

QUALITY OF CARE ASSESSMENT GUIDELINES  
Adopted as amended, May 8, 1996

This policy is set forth to assure quality plan/provider performance and peer review activities are conducted. Quality improvement/quality of care activities should consistently reflect evidence that effective corrective action was taken when indicated.

1. A governing body with ultimate responsibility and authority for development of the Quality Management Program evidenced by routine and periodic meetings with documentation of ongoing program oversight.
2. A written Quality Management Program description to periodically and systematically monitor and evaluate patient care and service.
  - A. Written program objectives;
  - B. Implementation design; and
  - C. Scope, function and authority.
  - D. Evidence or coordination with the Utilization Management program.
  - E. Periodic evaluation of program effectiveness with evidence of changes as appropriate.
3. Written policies and procedures for periodic survey and evaluation of patient satisfaction.
4. Evidence of appropriate availability and accessibility of after hours urgent care and/or emergency care services for members.
5. The Health Maintenance Organization shall collect and analyze data for the purpose of identifying opportunities for improvement.
6. Written policies and procedures identifying the rights and responsibilities of patients and a mechanism for member grievance, which are readily available to the member.

Grievance means a complaint submitted in writing in accordance with the health maintenance organizations' (HMO) formal grievance procedure by or on behalf of the enrollee regarding the interpretation of the certificate of coverage or dissatisfaction with the quality of health care provided by the HMO employee or a contracted provider.

7. An ongoing credential and periodic re-credential process of licensed independent practitioners, which will minimally include verification of maintenance of licensure and absence of sanctions.

These standards have been adopted by the Kansas Insurance Department for application by accrediting agencies to monitor each HMO in Kansas.

KANSAS MANAGED HEALTH CARE ASSOCIATION  
QUALITY ASSURANCE PROGRAM REVIEW  
INSTRUCTIONS FOR REVIEW ORGANIZATIONS

As required by [K.S.A. 40-3211\(b\)](#), at least once every three years and at other such times as the Kansas Insurance Commissioner may require, a managed health care organization shall obtain an on-site quality of care review. This review must be conducted by an independent quality review organization acceptable to the commissioner. The purpose of this review is to evaluate the quality of health care delivery according to prevailing industry standards.

The review organization is expected to examine the managed health care organization in the context of the entire time frame of the review period and make a determination about its current ability to monitor and improve quality.

The Kansas Managed Health Care Association has developed 7 quality assurance guidelines that the Kansas Insurance Department (KID) has approved for use in this review.

Upon completion of the review, the reviewing organization prepares a letter to the KID. This letter must state that the guidelines have been considered in the review and must indicate the level of compliance for each of the 7 guidelines. The managed health care organization should be reported as compliant, non-compliant, or in qualified compliance with each guideline. If all of the guidelines are reported as compliant or in qualified compliance, the review organization indicates a favorable opinion for the review. If any of the guidelines are judged non-compliant, the review is reported as unfavorable.

The qualified compliance designation is to be used under limited circumstances and only with KID approval;

- If the managed health care organization has a very low membership that prevents adequate assessment of the effectiveness of the QA program, the organization may be considered in qualified compliance with some guidelines.

To apply a qualified compliance for any QA guideline the review organization must confirm that the following criteria are met.

- The managed health care organization must have an appropriate structure and process capable of demonstrating effectiveness when the membership increases over time.
- A time frame for a review site visit to the managed health care organization must be established by the review organization and approved by the KID. This time frame may be extended with KID approval.