

JAI MEDICAL SYSTEMS
MANAGED CARE ORGANIZATION, INC.

QUALITY ASSURANCE PROGRAM DESCRIPTION

2026

Quality Assurance Program

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I. Quality Assurance Program Description

Please Note:

This program description was prepared in response to the requested pre-site documents for the EQRO Annual Systems Performance Review. The entirety of the 2026 Quality Assurance Program is located in the administrative offices of Jai Medical Systems. The Quality Assurance Program includes, but is not limited to the Utilization Review Plan, Credentialing/Recredentialing Plan, Availability & Access, Enrollee Rights and Responsibilities, Continuity of Care (including Case Management and Disease Management Programs), Health Education Plan, and Outreach Plans. All of these documents are an integral part of the Quality Assurance Program and were submitted in separate binders as part of the requested pre-site documents.

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A. ORIENTATION

The Jai Medical Systems Managed Care Organization, Inc.(Jai Medical Systems) Quality Assurance Program has been specifically designed to monitor, measure, evaluate, and improve the quality of health care that members of Jai Medical Systems receive. The Jai Medical Systems Quality Assurance Program is in compliance with the guidelines of care specified in the Centers for Medicare and Medicaid Services (CMS) Health Care Quality Improvement System.

The Quality Assurance Program is centered around the internal Quality Assurance Plan of Jai Medical Systems and relies on the active participation of several parties including Medicaid recipients, the Quality Assurance Committee, Health Care Providers, the Maryland Department of Health (MDH), and CMS. The goal of the Jai Medical Systems Quality Assurance Program is to maximize the quality of health care Jai Medical Systems members receive. Jai Medical Systems defines Quality Assurance and its vision below:

Definition: Jai Medical Systems defines Quality Assurance as a continuous process designed to:

- Monitor and evaluate the adequacy and appropriateness of health care and administrative services;
- Pursue opportunities to assure and/or improve health outcomes and member satisfaction.

Vision: The Jai Medical Systems Quality Assurance Program is designed to promote and facilitate maintenance of good health and a sense of well-being to its members by ensuring access to superior quality health care for members.

What follows is a detailed description of the current Quality Assurance Program of Jai Medical Systems which was developed by the Jai Medical Systems Quality Assurance Committee and approved by the Jai Medical Systems Board of Directors (BOD). The Program is reviewed and updated on an annual basis. It includes the major features addressed in the CMS Health Care Quality Improvement System document, i.e.:

1. Ensuring that the process of quality assessment and improvement is systematic.
2. Addressing the accountability and supervision of the Quality Assurance Committee by the Board of Directors.
3. Describing the structure and process of an active Quality Assurance Committee.
4. Ensuring the provision of adequate staffing and material resources to the active Quality Assurance Committee.
5. Requiring active participation from Jai Medical Systems' health care providers on the Quality Assurance Committee.
6. Demonstrating the implementation responsibilities of various aspects of the Quality Assurance Program.
7. On-going credentialing and recredentialing processes.
8. Updated member rights and responsibilities policies and principles.
9. Updated policies regarding member availability of and access to health care.
10. Updated policies regarding standards for keeping medical records.
11. Utilization Management policies.

12. Ensuring the continuity of care across the life span and/or across disciplines at any point in time.
13. Procedures for coordination of Quality Assurance Activities with other management activities within Jai Medical Systems.

B. PURPOSE

The purpose of the Jai Medical Systems Quality Assurance Program is to provide a formal process for continuously and systematically monitoring and evaluating the adequacy and appropriateness of health care services, as well as administrative services, received by the members of Jai Medical Systems. This proactive process provides the mechanisms to study and review multifaceted components of managed health care, to recommend changes when opportunities to improve are identified, to incorporate recommended enhancements, and to re-examine the components to assure improvements because of the process.

C. GOAL

The goal of the Quality Assurance Program is to ensure that the health care provided to members is of the highest possible quality. This goal is achieved through continuous, systematic monitoring, evaluation, and improvement of all aspects of the operation of Jai Medical Systems. Essential components of this goal include:

1. Complaint specific care and general well-member care;
2. Access to care;
3. Continuity and coordination of care;
4. Qualified providers of primary, specialty and tertiary care;
5. Appropriate support services and equipment;
6. All health care meets patient safety guidelines
7. Regular quality assessment.

D. OBJECTIVES

The Quality Assurance objectives of Jai Medical Systems are designed to capture opportunities to improve member health status, member safety, and services by:

1. Overseeing, monitoring, and reviewing the adequacy of health care delivery; and making recommendations to improve health and administrative services utilizing problem identification, analysis, and resolution processes. This process includes, but is not limited to medical record review, adverse outcomes, target diagnoses, case management, and member and provider satisfaction surveys;

2. Conducting provider credentialing and recredentialing and incorporating Quality Assurance data into the process to develop and promote quality provider networks. This will facilitate identifying those providers who do not meet minimum standards of Jai Medical Systems and will promote further improvement by all network providers;
3. Consistently monitoring guidelines in the pre-certification process. Guidelines are applied as tools to detect and prevent over/under utilization of health services;
4. Establishing common quality assurance and improvement goals and objectives for all departments within Jai Medical Systems, periodically monitoring attainment of goals, and developing action plans for improvement;
5. Maintaining the confidentiality of data relating to individual members and/or providers;
6. Promoting ongoing professional peer review of participating providers to assure maintenance of professional integrity, adherence to the standards of Jai Medical Systems, and the delivery of high quality health care;
7. Evaluating member satisfaction through the use of member satisfaction surveys;
8. Monitoring and reviewing the adequacy of health care delivery; and continuing to improve health and administrative services utilizing problem identification, analysis, and resolution;
9. Monitoring compliance with utilization review and quality assurance regulations which may be established by local, state, or federal authorities;
10. Maintaining external accreditation and Maryland Department of Health (MDH) approval;
11. Initiating actions to study and address impact of problems/issues affecting Jai Medical Systems' members and providers;
12. Establishing, documenting, and updating standards of care after identifying specific health related needs. Monitoring compliance with Standards to promote improved quality of care;
13. Maintaining quality assurance oversight of delegated services;
14. Maintaining open lines of communication with providers, internal management areas linked to Quality Assurance, and MDH to facilitate the flow of quality assurance data. Data may be useful in improving health care and administrative services to members;
15. Communicating Quality Assurance Program expectations to members and providers after revision of current medical standards of care and/or development of additional standards of care;
16. Allocating adequate staff resources to the Quality Assurance Program to facilitate monitoring of clinical activity and administrative services;
17. Promoting and providing ongoing education for the Quality Assurance Committee members;
18. Utilizing internal and external resources to improve study design and analysis.
19. Increasing the cultural competency of staff and contracted providers and continuing to monitor member satisfaction with staff and provider cultural competency. Providing cultural competency training at least annually, on request, and when issues are identified.
20. Creating, following, and evaluating our Culturally and Linguistically Appropriate Services (CLAS) Program annually. (Please see the CLAS Program Description.)

Goals for the Coming Year

The following items have been identified as goals to focus on in 2026:

Quality Assurance

- ❖ Maintain **NCQA Accreditation** under the **2025 Standards**, with the review occurring in 2026.
- ❖ Improve population health and medication adherence through implementation of a **Statin Compliance Program**, increasing the **SPC (Statin Therapy for Patients with Cardiovascular Disease) score by at least 10 percentage points** compared to MY 2025 performance.
- ❖ Support network providers in the **accurate and appropriate use of CPT II codes** through targeted education and technical guidance.

Customer Service

- ❖ Improve the **timeliness of the Welcome Call** to ensure consistent compliance with regulations while completing any missed health risk assessments and assisting new members with their initial PCP appointment.
- ❖ Achieve an above-average Service Level of 95% for at least one quarter.
- ❖ Redesign the **email response workflow** to ensure compliance with timeliness standards and improve the quality, consistency, and accuracy of member communications.

Systems Management

- ❖ Oversee the **configuration, development, testing, and deployment** of the new **Member and Provider Portal**, ensuring a smooth transition of system and validating data accuracy and completeness post-implementation.
- ❖ Ensure **monthly claim audits** are conducted by the Department in accordance with established requirements and documented for compliance review.
- ❖ Monitor the migration from **ClaimsXten to Optum CES**, including configuration, testing, and go-live support. Closely monitor claims processing during deployment to ensure no adverse operational or financial impact and assess new Optum edits with the Executive Team for potential configuration enhancements.

Case Management and Utilization Management

- ❖ Reduce **emergency room utilization** by achieving a measurable reduction in ER visits **among the top 25 ER utilizers** identified in CY2025.
- ❖ Improve discharge planning to reduce **30-day inpatient readmissions** by **3 percentage points**, decreasing from **20% in Q3 2025 to 17% or less in Q3 2026**.

- ❖ Decrease **ER visits within 30 days of an inpatient stay** by **10 percentage points**, reducing from **36% in Q3 2025 to 26% or less in Q3 2026**.

Provider Relations

- ❖ Ensure the **Provider Directory accurately reflects PCP availability**, specifically whether providers are accepting new patients, as validated through the **EQRO Secret Shopper Study**.
- ❖ Maintain **provider engagement** through at least **9 provider communications** throughout calendar year 2026.
- ❖ **Strengthen provider network relationships** by conducting a minimum of **5 PCP office visits** per quarter throughout 2026.

Information Technology

- ❖ Support a network provider group in the **implementation of a new EMR solution**, ensuring appropriate configuration, testing, deployment, training, and operational readiness.
- ❖ Develop and maintain an **inventory of IT Standard Operating Procedures (SOPs)**, assess completion and adequacy, and create additional SOPs as needed to address identified gaps.

E. QUALITY ASSURANCE POLICY

General: It is the policy of Jai Medical Systems to support a proactive Quality Assurance Program that systematically monitors and evaluates the quality and appropriateness of member services and that utilizes the information obtained to pursue opportunities to improve the quality of all services. The major thrust of the program is geared to the prevention of illness and disease, and to the clinical aspects of member care. Service issues, e.g., accessibility and availability of care, are also a program priority and are closely monitored.

Confidentiality: Documents created as part of the quality assurance process are confidential and are maintained in a manner that protects members' and providers' identities. Such paperwork is also in compliance with legal requirements, accrediting standards, and Jai Medical Systems' Confidentiality Policy. These documents include:

- Systematic internal review, including member care and peer review studies;
- Utilization Management studies including reports and recommendations;
- Reports/Minutes of Quality Assurance Committee, Subcommittees, and Task Forces.

Administrative processes are also covered by the Confidentiality Policy. Upon hire, Jai Medical Systems staff, clinical and administrative, sign a statement requiring adherence to Confidentiality Standards.

F. MEMBER SAFETY

Jai Medical Systems is very concerned with protecting member safety and has instituted many safeguards, including programs to prevent pharmaceutical interactions and duplications of

therapy and pre-surgical reviews to prevent unnecessary procedures. Pharmacy DUR reports that are reported quarterly to the P&T Committee look at Pregnancy and Drugs with the Potential for Teratogenicity, Therapeutic Duplication, and Overutilization.

Pharmacy Drug Utilization Review Reports:

Pregnancy and Drugs with Potential for Teratogenicity DUR – HMG CoA Reductase Inhibitors, ACE Inhibitors, angiotensin receptor blockers (ARB's), and warfarin are known to potentially cause fetal harm, in some cases even death, when consumed by a pregnant woman. A DUR is conducted monthly, monitoring for pregnant members receiving these agents concomitantly with prenatal vitamins. In these cases, the prescriber is contacted to verify that the member is pregnant and that the prescriber is aware of the potential for teratogenicity. The majority of the members identified in this review are confirmed to not be pregnant by their doctors and are taking prenatal vitamins because that is what their doctor prescribed.

Therapeutic Duplication DUR Program – The DUR department conducted an analysis of members receiving duplicate therapy for multiple medication classes. Classes were selected based on lack of information in manufacturer's recommendations, clinical literature and treatment protocols that supported combination therapy with multiple agents. The analysis identifies members receiving duplicate agents within the same therapeutic class or treatment category. The classes include non-steroidal anti-inflammatory agents, COX-2 inhibitors, calcium channel blockers, lipid lowering agents, gastrointestinal agents, ACE inhibitors and angiotension receptor blockers. After consulting with the prescriber listed on the claims, most members were identified as transitioning to the second medication.

Overutilization DUR – The DUR department conducted an analysis for possible member overutilization of beta-agonist inhalers. Pharmacy claims data was analyzed to identify all members receiving more than 3 beta-agonist inhalers without concomitant anti-inflammatory therapy.

Overutilization DUR – The Drug Utilization Review department conducted an analysis of members obtaining opioid medications from multiple pharmacies. Pharmacy claims data is analyzed on a quarterly basis to identify all members receiving an opioid prescription from 2 or more pharmacies during the quarter. The notification letter is sent to each of the prescribing physicians and lists the following: drug name and strength, pharmacy, date(s) of service, and prescriber. This notification is intended to make sure that prescribers are aware of what medications their patients are filling so they can determine if there is a need to discuss potential risks of accidental overdose, abuse/addiction treatment services, along with risks and benefits of these medications with their patient.

According to the Drug Use Management Program report, this is the list of the types of prospective DUR alerts utilized by our MCO. The list indicates which alerts result in a claim denial, and whether MCO or PBM overrides the claim denial, if appropriate. Only drug-drug interaction, early refill, and quantity limits (including special ones for emergency contraceptives and glucometers) result in claims denials.

Type of Prospective DUR Alert	Utilized by MCO/PBM		Claim Denial		Claim Denial Override	
	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> MCO	<input checked="" type="checkbox"/> PBM
Drug-drug interaction	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> MCO	<input checked="" type="checkbox"/> PBM
Therapeutic duplication	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> MCO	<input type="checkbox"/> PBM
Drug-disease contraindication	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> MCO	<input type="checkbox"/> PBM
Drug-allergy interaction	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> MCO	<input type="checkbox"/> PBM
Early refill	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> MCO	<input checked="" type="checkbox"/> PBM
Late refill	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> MCO	<input type="checkbox"/> PBM
High dose	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> MCO	<input type="checkbox"/> PBM
Low dose	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> MCO	<input type="checkbox"/> PBM
Incorrect duration of drug treatment	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> MCO	<input type="checkbox"/> PBM
Other – Emergency Contraceptive prescriptions limited to 1 kit/month, 3 kits/year*	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> MCO	<input checked="" type="checkbox"/> PBM
Other – Blood Glucose Meters are limited to 1 device/year*	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> MCO	<input checked="" type="checkbox"/> PBM

Opioid Medication Policy Changes – Jai Medical Systems is partnering with the Maryland Department of Health and the other MCOs to implement more stringent policies regarding prior authorizations for opioids to reduce the opioid-related deaths in Maryland. These new policies were put in place July 1, 2017, and they require prescribers to attest to reviewing the patient’s prescription history along with offering overdose prevention options and other counseling. The changes should help improve member safety across the State. Additional policy changes were made in late 2021 to reduce the number of days an opioid naïve member may fill on an ongoing basis to help reduce the chance of the member becoming addicted to opioids. In 2023, further changes were made to block members from filling opioids concurrently with certain other medications without first receiving prior authorization. This includes certain opioid addiction treatment medications (e.g., buprenorphine with or without naloxone), as well as two or more opioid potentiators (e.g., benzodiazepines, muscle relaxants, sedative hypnotics, gabapentinoids). If the member is receiving an opioid while concurrently filling a single potentiator, the pharmacy has the option to override the soft reject without seeking prior authorization.

In addition, beginning in 2023, automated letters were sent to members filling an opioid who were considered opioid naïve, educating them about the dangers of opioid addiction and important facts about safe handling of opioids as well as resources for help with substance use disorders and other mental health issues.

Utilization Review:

All surgeries that require prior authorization must be approved by the Utilization Management Department. This process ensures that the surgery ordered is medically necessary and that the member is medically cleared and approved by his or her Primary Care Provider before proceeding with the surgery. In addition, annual inter-rater reliability studies are performed involving all personnel involved in medical reviews to ensure that medical necessity criteria is applied appropriately and consistently.

Additional Member Safety Related Actions:

Most of the goals, objectives, and policies in the Quality Assurance Program will help ensure member safety. For example, our credentialing policies are in place, not only to satisfy regulated guidelines, but to assist in the selection of competent practitioners who will follow nationally accepted standards of care. The initial site review of all contracted primary care providers also allows us to evaluate the office site and medical record keeping practices to ensure member safety.

The tracking of potential quality issues, complaints, utilization of services, etc. helps the MCO evaluate the safety of care offered to our members. All of these efforts combined from each department create a plan for increased member safety for the members enrolled in our health plan.

G. STRUCTURE***Oversight***

The Board of Directors is ultimately responsible for overseeing the Quality Assurance Program, including quality of clinical and administrative services, which are provided to members of Jai Medical Systems. The Board of Directors delegates to the Chief Quality Officer and the Quality Assurance Committee the management of activities that monitor and assess the quality and appropriateness of administrative and clinical services provided through Jai Medical Systems. The Board of Directors delegates to the Delegation Committee the review of all delegated vendor activities, including the review of all quarterly and annual reports and documents from vendors. The Board of Directors delegates to the Physician Advisory SubCommittee all credentialing and recredentialing, hospital and ancillary provider contracting, review of clinical guidelines, quality of care concerns, and provider grievances. The Board of Directors delegates to the Policy and Procedure SubCommittee the annual review or revision of policies and procedures. The Board of Directors delegates to the Fraud, Waste, and Abuse Compliance Committee the internal monitoring of all suspected cases of fraud, waste, and abuse, as well as the education of staff, members, and providers regarding federal, state, and internal fraud, waste, and abuse rules and regulations. The Board of Directors delegates to the Utilization Management Department quarterly review of over and under-utilization issues as well as trending statistics. The Board of Directors delegates to the Pharmacy and Therapeutics Committee the oversight of the Drug Use Management Program. Other delegated functions include formulary updates, the development of step therapy protocols, and evaluation of preferred product status proposals.

The Board of Directors delegates to the Information Technology (IT) Integration Committee, the review, monitoring, and prioritization of projects to ensure alignment with business objectives. The Board of Directors delegates to the Information Technology (IT) Security Committee the

security and recovery operations for Jai Medical Systems. The IT Security Committee is responsible for reviewing, monitoring, and assessing the security of the Information Technology department and facilities.

The Board of Directors is comprised of the following participants:

- President/Chief Executive Officer
- Assistant Medical Director
- Vice President
- Chief Compliance Officer
- Corporate Secretary

Committee Structure

Quality Assurance Committee

The Jai Medical Systems Quality Assurance Committee (QAC) is the main advisory body providing oversight of all activities that monitor and assess the quality and appropriateness of health care services provided with the ultimate goals of disease prevention, health maintenance, and improved member outcomes. The QAC has input in the development of tools for monitoring and evaluating health care services, selection and design of clinical studies, and subsequent evaluation of study results with recommendations for improvement, member appeals, and will identify problems and seek alternative solutions to improve all existing services.

Delegation Committee

This subcommittee of the QAC focuses on overseeing the performance and activities delegated to our vendors. The Committee will review all aspects of the customer service related functions, along with the quality assurance functions, delegated to these vendors. The Committee will also ensure the Quarterly UM Committee receives the information needed to review the UM criteria annually and the UM processes on an annual basis. Additionally, the Committee will ensure the PASC has the credentialing information needed for a semi-annual review of delegated credentialing activities, and the Fraud, Waste, and Abuse Compliance Committee has all needed information for a quarterly review of suspected fraud cases. The Delegation Committee will oversee applicable reviews by the Quarterly Utilization Management (UM) Committee, the Physician Advisory Subcommittee, and the Fraud, Waste, and Abuse Compliance Committee, as appropriate. The Committee will report all of its activities and findings to the QAC, which in turn reports to the BOD.

Physician Advisory Subcommittee

The Jai Medical Systems Physician Advisory Subcommittee (PASC) functions primarily in the peer review process. Jai Medical Systems' physicians provide input into physician credentialing and recredentialing, hospital and ancillary provider contracting, review of clinical protocols, quality of care concerns, and provider grievances. Members of the PASC may be actively involved in the medical record review process; function as Jai Medical Systems' consultants in their specialty; and participate with in-service educational programs.

Policy and Procedure SubCommittee

The Jai Medical Systems Policy and Procedure SubCommittee functions primarily in the annual review of policies and procedures. Executive management personnel review policies and procedures to ensure compliance with State and Federal standards and regulations. All significant additions and revisions to policies and procedures are included in an Annual Report that is presented to the Board of Directors for approval.

Pharmacy and Therapeutics Committee

The Jai Medical Systems Pharmacy and Therapeutics Committee (P&T Committee) is responsible for the development, evaluation, implementation, and maintenance of the formulary and the Drug Use Management Program. The function of the P&T Committee includes the evaluation of proposed product additions and deletions, the development of step therapy protocols, and the evaluation of preferred product status proposals utilizing peer reviewed medical preferences, primary research, and medical standards of practice. Decisions may be based upon information or recommendations provided by our pharmacy vendor's Formulary Committee regarding drug-specific parameters, including side effect profiles, pharmacodynamics, pharmacokinetics, and cost effectiveness.

The P&T Committee also evaluates the prospective and retrospective DUR criteria on an annual basis. The P&T Committee's decisions regarding the criteria used may be based on recommendations provided by our pharmacy vendor, as well as the Maryland Department of Health.

Fraud, Waste, and Abuse Compliance Committee

The Jai Medical Systems Fraud, Waste, and Abuse Compliance Committee (Compliance Committee) plays an integral role in seeking out potential and/or suspected fraud, waste, and abuse in areas including, but not limited to, encounter data, claims submission, claims processing, billing procedures, underutilization, overutilization, customer service, enrollment and disenrollment, and marketing. The Compliance Committee is also responsible for the appropriate annual fraud, waste, and abuse education of Jai Medical Systems staff, members, and providers. Additionally, the Compliance Committee ensures adherence with state and federal regulations as well as internal policies and procedures concerning fraud, waste, and abuse.

Quarterly Utilization Management Committee

The Utilization Management Department began holding quarterly meetings in April 2005 in addition to their weekly Utilization Management meetings. These quarterly meetings focus primarily on issues of over and underutilization as well as trending statistics. As over and underutilization issues permeate all disciplines within Jai Medical Systems, guest speakers from within other departments are invited, as necessary, to address specific subjects.

The Information Technology Integration Committee

The Information Technology (IT) Integration Committee reviews, monitors and prioritizes major IT projects from a cross-functional perspective. The purpose of the IT Integration Committee is to assist with IT project prioritization, change management approval, and IT strategic planning. This Committee should help us realize better IT project priority setting, as well as improved alignment with business objectives.

The Information Technology Security Committee

The Information Technology (IT) Security Committee reviews, monitors and assesses the facilities and security footing of Jai Medical Systems, with particular focus on the Information Technology department. The purpose of the IT Security Committee is to direct and control risk assessments and mitigation including organizational security, network and storage security, physical assess controls, business continuity planning, and disaster recovery. This Committee will help us realize enhanced organizational security and recovery operations.

Membership

Quality Assurance Committee

The Jai Medical Systems Quality Assurance Committee (QAC) is composed of representatives of all functions integral to the operations of Jai Medical Systems, i.e., health care providers and administrative staff (including subcontractors).

The Quality Assurance Committee (QAC) includes the following participants:

- Medical Director of Quality Assurance
- President / Chief Executive Officer
- Vice-President
- Chief Medical Officer
- Assistant Medical Director
- Chief Operating Officer
- Chief Quality Officer
- Chief Financial Officer
- Chief Compliance Officer
- Chief Information Officer
- Chief Data and Analytics Officer
- Quality Assurance Leadership
- Director of Provider Relations
- Customer Service Leadership
- Marketing Manager
- Special Needs Coordinator
- Health Equity Director
- Program Integrity Director
- Director of UM and Nursing
- Laboratory Representative
- Utilization Review Specialists
- Case Managers
- Data Analysts
- Quality Assurance Specialists
- Customer Service Representatives
- Comptroller
- Administrative Staff
- Officer Managers
- Pharmacy Benefits Manager
- PASC Representative

- Laboratory Representative
- Certified Medical Assistants
- Representatives from contracted hospitals
- Representatives from contracted specialty networks
- Home Health Care Representative
- Representatives from other subcontractors

Physician Advisory SubCommittee

The Physician Advisory SubCommittee (PASC) is composed of physicians representing major clinical specialties as well as representatives from internal departments which are directly involved in health care delivery services. The term for physician representatives is rotational (minimum 2 years); administrative members serve on a permanent basis.

The PASC is composed of the following participants:

- Medical Director of Quality Assurance
- Jai Medical Systems Physicians (Representatives from primary care and specialties)
- Director of Provider Relations
- Chief Quality Officer

Policy and Procedure SubCommittee

The Policy and Procedure SubCommittee is composed of Jai Medical Systems' executive management team representing internal departments which are directly involved with compliance with State, Federal, and NCQA standards and regulations. Departmental Directors are often solicited or invited to SubCommittee meetings when policies and procedures pertaining to their department are under review. The Policy and Procedure SubCommittee is composed of members of senior management, including the Chief Quality Officer and the Chief Compliance Officer.

Pharmacy and Therapeutics Committees

The Pharmacy and Therapeutics (P&T) Committee is composed of physician practitioners, Pharm.D.s, registered pharmacists, and members of the Board of Directors.

The P&T Committee is composed of the following participants:

- Assistant Medical Director
- No less than three physician practitioners
- No less than one Pharm. D. or RPh.

Fraud, Waste, and Abuse Compliance Committee

The Fraud, Waste, and Abuse Compliance Committee is composed of Jai Medical Systems' executive management team representing internal departments which are directly involved with the compliance of State and Federal standards and regulations concerning fraud, waste, and abuse. As necessary, Departmental Directors, administrative staff, providers, etc., are invited to attend Compliance Committee meetings.

The Fraud, Waste, and Abuse Compliance Committee is composed of at least the following participants:

- The Program Integrity Director
- The head or designee of the Customer Service Department
- The head or designee of the Provider Relations Department
- A budgetary official

Quarterly Utilization Management Committee

The quarterly meetings of the Utilization Management Department are composed of Jai Medical Systems' executive management team representing internal departments which are directly involved with the monitoring and review of issues of over and under-utilization and trending statistics. Guest speakers from other departments are invited, as necessary, to address specific subjects.

The Utilization Management Department Quarterly Meeting is composed of the following participants:

- Chief Medical Officer
- UR Physician Advisor
- Director, Utilization Management and Nursing
- Chief Quality Officer
- UR/CM Staff

The Delegation Committee

Membership will consist of the Chief Quality Officer, the Quality Assurance staff, the Program Integrity Director, leadership from Customer Service, the Director of Utilization Management and Nursing, the Chief Data and Analytics Officer, and staff from the Provider Relations Department responsible for credentialing. Representatives from any of the vendors, or other staff, may be invited on an as needed basis. This multi-disciplinary group will be able to appropriately assess all types of reports.

The Information Technology Integration Committee

The Information Technology (IT) Integration Committee is composed of Jai Medical Systems executive management team and members of the Board of Directors.

The IT Integration Committee Quarterly Meeting is composed of the following participants:

- Chief Information Officer, Chair
- Chief Executive Officer, Advisor
- Chief Operating Officer, Member
- Chief Quality Officer, Member
- Chief Data and Analytics Officer, Member
- Manger of Customer Service, Member
- Director of Provider Relations, Member
- Director of Human Resources, Member
- Director of Utilization Management and Nursing, Member
- Project Manager, Scribe

The Information Technology Security Committee

The Information Technology Security Committee is composed of the following participants:

- Chief Information Officer, Chair
- Chief Executive Officer, Advisor
- Systems and Network Administrator, Member

Meetings

The Board of Directors, the Pharmacy and Therapeutics Committee, the QAC, the Delegation Committee, and the Quarterly Utilization Management Committee will meet at least quarterly. The PASC, the IT Integration Committee, and the IT Security Committee will meet at least four times a year. The Policy and Procedure SubCommittee will meet at least annually, or as needed. The Fraud, Waste, and Abuse Compliance Committee will meet at least four times a year and additionally, if needed, as suspected cases of fraud, waste, and abuse arise and require review and investigation.

Documentation (Minutes/Reports)

Minutes of all Committee and SubCommittee meetings are recorded by the designated staff personnel and maintained in a separate, secure, and confidential file housed in Jai Medical Systems' administrative office.

Quarterly reports summarizing the activities, findings, recommendations, and actions are produced by the Quality Assurance Committee. These reports are given to committee members and a copy is forwarded to MDH as required.

Copies of meeting minutes, quarterly reports, and/or annual reports which include the Committee's activities, findings, recommendations, and actions are forwarded to members of the Board of Directors.

Monitoring and Evaluation

Ongoing monitoring and evaluation is designed to evaluate all aspects of care and administrative services, with particular emphasis on preventive health care and services. Quality Assurance activities are ongoing, planned, and systematic. Preventive care studies and focused reviews follow this format:

1. Identify targeted clinical condition or health service delivery issue.
2. Evaluate the care delivered for the targeted clinical condition or delivery issue based on clinical care standards/practice guidelines.
3. Screen and monitor care or services delivered using quality indicators derived from the clinical care standards/practice guidelines.

In order to perform proper oversight responsibilities, the Board of Directors requires that the Chief Quality Officer, in association with the QAC, submit evidence that the quality assurance functions specified in the Jai Medical Systems Quality Assurance Plan are taking place. The goal of these reporting requirements is to ensure that all aspects associated with the delivery of comprehensive quality care are monitored on a regular, ongoing basis.

The following is a list of the required reporting elements.

1. Quarterly report on progress or completion of all chart audits (which include, but are not limited to, sample size and demographic scope, purpose, aggregated data and analysis, summary of all findings, and recommendations on corrective actions, if necessary);
2. Report on provider and member satisfaction surveys, at least annually;
3. Quarterly report on utilization trends (which include, but are not limited to evidence that all claims data collected in the previous quarter, has been analyzed, reviewed, and compared to national standards or previous claims experience, to detect over and underutilization);
4. Quarterly summary of all member complaints or grievances;
5. Quarterly summary of all provider complaints or grievances;
6. Report on subcontractor oversight, at least annually (which include, but are not limited to, degree to which all subcontractors comply with contract terms and performance specifications);
7. Quarterly review of any activity of the Fraud, Waste, and Abuse Compliance Committee.
8. Quarterly submission of all QAC minutes for review.

The aforementioned reports must be available no later than forty-five business days following the end of each quarter. Please note that this list is subject to change (*Please see Jai Medical Systems' Reporting Requirements Policy and Procedure for a comprehensive list of reporting requirements*).

The activities of all subcontractors involved in Jai Medical Systems' managed care delivery system are closely monitored. Jai Medical Systems closely monitors the quality of health care delivered by its physicians by use of the following:

1. Annual member satisfaction surveys;
2. Periodic assessment of complaints (number of complaints and type);
3. Periodic review of utilization patterns;
4. Site visits to assess EPSDT records, medical records, cleanliness of office, wait time of members for scheduled appointments, etc.

All other subcontractors, e.g., SS&C (*formerly DST*), Inc., ProCare Rx (*formerly MCRx*), Superior Vision/Versant Health (*formerly Block Vision*), and other ancillary service providers, are required to submit quarterly and end of year summary reports to executive management which include, but are not limited to, the following information:

1. Member demographic information;
2. Type of service provided;

3. Date(s) of service;
4. Outcome.

All monitoring reports and information are forwarded to a designated Jai Medical Systems' staff member responsible for overseeing the individual contract. The staff member reviews the information with the Chief Medical Officer and executive management. If it is determined that the services of a subcontractor do not meet the standards of Jai Medical Systems, the Physician Advisory SubCommittee will determine what necessary quality assurance corrective action(s) should be taken.

H. RESPONSIBILITY AND ACCOUNTABILITY

Members of the QAC are responsible for informing their staff members of Quality Assurance activities, coordinating the Quality Assurance activities within their areas of responsibility, and coordinating Quality Assurance activities with other departments. This coordination includes the identification of continuous monitors, focused reviews, and identification and improvement within their department/area of responsibility. The QAC will assist other departments/areas within Jai Medical Systems on improving activities that may impact both departments/areas. Commitment and active involvement of all employees of Jai Medical Systems in the Quality Assurance Program is essential to its success. Jai Medical Systems remains accountable for all Quality Assurance Plan functions, even when certain functions are delegated to other entities.

In addition to the responsibilities of the Quality Assurance Committee and its Subcommittees, the following Jai Medical Systems staff/departments are responsible for major quality assurance activities:

BOARD OF DIRECTORS

- Has the ultimate responsibility and authority to ensure that a Quality Assurance Program is established, maintained, and supported by all Jai Medical Systems staff and providers on a continuous basis;
- Ensures the legal constitution of Jai Medical Systems;
- Maintains responsibility and accountability for ensuring that the Jai Medical Systems QA Program reflects the Maryland Medicaid Managed Care Program (HealthChoice) priorities;
- Oversees any revisions and/or additions to policies and procedures as set forth by the Policy and Procedure Subcommittee to ensure the quality of care;
- Reviews, approves, modifies, and implements QA recommendations, as appropriate;
- Ensures the QA Program is evaluated and, if necessary, revised at least annually;
- Supervises the identification and resolution of problems in all departments within Jai Medical Systems;
- Maintains responsibility for the overall effectiveness of the QA Program;
- Maintains responsibility for the quality and effectiveness of clinical services provided by Jai Medical Systems;
- Supervises the identification of problems and QA activities;

- Promotes identification and monitoring of over/under utilization as an integral part of preventive care studies, focused reviews, and medical record audits;
- Maintains recorded minutes of all meetings and actions taken to validate the performance of Jai Medical Systems;
- Ensures that physician and member confidentiality are maintained in all recorded minutes.

PRESIDENT / CHIEF EXECUTIVE OFFICER (*Jai Mitra Seunarine*)

It is the President / Chief Executive Officer's responsibility to improve the planning and deployment of Quality Assurance initiatives on a continual basis by educating staff about goals, objectives, and current performance by managing the daily operations of Jai Medical Systems. The President / Chief Executive Officer establishes policies and procedures to ensure:

- Jai Medical Systems meets the public health goals and objectives established by MDH in the annual HealthChoice contract.
- Appointment of administrative staff to oversee the daily operations of Jai Medical Systems;
- Enforcement of all health care policies established by the governing body;
- Adequate, qualified, and competent health care personnel provide efficient delivery of services;
- Appropriate personnel practices are consistent with applicable laws;
- Protection of material assets;
- Communication within Jai Medical Systems;
- Acts as liaison with outside groups and organizations;
- Adequate communication and reporting to all personnel and professional staff;
- Execution of short- and long-term planning for expansion and improvements in technology and equipment;
- Adequate purchasing and distribution of equipment and supplies;
- Negotiation of contracts;
- Monitoring of marketing activities;
- Annual performance-based evaluations of all personnel;
- A method to evaluate member and provider satisfaction/grievance;
- Maintenance of appropriate confidentiality of all medical records, contracts, and other business-related records.

CHIEF MEDICAL OFFICER (*Peter Gregg, M.D., MPH*)

The Chief Medical Officer, with the assistance of the President / Chief Executive, has the responsibility to ensure, or to delegate, the following tasks as they relate to the Quality Assurance Plan:

- Monitors quality assurance, utilization review, and risk management activities;
- Monitors and evaluates physicians and allied health care professionals;
- Develops policies and procedures to maintain high professional standards;
- Ensure appropriate responses to member surveys and member grievances;

- Oversees Utilization Management activities;
- Maintains responsibility for the clinical activities of Jai Medical Systems;
- Delegates peer review of primary care physician and specialty care physician medical records to same specialty physician reviewer;
- Has overall responsibility for counseling and educating quality outliers, especially during the medical record review and recredentialing processes and other times, as may be necessary to maintain Jai Medical Systems' standards of care and services;
- Encourages all personnel to maintain a current level of competence through continuing education
- Provides oversight of Jai Medical Systems' educational programs;
- Recruits, selects, and retains physicians;
- Schedules physicians;
- Ensures that all physicians and licensed personnel are qualified based on education, training, and experience;
- Reviews credentialing and recredentialing files and makes recommendations to the Physician Advisory SubCommittee;
- Helps to identify and define new and innovative strategies to achieve organizational goals and meet quality improvements measures while meeting the needs of our members.
- Provides clinical guidance, support, and education to clinical and nonclinical staff;
- Assists with developing, directing, and implementing clinical and non-clinical activities that impact health care quality, cost, and outcomes;
- Ensures clinical review guidelines are appropriate and that clinical protocols are reviewed regularly;
- Participates in the design and implementation of disease management programs;
- Works directly with participating providers to promote excellence in care and service delivery;
- Works collaboratively with and provides direction to improve quality improvement objectives.
- Assists the Assistant Medical Director in performing their functions as necessary.

ASSISTANT MEDICAL DIRECTOR (*Aye Lwin, M.D., and Teri Richardson, M.D.*)

- Assists the Chief Medical Officer in performing their functions as necessary;
- Assists the Chief Medical Officer in the review of Utilization Management Appeals and Denials;
- Reviews and modifies treatment protocols in order to reflect current medical practice;
- Makes recommendations on Quality of Care Studies based on direct clinical experience with Jai Medical Systems' members.

QUALITY ASSURANCE DEPARTMENT (*Frances Bird, M.D., Medical Director*)

It is the Quality Assurance Director's responsibility to ensure, or to delegate, the following tasks as they relate to the Quality Assurance Plan:

- Provides the coordination and technical assistance necessary for an effective, comprehensive, and integrated QA Program;
- Coordinates QA activities to implement QA Program and Work Plan including surveys and focused reviews, continuous monitors, problem identification, and follow-up;
- Actively participates in QA educational programs each year to expand working knowledge of the QA process;
- Maintains QA oversight of delegated providers;
- Assists with development and revision of standards of care;
- Reviews reported guarded conditions (adverse outcomes) and target diagnoses and initiates necessary action;
- Develops drafts of policies and procedures for approval/recommendations of Jai Medical Systems' Policy and Procedure Subcommittee and the Board of Directors;
- Coordinates and participates in the Medical Record Review process; maintaining responsibility for verification of delivery of quality, accessible, preventive health care services;
- Oversees administrative Medical Record Review
- Works closely with the Chief Medical Officer in developing and implementing corrective action plans and addressing quality outliers noted in the Medical Record Review process;
- Coordinates QAC meetings;
- Attends quarterly Quality Assurance Liaison Committee meetings.

CASE MANAGEMENT & UTILIZATION REVIEW DEPARTMENT

Staff: 16 FTEs - 1 Director of Case Management, 3 Team Leads, 1 Special Needs Coordinator, 9 Case Managers, 2 Support Persons

Responsibilities:

- Completes a comprehensive health assessment of the member's physical, psychological, social, environmental, financial, and functional status, in addition to evaluating for social risk factors. Assesses community, institutional, and family support systems and resources;
- Updates assessment materials through regular contact with members;
- Facilitates, organizes, and arranges for implementation of care plan;
- Educates members and providers on preventive health issues and clinical services;
- Interacts with Provider Relations and Customer Service to meet member and provider needs;
- Coordinates special needs and case management services for members;
- Links members with the most appropriate institutional and community resources, advocating on behalf of the member for scarce resources;
- Performs oversight of outsourced case management functions;
- Monitors sentinel conditions, target diagnoses and other quality of care processes and outcomes as needed, and reports to the Quality Assurance staff for follow up;

- Participates in the development of discharge planning for members who were involved in case management prior to admission or who meet Special Needs Population criteria as a result of admission;
- Coordinates and monitors services provided to members in case management who utilize School-Based Health Centers;
- Coordinates Jai Medical Systems' health education programs;
- Maintains contact with MDH and local health departments and provides appropriate reports and documentation as required;
- Appropriately maintains confidentiality of member, staff, and administrative information.

PROVIDER RELATIONS DEPARTMENT

Staff: 5 FTEs - 1 Provider Relations Director, 1 Provider Relations Team Lead, 3 Provider Relations Representatives

Responsibilities:

- Ensures that an adequate number of accessible and appropriately credentialed hospitals, physicians, and ancillary providers are contracted to provide high quality health care services and that overall access standards are met;
- Makes initial presentations to prospective network physicians and other providers;
- Carries out credentialing and recredentialing procedures under the guidance of the Physician Advisory SubCommittee;
- Maintains a current Provider Manual which includes documentation of QA Standards and HealthChoice Program requirements and distributes a copy to each participant in Jai Medical Systems' provider network;
- Informs physicians in writing of pertinent policy and procedure additions and revisions;
- Maintains periodic communication with each participating provider and staff;
- Resolves administrative and contractual problems with providers;
- Investigates and resolves provider concerns and complaint issues;
- Interacts with the Executive Medical Director, Customer Service Department, and other departments as necessary to address/resolve member complaints concerning providers;
- Maintains oversight of delegated credentialing and vendor compliance.

CUSTOMER SERVICE DEPARTMENT

Staff: 19 FTEs - 2 Customer Service Managers, 14 Customer Service Phone Representatives (1:2500), 1 Health Equity Director, 1 Member Orientation/Outreach Representative

Responsibilities:

- Responds to member questions and issues;
- Conducts annual member satisfaction surveys;

- Aggregates data and provides analysis and appropriate follow up to Member Satisfaction Surveys;
- Coordinates quarterly issues of member newsletter, *HealthBeat*;
- Reviews or revises the member handbook;
- Ensures compliance with submission of written and statistical reports;
- Continuously monitors access standards and quality improvement activities to ensure that members are receiving accessible and quality health care;
- Provides member education on how to access health care and services through welcome calls and proactive innovated methods;
- Coordinates and documents the member compliant process, as well as, the member grievance process for resolution and member satisfaction;
- Continuously monitors member rights to ensure Jai Medical Systems has demonstrated commitment to ensure members are afforded all rights;
- Interacts with Executive Medical Director, Provider Relations, etc. to address/resolve member complaints concerning provider and quality of care issues;
- Ensures member information is written in prose that is readable, easily understood, and is in the languages of the major population groups served;
- Interacts with external agencies to document and resolve member issues;
- Coordinates activities and annual reports of the Consumer Advisory Board;
- Provides outreach for members who are difficult to reach or are noncompliant;
- Coordinates and monitors health education programs for members;
- Conducts health fairs and other community events;
- Acts as TCA Liaison for DSS;
- Provide other assistance as needed to advance the goals and objectives of Jai Medical Systems;
- Appropriately maintain confidentiality of enrollee, staff, and administrative information.

I. SCOPE/SPECIFIC ACTIVITIES

Jai Medical Systems' Quality Assurance Program is comprehensive, addressing the quality and safety of clinical care as well as non-clinical entities; i.e., accessibility, availability, continuity, and coordination of health care services. The quality assurance activities cover the spectrum of care, including various population subgroups, case settings (home, office, hospital), and type of care (preventive, primary, specialty, ancillary). The Program includes evaluation and improvement activities for all components of preventive health care, clinical care, and administrative services provided to members. All departments of Jai Medical Systems are involved in the Quality Assurance process.

Jai Medical Systems Managed Care Organization, Inc. does not cover Substance Abuse or Behavioral Health Services due to the fact that both of these services are not covered by Maryland Medicaid MCOs, and instead are carved out. Both Behavioral Health Services and Substance Abuse Services are provided by the Behavioral Health Administrative Services Organization (BHASO). The BHASO is a separate vendor chosen by the State of Maryland.

J. SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT

The effectiveness of the Jai Medical Systems Quality Assurance Plan is continually appraised through a systematic process in which the Quality Assurance Program objectively evaluates the quality of care and service Jai Medical Systems delivers to its members.

Jai Medical Systems' quality of care assessment process analyzes the quality of care that members receive through the use of Quality of Care (QOC) studies. QOC studies are detailed investigations into certain areas of health care services which are designed to evaluate the quality and appropriateness of care delivered to members of Jai Medical Systems. The objective of these studies is to identify areas of care which are in need of improvement and to determine methods to be applied to achieve improvement. The QOC studies performed by Jai Medical Systems are not random. They are conducted by reviewing information found in medical records, claims, administrative data, surveys, or other information resources.

Each QOC study focuses on specific areas of both clinical and/or service delivery and relies on the analysis of quality indicators. The first step undertaken in each study is the formulation of a clearly defined study question which identifies relevant issues of concern regarding the health care received by Jai Medical Systems' members. The area of delivery to be monitored and evaluated is determined by Jai Medical Systems' member population's demographic distribution in terms of age groups, disease categories, special risks, or special needs. The Maryland Department of Health may also determine areas of concern for Jai Medical Systems to address.

The Centers for Medicare and Medicaid Services (CMS) have provided examples of clinical areas of concern, including the following:

- | | |
|---|---|
| 1. Childhood Immunizations | 21. Hepatitis B |
| 2. Pregnancy | 22. Otitis Media |
| 3. Breast Cancer / Mammography | 23. Mental Health |
| 4. Cervical Cancer / Pap Smears | 24. Prescription Drug Abuse |
| 5. Lead Toxicity | 25. Hip Fractures |
| 6. Comprehensive Well Child
Periodic Health Assessment | 26. Cholesterol Screening and
Management |
| 7. HIV Status | 27. Treatment of Myocardial
Infarctions |
| 8. Asthma | 28. Prevention of Influenza |
| 9. Hysterectomies | 29. Smoking Prevention and
Cessation |
| 10. Diabetes | 30. Medical Problems of the Frail
Elderly; e.g., incontinence and
confusion |
| 11. ETOH and Other Substance
Abuse | 31. Hearing and Vision Screening
and Services for Individuals
Less Than 21 Years of Age |
| 12. Hypertension | 32. Dental Screening and Services
for Individuals Less Than 21
Years of Age |
| 13. Sexually Transmitted Diseases | 33. Domestic Violence |
| 14. Heritable Diseases | |
| 15. Coronary Artery Disease | |
| 16. Motor Vehicle Accidents | |
| 17. Pregnancy Prevention | |
| 18. Tuberculosis | |
| 19. Sickle Cell Anemia | |
| 20. Failure to Thrive | |

Examples of Health Services Delivery areas of concern include:

- | | | | |
|----|-------------------------|----|---------------------|
| 1. | Access to care | 5. | Health education |
| 2. | Utilization of services | 6. | Emergency services |
| 3. | Coordination of care | 7. | Membership services |
| 4. | Continuity of care | | |

The selected area of concern is quantified and analyzed by clinical indicators which are monitored and evaluated to answer the study question. The quality indicators are selected by Jai Medical Systems' Quality Assurance Department and must be objective, measurable, and based on current knowledge and clinical experience. The clinical indicators are information collected from medical records, claims, administrative data, surveys, or other information resources. After all the data has been collected from the selected clinical indicators, it is interpreted by Jai Medical Systems' Quality Assurance Committee and compared with accepted medical standards of care.

The standards of care that the Quality Assurance Committee uses for comparison will vary according to the area of concern which has been identified. The standards of care which Jai Medical Systems has used to develop certain treatment protocols are examples of typical standards of care which will be used for comparison purposes. These sources include the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Please see Section 3 for separate QOC studies which are based on current demographics, as well as areas of interest as dictated by our Quality Assurance Committee and executive management.

K. CORRECTIVE ACTION PROCESS

Based on the results of the Quality Assurance Committee's analysis regarding the QOC study, the Quality Assurance Committee will formulate methods for Jai Medical Systems to improve its care delivery when necessary. The methods for improvement specified by the Quality Assurance Committee will include a clear identification of the types of problems requiring corrective action and full description of the corrective action plan including its implementation schedule. The Quality Assurance Committee will formally present its recommendations to the Board of Directors for review at their next meeting.

All corrective actions that have been recommended by the Quality Assurance Committee and approved by the Board of Directors are implemented as applicable throughout the Jai Medical Systems organization. Once implemented, corrective actions are monitored, evaluated, and adapted as necessary by Jai Medical Systems' Quality Assurance Committee to assure that the changes are effective.

L. PROVIDER PARTICIPATION IN THE QUALITY ASSURANCE PLAN

Participating physicians and other providers in the Jai Medical Systems provider network are kept informed of the written Quality Assurance Plan. Quarterly reports from the Quality Assurance Committee are available to providers. Jai Medical Systems includes in all of its provider contracts and employment agreements, for both physician and non-physician providers, a requirement securing cooperation with the Quality Assurance Plan.

Contracts with hospitals and other contractors specify that Jai Medical Systems will be allowed access to the medical records of its members.

M. ACCOUNTABILITY TO THE GOVERNING BODY

The Jai Medical Systems Quality Assurance Committee shall be accountable to the Jai Medical Systems Board of Directors. The Board of Directors shall delegate to the Quality Assurance Committee the initial monitoring, evaluating, and making improvements to the care delivered. The functions that the Board of Directors has ultimate responsibility for shall include:

1. Oversight of the Quality Assurance Program Description — The Board of Directors will annually review and approve the Quality Assurance Program Description. Updates can be made to the Quality Assurance Program Description until it is approved.
2. Oversight Entity — The Board of Directors has ultimate oversight of the Quality Assurance Program.
3. Quality Assurance Progress Reports — The Quality Assurance Program shall provide a Quality Assurance Report each quarter to the Board of Directors, which shall contain a description of the actions the Committee members have taken, progress towards Quality Assurance objectives, and any improvements made.
4. Annual Quality Assurance Program Review — The Board of Directors shall formally review an annual written report on the Quality Assurance Program which shall include: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered, to assess the Quality Assurance Plan's effectiveness.
5. Program Modification — The Board of Directors shall take action, when appropriate, upon receipt of regular written reports from the Quality Assurance Committee delineating actions taken and improvements made, and direct that the operational Quality Assurance Plan be modified on an ongoing basis to accommodate review findings and issues of concern within the Managed Care Organization. This activity with the Board of Directors will be documented in the minutes in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Assurance.

It should be noted that Jai Medical Systems structure allows all Board of Directors members to sit on the Quality Assurance Committee as well. Reports are distributed to all QAC members on a quarterly basis, including the Board of Directors. The Board of Directors has an opportunity to discuss QA activities in a confidential manner through regular meetings.

N. ADEQUATE RESOURCES

The Jai Medical Systems Quality Assurance Program has extensive material resources and staff with the necessary education, experience, and training to carry out its specified activities.

Material Resources

The standards to which the Jai Medical Systems Quality Assurance Program (QAP) adheres are based on the official, published practice parameters endorsed by professional organizations such as:

- The American Academy of Pediatrics (AAP)
- The U.S. Department of Health and Human Services' Public Health Service (PHS)
- The American College of Obstetricians and Gynecologists (ACOG)
- The National Committee for Quality Assurance (NCQA)

As these practice parameters are constantly being updated, new information must be obtained periodically, at least annually. The changes that these revisions entail will be incorporated, as they occur, into the Program by the Quality Assurance Committee and the Physician Advisory SubCommittee.

Jai Medical Systems will also provide adequate data and information management systems in order to ensure that the Quality Assurance Program committees function properly and have access to any needed data, as well as the ability to manipulate the information that they compile from record reviews.

Staffing Resources

The Jai Medical Systems Quality Assurance Program will be set into action by staff with the education, experience, and training necessary to accomplish the task to which they are appointed. Should a new appointee, to any facet of the Quality Assurance Program, be lacking in some aspect according to the above statement, such a deficit will be ameliorated in a timely fashion by reasonable means. For detailed information on staffing resources, please see staffing comparison document (Attachment 1).

O. CREDENTIALING AND RECREDENTIALING

(Please see Credentialing and Recredentialing binder.)

P. MEMBER RIGHTS AND RESPONSIBILITIES

(Please see Enrollee Rights binder).

Q. NON-DISCRIMINATION

(Please see 19.18 Non-Discrimination Policy)

R. STANDARDS FOR AVAILABILITY AND ACCESS

(Please see Access and Availability binder).

S. MEDICAL RECORDS STANDARDS

(Please see Jai Medical Systems' Medical Records Standards Policies and Procedures).

T. UTILIZATION MANAGEMENT PROGRAM

(Please see Utilization Review binder).

U. CONTINUITY OF CARE SYSTEM

(Please see Continuity of Care binder).

V. QUALITY ASSURANCE PLAN DOCUMENTATION

Scope

Jai Medical Systems monitors the quality of care across all services and all treatment modalities according to its Quality Assurance Plan. The review of the entire range of care is continuous and ongoing. Review and evaluation reports are provided on a quarterly basis.

Maintenance and Availability of Documentation

As indicated in its Quality Assurance Plan, Jai Medical Systems will maintain and have available to the Maryland Department of Health, reports, protocols, standards, worksheets, minutes, and other documentation as appropriate, concerning its Quality Assurance activities and corrective actions. Reports will be provided monthly, quarterly, or as often as necessary.

W. COORDINATION OF QUALITY ASSURANCE ACTIVITY WITH OTHER MANAGEMENT

The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of the Quality Assurance activity are documented and reported to appropriate individuals within Jai Medical Systems. Quality Assurance information is used for recertification, re-contracting, and/or annual performance evaluations. Quality Assurance activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.

Within Jai Medical Systems, there is a linkage between Quality Assurance and the following management functions:

1. Provider Relations

- a. Practice feedback to providers
 - b. Provider satisfaction survey
 - c. Provider complaint resolution process
 - d. Credentialing and recredentialing
 - e. Access/availability
 - f. Subcontractor and vendor compliance
2. Customer Service
 - a. Member education
 - b. Member complaint resolution process
 - c. Member satisfaction survey
 - d. Benefits design and redesign
 - e. Member rights and responsibilities
3. Systems Management
 - a. Enrollment/membership data
 - b. Claims/encounter data
4. Utilization Management
 - a. Medical management
 - b. Pre-certification
 - c. Continuity of care

The quality assurance functions for Jai Medical Systems are executed through the Quality Assurance Committee with input from the Consumer Advisory Board.

X. WRITTEN PROCEDURES OR GUIDELINES

Jai Medical Systems has developed guidelines for treating the diagnoses most frequently encountered in the populations served by the Jai Medical Systems, as well as treatment and referral guidelines for some special populations. These guidelines were developed by Jai Medical Systems' Chief Medical Officer members of the Special Populations Management Team, and the PASC to care for the Jai Medical Systems members more effectively and consistently.

The aforementioned guidelines are reviewed and/or updated annually by the Physician Advisory SubCommittee. The standard of care outlined in these guidelines is the expected, prescribed standard of care given to the members of Jai Medical Systems by the primary care providers - any less is considered unacceptable and will subject the provider to disciplinary actions upon routine Quality Assurance Reviews, focused Care Studies, and Peer Reviews. The primary care providers must, in the course of treating any member, document all actions, as well as reasons behind decisions. Deviation from the prescribed standard of care is acceptable only in cases when there is adequate documentation with research-based reasoning. Care delivered that exceeds the standards set forth is acceptable, but should also be documented.

All Jai Medical Systems staff members shall always conduct themselves in a respectful, professional manner towards members, other staff members, and any other person in contact with these offices. The staff shall act promptly on requests from members and aim to deliver

quality service consistently — whatever their role in the running of the office, they must always function as a team.

Y. GRIEVANCE COMMITTEE STRUCTURE & PROCESS

(Please see Enrollee Rights binder).

Z. CASE MANAGEMENT PLAN

The Utilization Management and Case Management Departments at Jai Medical Systems are committed to ensuring high quality care to our members. Case Management is a member-centered process designed to promote quality cost-effective care. Case Management addresses a broad spectrum of individual needs across a continuum – rather than a single episode – of care and can involve various levels of care. The purpose of the Case Management Plan for Jai Medical Systems is to have a comprehensive, systematic plan for assessing, planning, coordinating, monitoring, and arranging the delivery of medically necessary and appropriate health related support services to members in a cost-effective manner. The goals of the Case Management Plan for Jai Medical Systems are as follows:

1. To increase coordination of services provided.
2. To improve the cost-effectiveness of health care for members.
3. To decrease hospital utilization.
4. To increase member and provider satisfaction.
5. To improve member adherence to professional recommendations.
6. To enhance member functional abilities.
7. To improve member health status.
8. To ensure member safety.
9. To maximize the utilization of preventive health services.

The case management process includes assessment, planning, implementation, coordination, monitoring, and evaluation. Assessment is the process of collecting in-depth information about a member's situation and functional status to identify individual needs in order to develop a comprehensive case management plan that will address those needs. Planning is the process of determining specific objectives, goals, and actions designed to meet the client's needs as identified through the assessment process. Implementation is the process of executing specific case management activities and/or interventions that will lead to accomplishing the goals set forth in the case management plan. Coordination is the process of organizing, securing integrating, and modifying the resources necessary to accomplish the goals set forth in the case management plan. Monitoring is the ongoing process of gathering sufficient information from all relevant sources about the case management plan and its activities to enable the case manager to determine the plan's effectiveness. Evaluation is the process, repeated at appropriate intervals, of determining the case management plan's effectiveness in achieving the desired outcomes and goals. These components are applied across the continuum of care to address the needs of the member. Case Management involves interaction and collaboration with all relevant parties including family members, physicians, hospitals, and ancillary care vendors and facilities. The philosophy of Case Management is that all individuals, particularly those suffering from catastrophic and/or high risk or costly injuries or illnesses, should be afforded the services of a Case Manager regardless of the member's ability to pay. The provision of case management in

these most difficult health care situations will serve to identify care options which are acceptable to the client and family, thus increasing compliance with the treatment plan and successful outcomes. Case management in these instances will also reduce the fragmentation of care, which is often experienced by clients who obtain health care services from multiple providers. Taken collectively, the services offered by a professional Case Manager will enhance quality of life while reducing the total health care costs. Thus, effective case management will directly and positively affect the social, ethical and financial health of the country and its population.

(Please see Continuity of Care binder)

1. **POPULATION HEALTH MANAGEMENT (PHM) STRATEGY**

In 2019, JMSMCO began to focus on a PHM strategy that follows NCQA's guidelines. This strategy details our commitment to quality health care and addresses the needs, preferences, and values of our members.

The goal of the PHM strategy is closely aligned with the QA Program goals and objectives to ensure highest possible quality of health care. Four areas of focus of the PHM strategy include:

- Keeping members healthy
- Managing members with emerging risk
- Member safety or outcomes across settings
- Managing multiple chronic illnesses.

Through our PHM strategy, targeted populations are identified through routine review of membership, health outcomes, population assessment, and member risk stratification. (Please see Population Health Strategy).

The PHM program is one of our QA programs, and like other QA programs is operationalized by the Quality Assurance Committee to ensure we are meeting our QA goals. The QA Program and the PHM strategy are related in terms of operation and oversight, as both programs fall under responsibilities of the QA department. Additionally, the PHM program is a part of the QA program structure. As with other QA programs, the Quality Assurance Committee is responsible for the development, implementation, and oversight of the PHM program strategy.

2. **DIABETES PREVENTION PROGRAM**

Beginning September 1, 2019, Jai Medical Systems started offering the Diabetes Prevention Program at no cost for eligible members who qualify to participate in the program. The Diabetes Prevention Program is a lifestyle change program where members learn, share, and try new things, all while developing new habits and improving their overall health.

AA. **SUBCONTRACTOR QUALITY ASSURANCE MECHANISMS**

Jai Medical Systems will monitor, evaluate, and take action to address any needed improvements in the quality of health care delivered by Jai Medical Systems' providers. This includes assessing the quality of care provided by all of Jai Medical Systems' subcontracted providers, whether preventive, primary, specialty, emergency or ancillary services delivered in inpatient,

ambulatory, or home settings. In order to ensure subcontractor compliance with Jai Medical Systems' Quality Assurance Program, Jai Medical Systems includes, in all its provider contracts and employment agreements, a provision securing the provider's cooperation with Jai Medical Systems' Quality Assurance Program. In addition, all of Jai Medical Systems' contracts with hospitals and other providers specify that Jai Medical Systems be given access to the medical records of members.

To ensure provider performance, including all subcontractors, Jai Medical Systems provides to all practitioners a Provider Manual, which includes information and guidelines regarding medical records management, case management, and utilization review. Jai Medical Systems' provider relations department serves as a second source, in addition to the provider manual, for provider education.

Jai Medical Systems' most proactive mechanism for ensuring the quality of services delivered by its subcontractors is claims management. Jai Medical Systems' claims management process includes utilization management and fraud prevention and detection. Jai Medical Systems' utilization management process is designed to establish criteria for the appropriateness of given medical services, to evaluate the necessity of such given medical services, particularly those with a high cost, against the established criteria, and to ensure that the usage criteria is applied consistently across providers and members. Utilization management is applied both prospectively and retrospectively. Examples of situations in which Jai Medical Systems applies prospective utilization management are outpatient service pre-authorizations and inpatient pre-admission certifications. An example of retrospective utilization management is the review of medical records or encounters to evaluate the appropriateness of where a service was rendered or the level of service provided. Jai Medical Systems' fraud prevention and detection process is applied to every claim. The process includes the evaluation of member eligibility, place of service vs. procedure, provider type vs. procedure, procedure vs. diagnosis, appropriateness of code, and any other verifications.

Jai Medical Systems also conducts contract monitoring of all subcontractors. This monitoring includes a review of each provider's contract and an evaluation based on each subcontractor's compliance with contract terms. Contract monitoring is conducted by Jai Medical Systems' administrative staff either on site or off site and is performed thirty days following the initiation of all contracts and at least annually there-after.

BB. MEDICAL RECORD MAINTENANCE SYSTEM

(Please refer to Jai Medical Systems' Medical Records Standards Policies and Procedures)

CC. PROVIDER APPRAISAL OF OFFICE PROCEDURES

Jai Medical Systems providers are informed in writing regarding all provider performance requirements including, but not limited to, medical records maintenance, utilization review, and case management. Practice performance requirements and guidelines are covered in the Provider Manual which is given to every Jai Medical Systems provider. *(Please see separate bound copy of the Provider Manual.)* Jai Medical Systems' Provider Relations Department will supply additional information or educate providers as necessary or when the need arises. Further, all of

Jai Medical Systems' providers are contractually obligated to adhere to provider performance requirements.

DD. INCLUSION OF REFERRAL REPORTS IN MEDICAL RECORD

All contracted Jai Medical Systems providers are required by Jai Medical Systems' medical records maintenance guidelines to incorporate all medical reports from referral resources in the member's chart. Prior to being filed, the report must be signed and dated by the member's primary care provider. All referral resources are required to send a report back to the member's primary care provider following treatment. To ensure compliance, periodic audits of member records are conducted which include a thorough review of the member's referral history. In the event that a referral resource has been reimbursed for services for which they should have sent a report to the member's primary care provider but did not, the paid claim may be subject to review. Further, Jai Medical Systems' Provider Relations Department may be called upon to provide instructions to the referral resource regarding proper referral reporting procedures.

EE. PROVIDER COMPLAINT PROCESS

(Please see Credentialing/Recredentialing binder)

FF. MEDICAL RECORD RETENTION & RETRIEVAL SYSTEM

(Please refer to Jai Medical Systems' Medical Records Standards Policies and Procedures)

GG. RELATIONSHIP WITH SCHOOL-BASED CLINICS

Overview

Jai Medical Systems is committed to continuity of care for the school-aged population at the elementary, middle, and high school levels. Positive relationships will be established with school-based health centers to develop effective communication and a collegial spirit with the health center staff. The goal of the communication between the primary care provider and the school-based health center is that the primary care provider shall be in possession, as quickly as possible, of the complete medical record of the member. The primary care provider should function as the clearinghouse of information for each member under his/her care.

Process

To facilitate this relationship, Jai Medical Systems pediatricians shall obtain the current school information on each of its school-aged members, i.e., name of school, location, phone number, and note such information in the child's medical record. If the child's school is one with a school-based health center, the appropriate contact person at the health center will be sent an introductory letter from the member's primary care provider with signed copies of the School-Based Health Center Record Request Form. This practice shall facilitate the process of medical records communication between the school-based health center providers and the primary care provider. Parents of school-aged members will also be informed about the regulations regarding services that school-based health centers may provide and their purpose in the overall health care plan of the member.

By regulation, school-based health centers are required to:

- A. Refer the student back to the student's primary care provider for any additional, indicated follow-up services after providing acute or urgent follow-up care for somatic illness;
- B. Refer the student to the student's primary care provider whenever the student needs to have a treatment plan developed, or when any change in the student's treatment plan is needed; and
- C. Transmit to the student's Managed Care Organization, within 2 business days, reports regarding self-referred services provided, for inclusion in the student's medical record, but, if the student needs follow-up care by the primary care provider within 1 week, the school-based health center shall telephone or fax the information to the student's primary care provider.

Whenever a school-based health center accepts assignment of a Jai Medical Systems member for services the health center is eligible to provide, payment for such services is contingent upon the acceptance by that health center of the conditions of any subcontractor participating with Jai Medical Systems.

Services Eligible and Ineligible for Reimbursement

Eligible Services

Jai Medical Systems shall promptly reimburse undisputed claims, for which a report and appropriate billing data in 1500 form format are in receipt, for such services specified in COMAR 10.09.76.04 §A. These are:

- A. Diagnosis, treatment, and uncomplicated follow-up (limited to one follow-up visit at the school-based health center) of acute or urgent somatic illness and related prescribing of medications; and
- B. Family planning services specified in COMAR 10.67.04.20 §A (2), (6), (7).

Ineligible Services

Jai Medical Systems shall not reimburse claims for the following services, specified in COMAR 10.09.76.05 §B. These are:

- A. Basic school health services as defined in COMAR 13A.05.05.05 thru .15; and
- B. Follow-up treatment for acute or urgent somatic illness that exceeds one visit.

Contingency for Payment of Pharmacy & Laboratory Services

Jai Medical Systems shall require, pursuant to COMAR 10.67.06.28, members to utilize in-plan providers for pharmacy and laboratory services ordered by any school-based health center that is not within the Jai Medical Systems provider network, except when the pharmacy or laboratory service is provided in connection with the abovementioned authorized school-based health center services and the pharmacy or laboratory service is

to be delivered on-site by the out-of-plan provider at the same location as the above-referenced care.

HH. PROVIDER PRACTICE GUIDELINES

Purpose

The purpose of the Provider Practice Guidelines is to assist practitioners in approaching the health care they deliver in a systematic, appropriate manner.

Definition of Primary Care

Primary Care is defined as provision of health care in a fashion that is focused on wellness, education, member involvement, and preventative medicine for the whole spectrum of ages. It is holistic in approach and broad in scope.

Definition of Specialty Care

Specialty Care is defined as the provision of health care in a fashion that is concerned with complex, extreme, or otherwise unusual disease processes and such diseases that may be limited to specific age ranges. It is problem-oriented and limited in scope.

Goals for Guidelines

The goals of the Provider Practice Guidelines are as follows:

- A. To ease the assimilation of new providers into the Jai Medical Systems network;
- B. To serve as a reference for all providers as to the proper policies and procedures of the Jai Medical Systems network;
- C. To provide fair knowledge of such policies and procedures to providers in order to stave off member grievances;
- D. To enhance the providers' understanding of the resources available to him/her within the Jai Medical Systems network;
- E. To increase the uniformity among Jai Medical Systems providers' practice styles, thereby easing transfer of records and other member information among providers within the network.

Goals for Primary Care Providers

The goals for Primary Care Providers are as follows:

- A. To keep knowledge of practice standards within personal field of practice up-to-date to assist with administering quality health care;
- B. To practice in a collaborative way with other Jai Medical Systems providers and staff;
- C. To screen for likely potential disease processes, based on member's health history, lifestyle, and family history;

- D. To educate members regarding ways to prevent disease processes they are at risk for, based on the above reasons;
- E. To educate members regarding their current disease processes;
- F. To develop treatment strategies for prevention of current disease sequelae;
- G. To encourage members to develop healthy lifestyle habits;
- H. To facilitate the coordination of any necessary specialty care;
- I. To function as a case manager for those members with multiple needs;
- J. To monitor personal delivery of health care for cost-effectiveness.

Goals for Specialty Care Providers

The goals for Specialty Care Providers are as follows:

- A. To keep knowledge of practice standards within personal field of practice up to date to assist with administering quality health care;
- B. To practice in a collaborative way with other Jai Medical Systems providers and staff;
- C. To monitor personal delivery of health care for cost-effectiveness;
- D. To augment the primary care providers by providing advanced knowledge about disease processes;
- E. To serve as a resource in the ongoing care of members with complex or unusual diseases;
- F. To aid in the development of treatment and referral protocols for members with complex and/or unusual diseases.

1. General Rights & Responsibilities of Providers:

Up-To-Date Clinical Knowledge

It is expected that the primary care provider will practice according to the most up-to-date practice standards available. This is a serious responsibility. Jai Medical Systems' member population includes members who are often quite sick and often suffer from multiple disease processes. It is vital to their care that the primary care provider understand the implications that these disease processes have on each other and on the member's health.

Collegial Attitude Towards Other Staff

Jai Medical Systems' network of health care delivery facilities are each organized similar to a group practice. Each primary care provider is expected to function as part of a team and to provide professional support to the other primary care providers.

This collegial attitude translates into recognizing the strengths of the other providers within the practice setting and offering one's strengths to them in return. It is also expected that each provider will be respectful of the other providers in such ways as not 'taking over' another's members unless the member has specifically requested a change of PCP. However, if the member's customary provider should be absent or unable to attend the member for any reason, the member might benefit from the experience of a different provider's particular strengths.

Expected Conduct Toward Members

- A. Consistently treat members with respect and dignity;
- B. Deliver quality health care regardless of age, race, nationality, gender, religion, physical or mental disability, or type of illness or condition;
- C. Respect the confidentiality of all medical records;
- D. Administer care in an efficient, courteous, and timely manner;
- E. Administer appropriate medical interventions for the diagnosed disease process;
- F. Explain to the member what their illness is and why it is treated in the manner in which you have chosen, as well as the consequences if the member chooses not to cooperate with the chosen plan of action;
- G. Document thoroughly all subjective information provided by member, all exam findings, and all care provided;
- H. Teach members about the products and services they utilize;
- I. Provide enough information that the member is able to make an informed decision regarding their health care prior to any procedure or medication regimen.

Expected Conduct from Members

- A. Consideration and respect for the treatment staff;
- B. Appropriate and timely returns when PCP requests such;
- C. Patience with staff in times of unforeseen delays in the running of the office;
- D. Provision, whenever possible, of all appropriate accurate medical information needed by provider;
- E. Expression of opinions, concerns, or complaints regarding health care in a manner prescribed by Jai Medical Systems' policies;
- F. Involvement in their care and interest in their own health management;
- G. Provision of true and up-to-date information on changes in family status and address;
- H. Cooperation with the designated care plan or discussion if the member does not agree to this plan;
- I. Not demand treatments that have been determined to be contrary to acceptable medical practices and/or Jai Medical Systems' Treatment Protocols;
- J. Compliance with prescribed treatment regimen;
- K. Not engage in illegal acts, such as forging or falsifying a provider's name on documents requiring such signatures or stealing all or part of a medical record, which is deemed to be the property of Jai Medical Systems.

II. HEALTH EDUCATION PLAN

(Please see Health Education binder)

JJ. COMPLAINT RESOLUTION PROTOCOL

(Please see Enrollee Rights binder)

KK. PROVIDER EDUCATION PLAN

(Please see Health Education binder)

LL. HEALTH EQUITY PLAN

(Please see Health Equity binder)

MM. APPROVAL OF ANNUAL REPORT AND QUALITY ASSURANCE PLAN

Jai Medical Systems evaluates the continuity and effectiveness of its Quality Assurance Program by developing a written Quality Assurance and Utilization Management Annual Report. The Annual Report is reviewed, evaluated, and approved annually by the Chief Quality Officer, the Quality Assurance Committee, and the Board of Directors. Approval of the Annual Report by these entities is represented by the meeting minutes of the Quality Assurance Committee and the Board of Directors. In order to develop a Work Plan for the following year, the evaluation addresses, at a minimum, Jai Medical Systems’:

- Impact on preventive care and health maintenance, clinical care and services delivered, and the achievement of stated goals and objectives;
- Demonstrated improvements in quality;
- Areas of deficiency and recommendations for corrective action;
- Quality assurance studies and other activities completed;
- Analysis of clinical and service indicators and other performance data; and
- An evaluation of the overall effectiveness of the Quality Assurance Program.

The Quality Assurance Plan, as well as the 2025 Quality Assurance and Utilization Management Annual Report were made available to members of the Quality Assurance Committee and the Board of Directors during the first quarter of 2026. All comments were incorporated into these documents and approved. Final approval of the documents is notated in the meeting minutes of both the Quality Assurance Committee and the Board of Directors.