sources to produce clinically relevant data on an ongoing basis for quality reporting. WellCare utilizes an NCQA-certified software system for HEDIS® data reporting that allows information to be entered electronically and extracted on a monthly, quarterly and annual basis. This software allows WellCare to utilize the data for other quality studies as needed. On a monthly basis, the system is refreshed and the plan reviews the volume of data by submitter to ensure data are coming in and are being captured for quality reporting. In addition, HEDIS® reports are run monthly and HEDIS® Provider Profiles are produced which track and trend Provider HEDIS® rates. This enables the Plan to conduct follow up with high volume and other key providers/provider groups for education regarding HEDIS® rates, benchmarking for comparison to peers, the overall plan rate and the NCQA thresholds.⁷

HEDIS measures address a broad range of important health issues. Among them are the following:⁶

- Asthma Medication Use
- Persistence of Beta-Blocker Treatment after a Heart Attack
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Breast Cancer Screening
- Antidepressant Medication Management

- Childhood and Adolescent Immunization Status
- Childhood and Adult Weight/BMI Assessment

Many health plans report HEDIS data to employers or use their results to make improvements in their quality of care and service. To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors using a process designed by NCQA. Consumers benefit from HEDIS data through the State of Health Care Quality report. This report offers a comprehensive look at the performance of the nation's health care system. HEDIS data also are the centerpiece of most health plan "report cards" that are disseminated to the public.

To ensure that HEDIS stays current, NCQA has established a process to evolve the measurement set each year. NCQA's Committee on Performance Measurement, a broad-based group representing employers, consumers, health plans and others, debates and decides collectively on the content of HEDIS. This group determines what HEDIS measures are included and field tests determine how it gets measured. The CAHPS® 5.0 survey is also included in HEDIS to measure members' satisfaction with care in areas such as claims processing, customer service, and getting needed care quickly.

HEDIS is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans. HEDIS results are included in Quality Compass, an interactive, web-based comparison tool that allows users to view plan results and benchmark information. Quality Compass users benefit from the largest database of comparative health plan performance information to conduct competitor analysis, examine quality improvement and benchmark plan performance.⁶ Additional information about HEDIS is [here](#).

Patient Safety and Quality of Care

The Quality Improvement program includes an emphasis on patient safety. The goals of incorporating Patient Safety into the Plan's QI Program are to:⁷

- Promote patient safety as an integral component of healthcare delivery
- Reduce member instances of potential quality issues which put patient safety at risk

The Plan's objectives of focusing on Patient Safety are to:⁷

- Inform members and providers regarding WellCare's progress towards patient safety initiatives
- Encourage the practitioner and provider community to adopt processes to improve safe clinical practices
- Promote members to be participants in the delivery of their own safe health care
- Communicate patient safety best practices

The scope of the Patient Safety Plan encompasses review of medical and pharmaceutical care and also administrative issues, such as provider and patient interactions. The source of data to monitor aspects of patient safety could encompass but is not limited to:⁷

- Practitioner-to-practitioner communication
- Office site visit review results
- Medical record review findings
- Clinical practice guideline compliance
- Potential QOC (PQOC) tracking/trending
- Concurrent review during the Utilization Management process
- Identification of potential trends in under and over-utilization
- Case and Disease management program participation
- Pharmaceutical management practices
- Member communication; and
- Provider/practitioner actions to improve patient safety.

All member demographic groups, care settings and types of services are included in Patient Safety activities.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)

The Centers for Medicare & Medicaid Services (CMS) develop, implement and administer several different patient experience surveys. The surveys ask patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others. The surveys focus on matters that patients themselves say are important to them and for which patients are the best and/or only source of information. CMS publicly reports the results of its patient experience surveys, and some surveys affect payments to CMS providers. Many of the surveys are covered by the Consumer Assessment of Healthcare Providers and Systems (CAHPS). All CAHPS surveys are approved by the CAHPS Consortium with oversight from the Agency for Healthcare Research and Quality (AHRQ).²

CAHPS surveys are developed with broad stakeholder input, including a public solicitation of measures and a technical expert panel, and the opportunity for anyone to comment on the survey through multiple public comments period through the Federal Register. Also, many CAHPS measures are statistically adjusted to correct for differences in the mix of patients across providers and the use of different survey modes. CAHPS surveys are an integral part of CMS’ efforts to improve healthcare in the United States; some surveys are used in Value-Based Purchasing (Pay for Performance) initiatives. Such initiatives represent a change in the way CMS pays for services – instead of only paying for the number of services provided, CMS also pays for providing high quality services. The quality of services is measured clinically, administratively, and through the use of patient experience of care surveys. CMS Patient Experience Surveys include:²

- Hospital CAHPS
- Home Health CAHPS
- Fee-for-Service CAHPS
- Medicare Advantage and Prescription Drug Plan CAHPS
- In-Center Hemodialysis CAHPS
- Nationwide Adult Medicaid CAHPS
- Hospice
- CAHPS® Survey for Accountable Care Organizations Participating in Medicare Initiatives
- Outpatient and Ambulatory Surgery CAHPS
- CAHPS for PQRS
- CAHPS for MIPS

Additional information including guidance on certain medical conditions and populations can be found [here](#).³

Utilization, Case, and Disease Management

*Utilization Management*⁷

Utilization management (UM) is an ongoing process of assessing, planning, organizing, directing, coordinating, monitoring and evaluating the utilization of healthcare services. The UM Program is a multidisciplinary, comprehensive approach and process to manage resource allocation. The UM process influences systematic monitoring of medical necessity and quality, and maximizes the cost effectiveness of the care and service provided to members. Integral factors in the UM process include:

- Consideration of individual member clinical needs, including those identified with special healthcare needs, cultural characteristics, safety and preferences
- An available and accessible care delivery system
- A diverse network of qualified providers
- Clinically sound, evidence-based medical/behavioral health necessity decision-making tools to facilitate the consistent application of criteria for appropriate utilization of available resources in an efficient and effective manner
- Available and applicable plan benefits

The scope of the UM Program includes an overview of policies, procedures and operation processes related to the delivery of medical care, behavioral health, dental care, and pharmaceutical management, including services and physicians who have an impact on the provision of health care. This includes the evaluation of medical necessity and the efficient use of medical services, procedures facilities, specialty care, inpatient, outpatient, home care, skilled nursing services, ancillary services, pharmaceutical services.

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*Case and Disease Management*⁷

The mission of the Case and Disease Management Departments is to educate members, coordinate timely, cost effective, integrated services for the individual health needs of members to promote positive clinical outcomes. The Case and Disease Management departments utilize multiple data sets to identify and treat high-risk members. These departments employ a multidisciplinary team model to approach outlying members from a variety of perspectives. Case and Disease Management monitors the participation rate of members being managed, the members' satisfaction with management, members' utilization of services, readmission rates, admissions rates and high-end service utilization. Case and Disease Management also reviews continuity of care between member's behavioral health care services and their medical care services for those members who are receiving both. Data are reported to the Utilization Management Advisory Committee (UMAC) and the Quality Improvement Committee (QIC) on a quarterly basis.⁷

*Clinical Practice Guidelines (CPGs)*⁷

The Plan uses Clinical Practice Guidelines (CPGs) to help practitioners and members make decisions about appropriate health care for specific clinical circumstances and behavioral health services. Clinical Practice Guidelines are reviewed annually or more frequently if national guidelines change. While clinical judgment may supersede the CPGs, the guidelines aid Providers with guidelines centered on procedures, pre-appraised resources and informational tools to assist in applying evidence from research in the care of individual members and populations.

The CPGs are based on medical evidence and are relevant to the population served. Guidelines support quality and efficiency of care by establishing guidance to improve care for behavioral health, chronic disease, and preventive care. When there are differing opinions noted by national organizations, the Plan will default to the member's benefit structure as deemed by state contracts and Medicaid and Medicare regulations. If there is no specific language pertaining to the topic, the Plan will default (in order) to the following:⁷

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

The Plan adopts guidelines from recognized sources or feedback of board certified practitioners from appropriate specialties that would use the guideline. Evidence of appropriate specialties involvement may also come through:

- Participation on a committee; or
- Consideration of comments from practitioners to whom guidelines were circulated.

CPGs are posted on the Plan website, in the provider section, as well as distributed via newsletters and provider manuals.⁷

Credentialing

Credentialing is the process by which peers evaluate an individual applicant's background, education, training, experience, demonstrated ability, patient admitting capabilities, licensure, regulatory compliance and health status (as applicable). Evaluations are performed through primary and secondary source verifications that are obtained in accordance with regulatory, accreditation as well as WellCare's Corporate policies and procedures. Information and documentation for individual practitioners or facilities is collected, verified, reviewed, and evaluated to approve (or

deny) provider network participation. Approved providers are assigned a specialty and scope of practice that is consistent with their boards of certification, accredited training or licensure, as applicable. Specialty designations and delineation of scope of services of approved facilities is consistent with recognized industry service standards and/or standards of participation developed by WellCare Corporate that may include certification, licensure, and/or accreditation, as applicable to provider type. Re-credentialing of a provider shall be undertaken at least every 36 months. This includes monitoring and evaluation of the quality and appropriateness of patient care; clinical performance' and utilization of resources of providers.

The Medical Director is responsible for peer review activities. Peer reviews are conducted during the investigation of quality of care or service concerns; this includes potential compromises of member safety. There are multiple reasons for the initiative of an investigation including adverse/sentinel events, member complaints, over/under utilization comparisons and coordination/continuity of care statistics. The scope of the review encompasses medical, behavioral, and pharmaceutical services as applicable and determines if there is evidence of poor quality.

The WellCare Credentialing and Peer Review Committee is the principal physician committee that reviews and makes recommendations on credentialing, re-credentialing, and peer review activity for quality of care or conduct issues. The Committee is chaired by a Medical Director and membership includes a credentialing department designee and at least one participating physician. The Credentialing Committee reports to the Quality Improvement Committee on a quarterly basis.⁷

Related WellCare Guidelines

WellCare has a library of CPGs on a variety of behavioral, chronic, and preventive conditions. Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

In addition to CPGs, WellCare has published the following Clinical Policy Guiding Documents: *CPG Hierarchy*; *Health Equity, Literacy, and Cultural Competency*; and *Long Term Services and Support (LTSS)*.

References

1. Provider Manual. WellCare Web site. <https://www.wellcare.com/Georgia/Providers/Medicare>. Published 2017. Accessed November 7, 2017.
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4. Medicare Health Outcomes Survey. Centers for Medicare and Medicaid Services Web site. <http://www.hosonline.org/>. Accessed November 7, 2017.
5. 2017 Star ratings. Centers for Medicare and Medicaid Web site. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-12.html>. Accessed November 7, 2017.
6. HEDIS® and Quality Compass®. NCQA Web site. <http://www.ncqa.org/hedis-quality-measurement/what-is-hedis>. Accessed November 7, 2017.
7. WellCare, Inc. 2017 Quality Improvement Program Description. Internal document. Accessed February 19, 2018.

Disclaimer

Clinical Policy Guiding Documents (CPGDs) are made available by WellCare are informational in nature and are not a substitute for the professional medical judgment of treating physicians or other health care practitioners. CPGDs are based on information available at the time and may not be updated with the most current information available at subsequent times. Individuals should consult with their physician(s) regarding the appropriateness of care or treatment options to meet their specific needs or medical condition. Disclosure of a CPGD is not a guarantee of coverage and is not intended to be used for Utilization Management Decisions or for claims. Members of WellCare Health Plans should consult their individual coverage documents for information regarding covered benefits. WellCare does not offer medical advice or provide medical care, and therefore cannot guarantee any results or outcomes. WellCare does not warrant or guarantee, and shall not be liable for any deficiencies in the information contained herein or for any inaccuracies or recommendations made by independent third parties from whom any of the information contained herein was obtained. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ WellCare Prescription Insurance ~ WellCare Texan Plus (Medicare – Dallas and Houston markets)
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
3/1/2018	<ul style="list-style-type: none"> • Approved by MPC. New.