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## Quality Management Program overview

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

The goals of the Independence QM Program include:

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

Our relationships with our network Providers are essential in achieving our quality goals. Since our Providers deliver care to our Members, our role is to assist their efforts and to provide the tools and information they need to maintain the highest standards of care. Likewise, participating network practitioners have a role in supporting the QM Program. They contribute to the planning, design, implementation, and review of the QM Program, policies, and goals through the Clinical Quality Committee and other quality committees, which include network Providers as voting Members.

For more information about our QM Program, including goals and activities, please visit *www.ibx.com* or call Customer Service at 1-800-ASK-BLUE. Members should call the Customer Service telephone number listed on their ID card.

### Provider obligation to cooperate with the QM program

All participating Providers are required to allow the Plan to use performance data for developing and implementing clinical and service quality improvement activities, public reporting to consumers, preferred status designation in the network, and cost sharing arrangements. All Providers are expected to cooperate with the QM Program, including requests for information and actions to support Member safety activities, complaint and occurrence inquiries, coordination of care, adherence to standards of care, non-discrimination, and other efforts to promote the health and well-being of our Members. Independence requires access to member medical records at times for a variety of purposes. Providers are responsible for providing member medical records for any member they treat, upon request, and coordinating with any file management vendors. In general, medical records must be provided at no charge to Independence. Please refer to your provider agreement for specific terms and exceptions.

## Quality Management activities

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

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

## Member safety activities

Nothing is more important than the safety of our Members when receiving clinical care. The QM Program investigates all quality of care complaints and occurrences for quality issues. There are a variety of ways the QM Program is alerted to potentially suboptimal care or medical errors that could impact safety for our Members: Member and Provider complaints and grievances, patient safety claim codes and never event reports, care management and coordination team reviews, records audits, appeals, and other sources. Through ongoing education and sharing of effective safety practices, close monitoring of quality data, and collaboration among health care providers, hospitals, consumers, purchasers, and other stakeholders the QM Program is able to enhance and promote patient safety for our members. Our member safety activities include:

- monitoring and assessing reported safety concerns related to health care delivery to our Members;
- close monitoring of quality, claim, and safety data sources to identify and respond to trends;
- alerting Providers to potential safety concerns and gaps in care for individual Members in their care;
- monitoring the coordination of care of our Members, including between medical and specialty care and medical and behavioral healthcare;
- identifying processes and practices that have potential to contribute to the reduction of medical and medication errors within our network;
- developing and disseminating information to Providers to promote safe clinical and prescribing practices and optimal outcomes;
- educating Members about patient safety and their role in reducing medical and medication error;
- evaluating the impact of Member safety interventions on our Members' health outcomes;

- recognizing and highlighting facilities that meet quality standards and demonstrate superior outcomes through our Blue Distinction Center® and Blue Distinction Center Plus® Specialty Care Designations;
- close collaboration with health care Providers, hospitals, consumers, and other stakeholders through the Partnership for Patient Care and other collaborations.

## Member complaint process

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

On receipt of a complaint, QM Complaint Coordinators assess and document the nature of the complaint, categorize it, and initiate an investigation involving review by a Medical Director for quality of care complaints and Clinical QM Specialists for quality of service complaints. Occurrences are assessed by Clinical QM Specialists, who document the nature of the occurrence, categorize it, and initiate an investigation involving review by a Medical Director.

Complaint and occurrence investigations include correspondence with the Provider and/or facility involved and may include requests for records. Requested records must be provided within 30 days. ***Failure to respond to inquiries regarding complaints and occurrences will result in an escalation of the assigned severity of the complaint or occurrence.*** Providers with complaints or occurrences assigned escalated severity levels may be subject to further peer review and corrective action, as appropriate. Providers are notified of any review of potential quality issues and the determination of any investigation in writing. If the Medical Director determines that there was an actual significant adverse effect on the Member, a corrective action plan addressing the quality issue identified will be requested.

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

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

## Monitoring of continuity and coordination of care

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

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

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

- exchange of information between Providers;
- appropriate diagnosis, treatment, and Referral of behavioral health disorders commonly seen in primary care;
- appropriate use of psychotropic medications;
- primary or secondary preventive behavioral healthcare program implementation;
- management of treatment access and follow-up for Members with co-existing medical and behavioral health disorders
- special needs of Members with severe and persistent mental illness.

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

## Blue Distinction®

Blue Distinction® was created by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross® and Blue Shield® Plans, to give consumers more information to make informed health care decisions and to work with Providers to improve health care quality outcomes and affordability.

### Blue Distinction® Specialty Care

Our centers of excellence program, Blue Distinction Specialty Care, focuses on hospitals and other healthcare facilities that excel in delivering safe, effective treatment for specialty procedures. Specialties include: Bariatric (weight-loss) Surgery, Cardiac Care, Cellular Immunotherapy, Gene Therapy, Knee and Hip Replacement, Maternity Care, Spine Surgery, Substance Use Treatment and Recovery, and Transplants. The Blue Distinction Center for Fertility Care designation recognizes practitioners rather than facilities.

Specialty Care recognizes providers at two levels:

- **Blue Distinction Center.** Demonstrates quality care, treatment expertise, and better overall Member outcomes.
- **Blue Distinction Center+.** Demonstrates more affordable care, in addition to meeting Blue Distinction Center quality criteria.

Blue Distinction Centers for Specialty Care are recognized and are searchable based on the distinction in the online Find a Doctor tool:

- **Commercial Members:** *www.ibx.com/Providerfinder*
- **Medicare Advantage Members:** *www.ibxmedicare.com/Providerfinder*

Specialty Care Providers can also be found on the BCBSA's National Doctor and Hospital Finder at *www.bcbs.com/find-a-doctor*. Some benefit designs offer Members reduced cost sharing for choosing a Blue Distinction Center or Blue Distinction Center+ for their care.

The QM Program facilitates applications for Blue Distinction recognition. For more information about Blue Distinction Center Specialty Care, including criteria, visit the BCBSA website at *www.bcbs.com/about-us/capabilities-initiatives/blue-distinction/blue-distinction-specialty-care.*

## Rights and responsibilities

### Commercial Member rights

A Commercial Member has the *right* to:

- receive information about Independence, its benefits, services included or excluded from coverage, policies and procedures, participating practitioners/Providers, and Members' rights and responsibilities. Written and Web-based information provided will be in a manner and format that is easily understood and readily accessible.
- be treated with courtesy, consideration, respect, and be recognized for his or her dignity and right to privacy;
- participate with practitioners in making decisions about his or her health care;
- voice complaints or appeals about Independence or the care it provides and receive a timely response about the disposition of the appeal/complaint and the right to further

appeal, as appropriate.

- make recommendations regarding our Member rights and responsibilities policy by contacting Customer Service;
- choose practitioners within the limits of covered benefits, availability, and participation within the Independence network;
- have confidential treatment of personally identifiable health/medical information. Members also have the right to have access to their medical record, and ask that it be amended or corrected, in accordance with applicable federal and State laws.
- be given reasonable access to medical services;
- receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, health status, genetic information, color, religion, gender, national origin, source of payment, utilization of medical or mental health services or supplies, or other unlawful basis including, without limitation, the filing by such Member of any complaint, grievance, appeal or legal action against Professional Provider, a Group Practice Provider (if applicable) or Independence;
- formulate and have advance directives implemented.
- obtain a current directory of participating practitioners in the plan's network, upon request. The directory includes addresses, telephone numbers, and a listing of Providers who speak languages other than English.
- file a complaint or appeal about the health plan or care provided with the applicable regulatory agency and to receive an answer to those complaints within a reasonable period of time and to be notified of the disposition of an appeal or complaint and further appeal, as appropriate.
- appeal a decision to deny or limit coverage, first within the plan and then through an independent organization for a filing fee, as applicable. A doctor cannot be penalized for filing a complaint or appeal on a Member's behalf.
- for Members with chronic disabilities, the right to obtain assistance and Referrals to Providers with experience in treatment of their disabilities.
- have candid discussions of appropriate or Medically Necessary treatment options and alternatives for his or her conditions, regardless of cost or benefits coverage, in terms that the Member understands, including an explanation of their complete medical condition, recommended treatment, risks of treatment, and expected results reasonable medical alternatives. If the Member is not capable of understanding this information, an explanation shall be provided to his or her next of kin or guardian and documented in the member's medical record.
- have available and accessible services when Medically Necessary, including availability of care 24 hours a day, 7 days a week, for urgent and emergent conditions;
- call 911 in a potentially life-threatening situation without prior approval from Independence and have Independence pay per contract for a medical screening evaluation in the emergency room to determine whether an Emergency medical condition exists;
- continue receiving services from a Provider who has been terminated from the Independence network (without cause) in the time frames as defined by applicable State requirements of the Member's benefit plan. This continuation of care does not apply if the Provider is terminated for reasons that would endanger the Member, public health or safety, breach of contract, or fraud.

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

- be free from balance billing by Participating Providers for Medically Necessary services that were authorized or covered, except as permitted for copayments, coinsurance, and deductibles by contract;
- be free from lifetime or yearly dollar limits on coverage of essential health benefits;
- be free from unreasonable rate increases and to receive an explanation of rate increases of 15% or more before the Member's premium is raised;
- receive prompt notification of terminations or changes in benefits, services, or Provider network.
- have a choice of specialists among Participating Providers following an authorized Referral, as applicable, subject to their availability to accept new patients;
- choose an individual On-Exchange health plan rather than the one offered by an employer and to be protected from employer retaliation.
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

## Commercial Member responsibilities

A Commercial Member has the *responsibility* to:

- communicate, to the extent possible, information that Independence and Participating Providers need in order to provide care;
- follow the plans and instructions for care that he or she has agreed on with his or her practitioners. This includes consideration of the possible consequences of failure to comply with recommended treatment.
- understand his or her health problems and participate in developing mutually agreed upon treatment goals, to the degree possible;
- review all benefits and Membership materials carefully and to follow the rules pertaining to the health plan;
- ask questions to assure understanding of the explanations and instructions given;
- treat others with the same respect and courtesy expected for him or herself;
- keep scheduled appointments or give adequate notice of delay or cancellation;
- pay deductibles, coinsurance, or copayments, as appropriate, according to the Member's contract;
- pay for charges incurred that are not covered under, or authorized under, the Member's benefit policy or contract;
- for point of service contracts, to pay for charges that exceed what Independence determines as customary and reasonable (usual and customary, or usual, customary and reasonable, as appropriate) for services that are covered under the out-of-network component of the Member's benefit contract.

## Medicare Advantage HMO and PPO Member rights

A Medicare Advantage HMO or PPO Member has the *right* to:

- be treated with courtesy, fairness, respect, and recognition of his or her dignity and right to privacy;
- receive health care services without discrimination based on race, ethnicity, age, mental or

physical disability, health status, genetic information, color, religion, gender, sexual orientation, national origin or source of payment;

- confidential treatment of personally identifiable health/medical information. Members also have the right to have access to their medical record in accordance with applicable federal laws.
- know treatment choices and participate with Providers in making decisions about his or her health care in clear language the member can understand;
- get information in a way the Member understands from Medicare, health care providers, and, under certain circumstances, contractors;
- get information in a way the Member understands about Medicare and get answers to questions to help him or her make health care decisions, including what is covered, how doctors are paid, what Medicare pays, and how much they have to pay;
- choose participating doctors, specialists, and hospitals for medically necessary services within the limits of covered benefits, subject to their availability to accept new patients;
- candid discussions of appropriate or Medically Necessary treatment options for his or her medical conditions, regardless of cost or benefits coverage;
- see Independence providers and get covered health services and drugs within a reasonable period of time, in a language the member can understand and in a culturally sensitive way;
- get emergency care when you need it;
- use advance directives (such as a living will or a power of attorney);
- voice complaints (sometimes called grievances) or appeals about Independence or the care it provides and receive a timely response. Members have a right to be notified of the disposition of appeals/complaints and the right to further appeal, as appropriate;
- get information about Independence, its benefits, its services included or excluded from coverage, its Providers, and Member rights and responsibilities. Written and web-based information provided will be readable and easy to understand;
- make recommendations regarding our Member Rights and Responsibilities policy;
- get a decision about health care payment, coverage of services, or prescription drug coverage before getting services. If you disagree with the decision of your claim, you have the right to file an appeal.
- to be free from lifetime or yearly dollar limits on coverage of essential health benefits;
- to be free from unreasonable rate increases and to receive an explanation of rate increases of 15% or more before your premium is raised.

## Medicare Advantage HMO and PPO Member responsibilities

A Medicare Advantage HMO or PPO Member has the *responsibility* to:

- give Independence and Participating Providers the information they need in order to provide care (to the extent possible);
- follow the treatment plans and instructions for care that he or she has agreed upon with his or her practitioners. This includes consideration of the possible consequences of failure to comply with recommended treatment;

- be considerate and act in a way that helps the smooth running of Providers' offices and facilities;
- pay premiums and any cost-sharing owed for Covered Services and meet other financial responsibilities as described in the Evidence of Coverage;
- understand his or her health problems and participate in developing mutually agreed upon treatment goals, to the degree possible;
- advise Independence of any questions or concerns;
- notify Providers that he or she is enrolled in the health plan when seeking care (unless it is an Emergency);
- notify the health plan if he or she has additional health insurance or prescription drug coverage;
- notify the health plan if he or she moves.

### Hospital responsibilities

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

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

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

## Medical record keeping standards

A medical record documents a Member's medical treatment, past and current health status, and treatment plans for future health care and is an integral component in the delivery of quality health care. As such, we routinely distribute our established medical records standards.

## Medical record content and documentation standards

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

The History and physical should contain:

1. **History of present illness.**
2. **Past medical history**
   - A Past medical history (for patients seen three or more times) that is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
3. **Medications and allergies**
   - Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
   - Documentation of medications that are current and updated.
   - Documentation of food and other allergies, such as shellfish or latex, that may affect medical management.
4. **Family or social history**
   - For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history).
5. **Prevention screening**
   - An immunization record (for children) that is up to date or a suitable history has been made in the medical record (for adults).
   - Preventative, and risk screening.
   - Evidence that preventive screening and these services are offered in accordance with the organization's practice guidelines.
6. **Review of systems- physical exam**
7. **Data collection- tests**
8. **A problem list**
   - Significant illnesses and medical conditions are indicated on the problem list.
   - Unresolved problems from previous office visits are addressed in subsequent visits.
9. **Diagnoses**
   - The documentation of clinical findings and evaluation for each visit is included.
10. **Treatment plan**
    - Working diagnoses are consistent with findings.
    - Treatment plans are consistent with diagnoses.
    - There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
    - Laboratory and other studies are ordered, as appropriate.

## Medical record keeping system

Information filed:

1. All services provided directly by a practitioner who provides primary care services.
2. All ancillary services and diagnostic tests ordered by a practitioner.

3. All diagnostic and therapeutic services for which a member was referred by a practitioner, such as:
   - home health nursing reports
   - specialty physician reports
   - hospital discharge reports
   - physical therapy reports
4. An advance directive that is prominently documented in each adult (18 and older) member's medical record. Information as to whether the advance directive has been executed also noted.
5. Records of hospital discharge summaries and emergency room/department visits.
6. If a consultation is requested, there is a note from the consultant in the record.
7. Laboratory and other studies ordered.

Standards for availability and retrieval:

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

Organization:

1. Each page in the record contains the patient's name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status. Consider including race, ethnicity, primary language, sexual orientation, and gender identity.
3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier, or initials.
4. All entries are dated.
5. There is review for under - or overutilization of consultants.
6. The record is legible to someone other than the writer.
7. Encounter forms or notes that have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or on a schedule deemed necessary.
8. Specialty physician, other consultation, laboratory, and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify review. Review and signature by professionals other than the ordering practitioner do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.

## Confidentiality

1. Protected Health Information (PHI) must be protected against unauthorized or inadvertent disclosure.
2. Medical records must be safeguarded against loss or destruction and maintained

according to state requirements. At a minimum, medical records must be maintained, beginning on the date of the last medical service, for at least 11 years, or age of majority plus six years, whichever is longer.

3. Medical Records must be stored securely in a way that allows access by authorized personnel only.
4. Staff must receive periodic training on health information confidentiality.

### Monitoring and performance goals

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

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

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

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

## Maintenance of records and audits

### Medical and other records

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

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

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