Care1st QI Program Description
Medicare 2016
TABLE OF CONTENTS

1. MISSON STATEMENT

Care1st Health Plan's Quality Improvement Department has a mission of providing the highest quality of care and excellence in service to all members, providers and employees, with an assurance of basic and ethical values driven by integrity, honesty and respect.

Care1st's QI Program is committed to promoting continuous and coordinated care in a patient-centered environment that recognizes the positive relationship between health education, a culture of wellness, an emphasis on prevention and a cost-effective healthcare.

Care1st Health Plan is accredited by NCQA for both Medicare and Medicaid, and certified for MA Deeming.

2. PURPOSE/PROGRAM DESCRIPTION

The Quality Improvement Program is designed to objectively, systematically monitor and evaluate the quality, appropriateness and outcome of care/services delivered to our members. The QI Program provides mechanism that continuously pursues opportunities for improvement and problem resolution. In addition, the QI program utilizes a population management approach to members and providers and collaborates with local, state and federal public health agencies and programs, as well as with providers and other health plans.

3. SCOPE OF PROGRAM

The scope of the Quality Improvement Program is to monitor care and identify opportunities for improvement of care and services to both our members and practitioners. This is accomplished by assisting with the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service. This Quality Improvement Program covers all Medicare members. Behavioral Health Care is a covered benefit for our Medicare line of business. A formal evaluation of the Quality Improvement Program is performed annually. Specific elements of the Quality Improvement Program may include but not limited to:

- Practitioner accessibility and availability
- Member satisfaction/grievances
- Member Safety
- Continuity and coordination of care
- Clinical measurement and improvement monitoring
- Chronic Care Improvement Program (CCIP)
- Credentialing and Recredentialing
- Peer Review
- IPA/MSO oversight
- Clinical practice guidelines
- Under and over utilization
- Adverse outcomes/sentinel events
- Medical record keeping practices
- Facility site reviews
- Practitioner satisfaction
- Timeliness of handling claims
- High risk and high volume services
- Medication Therapy and Management
- Predictive Modeling
- Compliance with regulatory requirements and reporting

4. GOALS AND OBJECTIVES

A. Goals

- Ensuring members receive the highest quality of care and services.
- Ensuring members have full access to care and availability of primary care physicians and specialists.
- Monitoring, improving and measuring member and practitioner satisfaction with all aspects of the delivery system and network.
- Utilizing a multi-disciplinary approach to assess, monitor and improve our policies and procedures.
- Promoting physician involvement in our Quality Improvement Program and activities.
- Fostering a supportive environment to help practitioners and providers improve the safety of their practices.
- Meeting and assessing the standards for cultural and linguistic needs of our members.
- Meeting the changing standards of practice of the healthcare industry and adhere to all state and federal laws and regulations.
- Adopting, implementing and supporting ongoing adherence with NCQA standards.
- Promoting the benefits of a managed care delivery system.
- Promoting preventive health services and case management of members with chronic conditions.
- Emphasizing a caring professional relationship between the patient, Practitioner and health plan.
- Ensuring there is a separation between medical and financial decision making.
- Seeking out and identifying opportunities to improve the quality of care and services provided to our members.
- Seeking out and identifying opportunities to improve the quality of services to our Practitioners.

B. Objectives

- Ensuring that timely, quality, medically necessary and appropriate care and services that meet professionally recognized standards of practice are available to members by the identification, investigation and resolution of problems, focusing on known or suspected issues that are revealed through monitoring, trending and measuring of specific clinical indicators, preventive health services, access to services and member satisfaction, through the use of a total quality improvement philosophy.
- Systematically collecting, screening, identifying, evaluating and measuring information about the quality and appropriateness of clinical care and provide feedback to IPA/PMG's and Practitioners about their performance and also the network-wide performance.
- Maintaining a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity and performance.
- Objectively and regularly evaluating professional practices and performance on a proactive, concurrent and retrospective basis through Credentialing and peer review.
- Ensuring our members is afforded accessible health care by continually assessing the access to care and availability of our network of Practitioners and specialists.
- Designing and developing data systems to support Quality Improvement monitoring and measurement activities.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, DHCS, DMHC, and NCQA.

- Ensuring a full-time medical director whose responsibility is direct involvement in the implementation of the QI activities, in accordance with Title 22 CCR Section 53857
- Appropriately overseeing Quality Improvement activities of our contracted IPA/PMGs.
- Ensuring that at all times the Quality Improvement structure, staff and processes are in compliance with all regulatory and oversight requirements.
- Ensuring accountability through involvement of the governing body, designation of the Medical Services Committee with oversight and performance responsibility, delegation of the Medical Director with supervision of QI activities, and inclusion of contracting practitioners and providers in the QI process and performance review
- Actively working to maintain standards for quality of care and accessibility of care and service.
- Establishing and conducting focused review studies, with an emphasis on preventive services, high-volume Practitioners and services and high-risk services with implementation of processes to measure improvements.
- Ensuring that mechanisms are in place to support and facilitate continuity of care within the healthcare network and to review the effectiveness of such mechanisms.
- Identifying potential risk management issues.
- Effectively interfacing with all interdisciplinary departments and practices for the coordination of quality Improvement activities.
- Providing a confidential mechanism of documentation, communication and reporting of quality Improvement issues and activities to the Medical Services Committee, Board of Directors and other appropriate involved parties.
- Assessing the effectiveness of the Quality Improvement Program and make modifications and enhancements on an ongoing and annual basis.
- Ensuring that Care1st is meeting the members cultural and linguistic needs at all points of contact.
- Ensuring members have access to all available services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
- Ensuring mechanisms are in place to identify, support and facilitate patient safety issues within the network and review the effectiveness of these mechanisms.

5. CONFIDENTIALITY AND CONFLICT OF INTEREST

All information related to the Quality Improvement process is considered confidential. All Quality Improvement data and information, inclusive of but not limited to, minutes, reports, letters, correspondence, and reviews, are housed in a designated, secured area in the Quality Improvement Department. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

All quality Improvement activities including correspondence, documentation and files are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889 and the Health Information Portability and Accountability Act (HIPAA) for patient's confidentiality. All persons attending the Medical Services Committee or its related committee meetings will sign a Confidentiality Statement. All Care1st personnel are required to sign a Confidentiality Agreement upon employment. Only designated employees by the nature of their position will have access to member health information as outlined in the policies and procedures.

No persons shall be involved in the review process of Quality Improvement issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated. There is a separation of medical/financial decision making and all committee members, committee chair and Chief Medical Officer signs a statement of this understanding.

6. PROGRAM STRUCTURE

A. Governing Body

The Plan's Governing Body is the Care1st Board of Directors. The Board of Directors is responsible for the establishment and implementation of the Plan's Quality Improvement Program. The Board of Directors appoints the Chief Medical Officer and Medical Services Committee as accountable entities for oversight of the Quality Improvement Program. The Chief Medical Officer reports all Quality Improvement activities monthly and the Medical Services Committee reports all Quality Improvement activities to the Board every quarter. The Board of Directors formally reviews and approves all Quality Improvement activities quarterly and directs these operations on an ongoing basis.

B. Chief Medical Officer

The Chief Medical Officer is a physician who holds a current license to practice medicine with the Medical Board of California. The Chief Medical Officer is the Board of Directors designee responsible for implementation of Quality Improvement Program activities. The Chief Medical Officer works in conjunction with the Vice President of Quality Improvement to develop implement and evaluate the Quality Improvement Program. The Chief Medical Officer is Chairperson of the Medical Services, Credentials/Peer Review and Pharmacy & Therapeutics Committees.

Responsibilities include but not limited to:

- Ensuring that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
- Ensuring that the medical care provided meets the community standards for acceptable medical care.
- Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
- Developing and implementing medical policy.
- Actively participating in the functioning and resolution of the grievance procedures.
- Providing support and clinical guidance to the program and to all physicians in the network.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to CMS, DHCS, DMHC, and NCQA.
- Ensuring that the Quality Improvement and Utilization Management Departments interface appropriately to maximize opportunities for quality improvement activities.
- Directing the implementation of the Quality Improvement process.
- Overseeing the formulation and modification of comprehensive policies and procedures that support the Quality Improvement operations.
- Analyzing Quality Improvement data.
- Reviewing all clinical grievances, PQIs, QCIs; assign severity levels; and direct corrective actions to be taken, including peer review, if required.
- Reviewing Quality Improvement Program, Work Plan, Annual Evaluation and Quarterly Reports.
- Directing Health Education and Credentialing activities.
- Assisting with the development, conduct, review and analysis of HEDIS and IQIP studies.

C. Medical Director Quality Improvement (QI)

The Medical Director of Quality Improvement oversees the operations of the Quality Improvement Department and is responsible for the administrative execution and coordination of all Quality Improvement activities. The Medical Director, Quality Improvement, reports to the Chief Medical Officer (CMO). The Medical Director helps to administratively plan, develop, organize, monitor, communicate, and recommend modifications to the Quality Improvement Program and all policies and procedures. The Medical Director reports any areas of concern to the CMO and/or the Medical Services Committee:

Responsibilities include but not limited to:

- Overseeing the operations of the Quality Improvement Department and is responsible for the execution and coordination of all Quality Improvement activities.
- Overseeing and performing statistical analysis relevant to quality improvement functions and goals.
- Overseeing the development and or revisions annually to the Quality Improvement Annual Evaluation and Work Plan and presents for review and approval.
- Overseeing the development of quarterly Quality Improvement activity progress reports.
- Overseeing the development and/or revising annually of the Quality Improvement policies and procedures.
- Overseeing the QI management heads in ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
- Monitoring and reporting to the Medical Services Committee the resolution of quality improvement activities in accordance with the Quality Improvement Program.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Interfacing with all internal departments to ensure compliance to the Quality Improvement Program and policies and procedures, along with the AVP, QI..
- Acting as a liaison with each delegated IPA/.PMG and ancillary provider and facility regarding Quality Improvement issues.
- Ensuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Serving as liaison with Regulatory Agencies for Quality Improvement activities.
- Monitoring and overseeing follow up with all applicable Quality Improvement activities
- Ensuring that HEDIS and IQIP studies are conducted appropriately
- Ensuring Member and Practitioners Satisfaction Surveys are conducted annually
- Managing the Practitioner database modification process
- Identifying compliance problems and formulating recommendations for corrective action.
- Ensuring that Focused Review Studies are conducted appropriately.
- Ensuring the department adheres to HIPAA compliance standards.'
- Overseeing the pre-contractual and annual Due Diligence audit process.
- Monitoring delegated Quality Improvement activities to ensure proper performance of Quality Improvement functions in compliance to regulatory and delegation requirements.
- Submitting a written report summarizing each pre-contractual or annual review.
- Tracking compliance with reporting requirements and provide reports for Delegated Oversight Committee and Joint Operating Committee meetings.
- Reviewing Quality Improvement corrective action plans and other Quality Improvement reports for compliance to standards.
- Reporting IPA/PMG findings of non-compliance to the CMO and Delegated Oversight Committee.

D. Vice President, Quality Improvement

The Vice President of Performance Improvement is a Registered Nurse with a current California licensure and oversees the operations of the companies Quality Performance Metrics and Improvement Programs and is responsible for the execution and coordination of all Performance Improvement activities. The Vice President of Performance Improvement reports to the Medical Director of Quality Improvement. The Vice President helps to plan, develop, organize, monitor, communicate, and recommend modifications to Performance Improvement Projects and the Quality Improvement Program. It is the Vice President of Performance Improvement's responsibility to interface with other departments on Performance Improvement issues. The Vice President reports any areas of concern to the QI Medical Director and/or the Medical Services Committee. Additional responsibilities include but not limited to:

- Performing statistical analysis relevant to quality improvement functions and goals.
- Developing and/or revising annually the Performance Improvement functions of the Annual Evaluation and Work Plan and presenting for review and approval.
- Developing quarterly Performance Improvement activity progress reports.
- Developing and/or revising annually Performance Improvement policies and procedures.
- Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
- Monitoring and reporting to the Medical Services Committee the status of Performance Improvement interventions and in accordance with the Quality Improvement Program.
- Overseeing compliance required by regulatory agencies.
- Interfacing with all internal departments to ensure compliance to the Performance Improvement activities and policies and procedures.
- Assist the liaison with each delegated IPA/PMG and ancillary provider and facility regarding Performance Improvement issues.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
- Serving as liaison with Regulatory Agencies for Performance Improvement activities.
- Monitoring and follow up with all applicable Performance Improvement activities.
- Ensuring that staff collects and monitors data and report identified trends to the QI Medical Director and Medical Services Committee.
- Ensuring that HEDIS, QIP, PIP, PDSA, and IP studies are conducted appropriately.
- Ensuring Member and Practitioner Satisfaction Surveys are conducted annually.
- Identifying compliance problems and formulating recommendations for corrective action.
- Ensuring that Focused Review Studies are conducted appropriately.
- Interfacing with the QI Medical Director and Chief Medical Officer for clinical quality of care and service issues.
- Assuring the department adheres to HIPAA compliance standards.
- Reviewing potential risk management issues and reports them to the QI Medical Director and Chief Medical Officer.
- Developing policies and procedures in conjunction with the QI Medical Director and Chief Medical Officer.
- Collecting, monitoring and reporting data for tracking and trending.
- Monitoring delegated Quality Improvement activities to ensure proper performance of Quality Improvement functions in compliance with regulatory and delegation requirements.
- Reviewing Quality Improvement corrective action plans and other Quality Improvement reports for compliance to standards.

- Reporting IPA/PMG findings of non-compliance to the QI Medical Director, CMO and Delegated Oversight Committee

E. AVP, Quality Improvement

The AVP of Quality Improvement is a Registered Nurse with a current California licensure and oversees the managers in the administrative daily operations of the Quality Improvement Department and is responsible for the execution of Quality Improvement activities. The AVP of QI reports to the Medical Director of Quality Improvement. It is the AVP of Quality Improvement's responsibility to interface with other departments on daily Quality Improvement processes and issues.

Additional responsibilities include but not limited to:

- Writing and collecting information for quarterly QI activity progress reports as they apply to FSR, PQI, Credentialing and Appeals & Grievances.
- Assuring that all staff members are adhering to company standards of conduct.
- Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
- Ensuring that staff collects and monitors data and report identified trends to the CMO and Peer Review and Medical Services Committee.
- Ensuring appropriate resources and materials are available and ordered to meet the department's needs.
- Overseeing the Managers in the Reviewing of daily staff time clock logs and ensuring compliance with company standards and acting as department liason with Human Resources (HR) on all HR issues.
- Assisting in the development of Focused Review Studies.
- Interfacing with the Medical Director, QI and Chief Medical Officer for clinical quality of care and service issues.
- Ensuring the maintenance of the PQI/QCI database to track pertinent case data that facilitates capture, tracking and trending of quality data.
- Overseeing the processing of all member grievances and appeals
- Overseeing member clinical grievance case files and the process for the Chief Medical Officer and Medical Director.
- Overseeing the preparation of peer review case files for the Chief Medical Officer's action.
- Collecting, monitoring and reporting data for tracking and trending.
- Serving as a Liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues.
- Overseeing the preparation of PQI/QCI and grievance reports for management, Board of Directors, Medical Services Committee, Joint Operating Committee and Delegated Oversight Committee meetings
- Overseeing the collaboration with Member Services Administrative Grievance Coordinator to identify quality of care issues.
- Reporting IPA/PMG findings of non-compliance to the Medical Director, QI and CMO.

F. HEDIS and Stars Team

Under the direction of the Medical Director and the QI AVP the HEDIS and Stars Team's primary responsibilities range from oversight of medical record review, data extraction, maintaining data systems, leading the physician/physician office staff as it relates to HEDIS and other intervention programs initiated through the Quality Improvement Department.

Additional responsibilities include but not limited to:

- Provides oversight and support and expertise for interventions initiated by the Quality Improvement Department and Quality Outreach programs, including medical record abstraction for HEDIS, Outreach Education, , and STAR rating projects.
- Effectively leverages available resources (financial, people, time) to accomplish project objectives and contribute to the successful implementation of QI Outreach programs.
- Oversight of the field teams educational and data collection efforts with possible traveling to assigned Physician/IPA office sites.
- Ability to oversee the annual HEDIS Compliance audit including submission and dissemination to HSAG and CMS and other regulatory agencies. Extensive education, validation, and documentation of physician and physician's office staff regarding HEDIS measures, compliance guidelines.
- Oversight of the HEDIS data abstraction processes to ensure we adhere to NCQA standards for data abstraction.
- Knowledge and experience with HEDIS Technical Specifications, NCQA Survey and Outcome Measures and be able to write a HEDIS Road Map.
- Must be skilled and knowledgeable with the Minimum Performance Levels (MPL's).
- Ensures physicians and physician's office staff meets the HEDIS requirements by concurrent and ongoing evaluation.
- HEDIS Team consists of nurses and coordinators who educate physician and physician's office staff to use various QI Outreach incentive programs.
- Empowers physician/physician's office staff, promotes physician/physician's office staff relationships, and ensures client satisfaction.
- Concurrent and ongoing assessment of physician offices' current practices and streamlining the process as per the QI Outreach implementation project plans.
- Develops new interventions and corrective action plans for physician office sites that fall below the QI Outreach measurement benchmarks.
- Promotes a team and positive work environment, and quality assurance of QI Outreach team.
- Makes appropriate decisions in the face of ambiguity. Anticipates and resolves barriers while managing multiple priorities.
- Provides support to the CMO and Medical Director, under Quality Improvement to work as part of the Quality Improvement Management Team on projects pertaining to HEDIS. Oversees the PCP and IPA QI report card mailings.
- Attends annual HEDIS certification classes.
- Assists in the annual preparation of the Baseline Assessment Tool and audit process.
- Prepares audit result reports, graphs and presentations.
- Other duties as assigned by the Medical Director, Quality Improvement and as needed to assist the Quality Improvement Department with HEDIS related Accreditation Projects.

G. Additional Quality Improvement Staff and Resources

The Quality Improvement Department has multidisciplinary staff to address all aspects of the department functions. A full organizational chart is attached to this program description with all appropriate job descriptions. Care1st has staff and resources to conduct statistical and data analysis sufficient to establish quality controls and improvement projects. Data analysts are capable of developing Access databases relevant to specific functions and pulling appropriate information relevant to specific studies. The staff includes but not limited to:

- Director, Performance Improvement & Accreditation
- PI/NCQA Clinical Specialist and PI/QI Specialists & Coordinator

- QI Manager, Facility Site Review, and PQI
- Facility Site Review Nurses & Coordinators
- FSR Auditors
- IHA Coordinator
- QI/FSR Senior Project Coordinator
- Sr. QI Nurse Specialist, Case Finding
- PQI Clinical Supervisor
- Sr. PQI Nurses & PQI Nurse Specialists
- Lead PQI Coordinator & PQI Coordinators
- Director, Appeals and Grievance
- Manager, Appeals and Grievance
- Supervisor, Appeals and Grievance Manager, Credentialing
- Sr. Credentialing Auditor & Credentialing Auditors
- Credentialing Coordinators
- HEDIS Outreach Supervisor
- Sr. Data Analysts
- HEDIS Provider Network Specialist
- HEDIS Data Specialist
- HEDIS/Quality Outreach Leads & Coordinators
- Sr. Medicare Services Analyst
- Medicare Revenue Management Supervisor
- HCC Auditing Specialists
- Other support staff

7. MEDICAL SERVICES COMMITTEE

A. Description

The Medical Services Committee is established by the authority of the Care1st Board of Directors as a standing committee and is charged with the development, oversight, guidance and coordination of all Medical Services Department activities, including Quality Improvement and Utilization Management. The Medical Services Committee has a specific portion of the meeting designated for the Quality Improvement Program. The Medical Services Committee has been delegated the responsibility of providing an effective Quality Improvement Program. The Medical Services Committee monitors provisions of care, identifies problems, recommends corrective action, and guides the education of Practitioners to improve health care outcomes and quality of service. The Medical Services Committee is also responsible for Utilization Management activities as outlined in the Utilization Management Program.

B. Scope (includes but not limited to):

- Directing all Quality Improvement activity.
- Recommending policy decisions.
- Reviewing, analyzing and evaluating Quality Improvement activity.
- Ensuring practitioner participation in the QI program through planning, design, implementation and review.
- Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Credentials/Peer Review, Pharmacy & Therapeutics or Delegated Oversight Committees).
- Monitoring, evaluating and directing the overall compliance with the Quality Improvement Program.

- Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, DHCS, DMHC, and NCQA.
- Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols.
- Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria.
- Developing relevant subcommittees for designated activities and overseeing the standing subcommittee's roles, structures, functions and frequency of meetings as described in this Program. Ad-hoc subcommittees may be developed for short-term projects.
- Conducting peer review, assigning severity levels and making recommendations for corrective actions, as needed.
- Reviewing and evaluating reports regarding any/all potentially litigious incidents and sentinel events.
- Reviewing and evaluating reports submitted by the Plan's counsel.
- Developing and coordinating Risk Management education for all Health Plan Practitioners and staff.
- Evaluating and giving recommendations concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access audits, HEDIS audits and IQIP studies.
- Evaluating and giving recommendations from monitoring and tracking reports.
- Ensuring follow-up, as appropriate.

C. Reporting

The Medical Services Committee shall submit a summary report of quality activities and actions for review and approval to the Care1st Board of Directors on a quarterly basis. This is completed by the approval of the Quality Improvement quarterly report.

D. Composition

1. Chairperson

The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:

- Directing the Medical Services Committee meetings
- Reporting Medical Services Committee activities to the Board
- Acting on behalf of the committee for issues that arise between meetings
- Ensuring all appropriate QI activity and reports are presented to the committee
- Ensuring there is a separation between medical and financial decision making

2. Membership

Membership is assigned and will include representatives from the following disciplines:

- Primary Care Practitioners
- Specialty Care Practitioners
- IPA/PMG Medical Directors
- VP, Utilization Management, Medical Services
- Director, Medical Services
- Medical Directors
- VP, Performance Improvement
- AVP, Quality Improvement

- Director, PI & Accreditation
- QI, Manager
- Manager, Credentialing
- Director, Health Education
- Member Services and Provider Relations (as needed)
- Other members appointed at the discretion of the Chairperson

Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of the committee functions. Representatives of CMS, DHCS and DMHC may attend upon request.

E. Quorum and Voting

Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. All approval of actions is by a majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. Non-Physician members of the Medical Services Committee may not vote, but shall attend the meetings and provide support to the deliberations. In the event that the Medical Services Committee is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

F. Meetings

The Medical Services Committee meets at least three times per year but can meet more frequently if needed to accomplish the committee's objectives. The Chief Medical Officer may act on the Committee's behalf on issues that arise between meetings

G. Confidentiality

All committee members and participants, including network Practitioners, consultants and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement. All members and invited guests to Medical Services Committee meetings annually sign a Confidentiality Statement that is kept on file in the Quality Improvement Department. Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the Medical Services Committee are for the sole and confidential use of Care1st Health Plan and are protected by State and Federal laws (1157 of the California Code of Evidence, Federal Information Act SB 889 and the Healthcare Portability and Accountability Act (HIPAA).

H. Recording of Meeting and Dissemination of Action

- All Medical Services Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the Medical Services Committee are the sole property of Care1st Health Plan and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format. All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are be maintained in the Quality Improvement Department.

- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

The dissemination of Medical Services Committee information and findings to physicians may take various forms. These methods may include but not limited to:

- Informal one-on-one meetings
- Formal medical educational meetings
- Care1st Newsletters
- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Directors

8. OTHER MEDICAL SERVICES COMMITTEES

A. Credentials Committee

1. Description

The Credentials Committee was established by the Board of Directors. The Credentials Committee is delegated the responsibility of monitoring credentialing and recredentialing activities for Practitioners.

2. Scope (includes but not limited to):

- Reviewing, recommending, approving or denying initial credentialing and recredentialing of the direct-contracted Practitioner network
- Reviewing and approving Credentialing policies and procedures and ensure they are carried out
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, DHCS, DMHC, and NCQA
- Ensuring appropriate reports, including 805, NPDB, etc, are made, as required
- Ensuring Fair Hearing Procedures are offered and carried out in accordance with approved policies and procedures

3. Reporting

The Credentials Committee shall report monthly to the Care1st Board of Directors. Practitioner network updates are reported regulatory agencies as per contract requirements.

4. Composition

Chairperson

The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:

- Overseeing the credentialing program
- Directing the Credentials Committee meetings
- Reporting Credentials Committee activities to the Board of Directors
- Reviewing credentials and recredentials applications
- Reviewing requested changes to credentialing status or specialty
- Acting on behalf of the committee for issues that arise between meetings
- Ensuring all appropriate credentials activity is presented to the committee
- Ensuring there is a separation between medical and financial decision making

Membership

Membership is assigned and will include representatives from the following disciplines:

- Primary Care Practitioners
- Specialty Care Practitioners
- Medical Director, Quality Improvement
- Director, Quality Improvement
- Quality Improvement Manager
- Credentialing Manager

Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of the committee functions. Representatives of CMS, DHCS and DMHC may attend upon request.

5. Quorum and Voting

Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. All approval of actions is by a majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. Non-Physician members of the Credentials Review Committee may not vote, but shall attend the meetings and provide support to the deliberations. In the event that the Credentials Committee is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

The Practitioner (PCP or Specialist) for any case under review may attend the meeting addressing the case to present and defend. That Practitioner will not vote nor engage in the Committee's discussion occurring in Executive Session. No Practitioner member of the Committee will vote on any case in which he/she has been a participant.

6. Meetings

The Credentials Committee meets not less than quarterly but can meet more frequently if circumstances require or to accomplish the committee's objectives. The Chief Medical Officer may act on the Committee's behalf on issues that arise between meetings.

7. Confidentiality

All committee members and participants, including network Practitioners, consultants and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement. All members and invited guests to Credentials Committee meetings annually sign a Confidentiality Statement that is kept on file in the Quality Improvement Department. Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the Credentialing/Peer Review Committee are for the sole and confidential use of Care1st Health Plan and are protected by State and Federal laws (1157 of the California Code of Evidence, Federal Information Act SB 889 and the Healthcare Portability and Accountability Act (HIPAA).

8. Recording of Meeting and Dissemination of Action

- All Credentials Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the Medical Services Committee are the sole property of Care1st Health Plan and are strictly confidential.

- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format. All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are be maintained in the Quality Improvement Department.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

The dissemination of Credentials Committee information and findings to physicians may take various forms. These methods may include but not limited to:

- Informal one-on-one meetings
- Formal medical educational meetings
- Monthly reports to the Board of Directors

B. Peer Review Committee

1. Description

The Peer Review Committee was established by the Board of Directors. The Peer Review Committee is delegated the responsibility of monitoring peer review of Practitioners.

2. Scope (includes but not limited to):

- Reviewing, recommending, taking action and monitoring the clinical practice activity of the Practitioner network and mid-level practitioners.
- Providing appropriate Peer Review that meets the level of practice of the Practitioners and specialists they are reviewing.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, DHCS, DMHC, and NCQA.
- Ensuring appropriate reports, including 805, NPDB, etc, are made, as required.
- Ensuring Fair Hearing Procedures are offered and carried out in accordance with approved policies and procedures.

3. Reporting

The Peer Review Committee shall report to the Care1st Board of Directors.

4. Composition

Chairperson

The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:

- Directing the Credentialing/Peer Review Committee meetings
- Reporting Credentialing/Peer Review Committee activities to the Medical Services Committee
- Acting on behalf of the committee for issues that arise between meetings
- Ensuring a separation between medical and financial decision making
- Ensuring all appropriate Quality Improvement activity and reports are presented to the committee

Membership

Membership is assigned and will include representatives from the following disciplines:

- IPA Medical Directors
- Primary Care Practitioners
- Specialty Care Practitioners
- Medical Director, Quality Improvement
- Director, Quality Improvement
- Quality Improvement Manager

Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of the committee functions. Representatives of CMS, DHCS and DMHC may attend upon request.

5. Quorum and Voting

Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. All approval of actions is by a majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. Non-Physician members of the Peer Review Committee may not vote, but shall attend the meetings and provide support to the deliberations. In the event that the Peer Review Committee is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

The Practitioner (PCP or Specialist) for any case under review may attend the meeting addressing the case to present and defend. That Practitioner will not vote nor engage in the Committee's discussion occurring in Executive Session. No Practitioner member of the Committee will vote on any case in which he/she has been a participant.

6. Meetings

The Peer Review Committee meets not less than quarterly but can meet more frequently if circumstances require or to accomplish the committee's objectives. The Chief Medical Officer may act on the Committee's behalf on issues that arise between meetings

7. Confidentiality

All committee members and participants, including network Practitioners, consultants and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement. All members and invited guests to Peer Review Committee meetings annually sign a Confidentiality Statement that is kept on file in the Quality Improvement Department. Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the Peer Review Committee are for the sole and confidential use of Care1st Health Plan and are protected by State and Federal laws (1157 of the California Code of Evidence, Federal Information Act SB 889 and the Healthcare Portability and Accountability Act (HIPAA).

8. Recording of Meeting and Dissemination of Action

- All Peer Review Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made

- Meeting minutes and all documentation used by the Peer Review Committee are the sole property of Care1st Health Plan and are strictly confidential. A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities. The minutes are recorded in a nationally recommended format.
- All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are be maintained in the Quality Improvement Department
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises

The dissemination of Peer Review Committee information and findings to physicians may take various forms. These methods may include but not limited to:

- Informal one-on-one meetings
- Formal medical educational meetings
- Reports to the Board of Directors

C. Behavioral Health Sub-Committee

Description

The Behavioral Health Medical Services Subcommittee (BH MSC) is established by the authority of the Medical Services Committee as a subcommittee and is charged with the development, oversight, guidance and coordination of all Behavioral Health Services Department activities, including Quality Improvement and Utilization Management. The BH MSC reports to the Medical Services Committee. The BH MSC monitors provisions of care, identifies problems, recommends corrective action, and guides the education of Behavioral Health Practitioners through our Managed Behavioral Health Organizations (MBHO's) to improve health care outcomes and quality of service.

1. Scope (includes but not limited to):

- Directing Behavioral Health Quality Improvement activity.
- Recommending policy decisions.
- Reviewing, analyzing and evaluating Quality Improvement activity.
- Ensuring MBHO participation in the QI program through planning, design, implementation and review.
- Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Credentials/Peer Review, Pharmacy & Therapeutics or Delegated Oversight Committees).
- Monitoring, evaluating and directing the overall compliance with the Quality Improvement Program.
- Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation of our MBHO's
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, DHCS, DMHC, and NCQA.
- Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols.
- Reviewing and evaluating reports regarding any/all potentially litigious incidents and sentinel events related to behavioral health..
- Reviewing and evaluating reports submitted by the Plan's counsel.

- Evaluating and giving recommendations concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access auditsEvaluating and giving recommendations from monitoring and tracking reports.
- Ensuring follow-up, as appropriate.

2. Reporting

The BH MSC shall submit a summary report of quality activities and actions for review and approval to the Medical Services Committee no less than three times per year.

3. Composition

Chairperson

The Chief Medical Officer and Behavioral Health Director shall co-chair the subcommittee and are primarily responsible for but not limited to:

- Directing the BH MSC meetings
- Reporting BH MSC activities to the Medical Services Committee.
- Acting on behalf of the committee for issues that arise between meetings
- Ensuring all appropriate QI activity and reports are presented to the committee
- Ensuring there is a separation between medical/behavioral health and financial decision making

4. Membership

Membership is assigned and will include representatives from the following disciplines:

- Vice President, Utilization Management
- Director, Medical Services
- Medical Director, Quality Improvement
- VP, Performance Improvement
- AVP, Quality Improvement
- Director, Performance Improvement & Accreditation
- MBHO's representatives
- Other members appointed at the discretion of the Chairperson

Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of the committee functions.

5. Quorum and Voting

Only Care1st members are allowed to vote. A quorum consists of a minimum of three Care1st members. All approval of actions is by a majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. In the event that the BH MSC is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.

6. Meetings

The BH MSC meets as often as is needed to accomplish the subcommittee's objectives. The Co-chairpersons may act on the subcommittee's behalf on issues that arise between meetings

7. Confidentiality

All committee members and participants, , consultants and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement. All members and invited guests to BH MSC meetings annually sign a Confidentiality Statement that is kept on file in the Quality Improvement Department. Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the Medical Services Committee are for the sole and confidential use of Care1st Health Plan and are protected by State and Federal laws (1157 of the California Code of Evidence, Federal Information Act SB 889 and the Healthcare Portability and Accountability Act (HIPAA).

8. Recording of Meeting and Dissemination of Action

- All BH MSC minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the BH MSC are the sole property of Care1st Health Plan and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format. All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are be maintained in the Medical Services Committee.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

D. MOC & Quality Improvement Committee

1. Internal Quality Performance Process

The Chief Medical Officer (CMO) who functions as the Chair of the MOC & QI Committee has the direct reporting responsibility to the CEO and the Board of Directors. The CMO, through the Board of Directors, is given all necessary decision making authority to ensure that the MOC program is implemented as developed and that it meets the quality thresholds that have been established. The CMO is also responsible for ensuring that corrective action plans are implemented for any measures not meeting established thresholds.

2. Roles and Responsibilities of MOC & QI Committee:

The MOC & QI Committee has the accountability for implementing and overseeing the performance of the MOC Program to ensure that it meets the established goals. The Subcommittee establishes direction, recommends changes, and evaluates results of ongoing clinical and service improvement activities. Roles and responsibilities include but are not limited to the following:

- Approves the scope of improvement activities as documented in the MOC program description annually.
- Reviews the progress as documented in the work plan and makes recommendations as needed every quarter.
- Ensures adequate practitioner participation in planning, implementing, and evaluating the MOC program.

- Communicates the results of the MOC program quarterly to Medical Services Committee, CEO, and the Board of Directors.
- Annually reviews and approves the annual evaluation, program description and work plan for the subsequent year.
- Responsibility for evaluating and giving recommendations, concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access audits, HEDIS audits, and QIP studies.
- Review and approves other ad-hoc reports and studies as needed

3. Frequency

The MOC & QI Committee meets at least three times per year but can meet more frequently if needed to accomplish the committee's objectives.

4. Composition

The Model of Care and QI Committee is a multi-disciplinary committee that includes the following members:

Chair: Chief Medical Office (CMO)

- **Corporate Medical Director**
- **QI Medical Director**
- **VP of Performance Improvement**
- **Director of Social Services**
- **Quality Improvement Specialist/Analyst**
- **Director of Provider Relations**
- **VP of Medical Services**
- **Director of Member Services**
- **Director of Behavioral Health Services**
- **Director of Pharmacy Services**

Community Providers/ Practitioners and other personnel as needed

9. DELEGATION

A. Independent Practice Association/Primary Medical Groups (IPA/PMG)

Care1st delegates responsibility for specific functional activities for the delivery of care and service to its members to IPA/PMGs. Care1st does not delegate Quality Improvement activities to contracted IPA's and Medical Groups and maintains accountability and ultimate responsibility for the associated activities by overseeing performance in the following areas: Utilization Management, Credentialing, Quality Improvement, Culture and Linguistics and Health Education. Delegated functions include, but are not limited to: preventive health services, health education activities, clinical practice guidelines, and access standards. Non-delegated functions include clinical studies, clinical grievances, appeals, HEDIS/QIP studies, facility site/medical record reviews, access studies, Health Education materials development and review, member and practitioner satisfaction surveys. Delegated IPAs will be expected to have a functioning quality improvement program in place. Care1st retains the right to revoke any delegated function if compliance with standards is not met.

Care1st has a process in place to assess and ensure the IPA/PMG's ability to perform the delegated functions. NCQA, DMHC, DHCS and LA Care regulations and requirements are used to evaluate and determine the IPA/PMG's potential for delegation. An initial assessment is conducted pre-contractually to determine the IPA/PMG's ability to provide delegated services and at least annually thereafter. Care1st's UM Delegation and Credentialing Departments are responsible for oversight of the IPA/MGs and reporting which is presented to Compliance Delegation Oversight Committee (CDOC). CDOC activity is reported to the Board of Directors for final review and approval.

B. Availability of Practitioners

In developing our delivery system of practitioners, Care1st takes into consideration assessed special and cultural needs and preferences of our members. Care1st establishes availability of primary care, specialty care, hospital based and ancillary Practitioners by:

- Ensuring that standards are in-place to define practitioners who serve as primary care practitioners (Pediatrics, Family Practice, General Practice, Internal Medicine, etc.).
- Assigning each member to a Practitioner with-in five (5) miles of their home unless specially requested by the member or family.
- Referring each member to a specialist within fifteen (15) miles of their home unless specially requested by the member or family.
- Ensuring a database is in-place which analyzes practitioner availability and ability to meet the special cultural need of our members.
- Ensuring members are within fifteen (15) miles or 30 minutes from a contracted hospital and ancillary service.
- Providing members with transportation as needed.
- Providing member requests with special cultural and language needs.
- Annually reviewing and measuring the effectiveness of these standards through specialized studies.

(Please refer to our Quality Improvement Policies and Procedures for Availability of Practitioners)

10. QUALITY IMPROVEMENT PROCESS

Care1st utilizes a Quality Improvement Process to identify opportunities to improve both the quality of care and quality of service for all Plan members. Care1st adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured. Compliance with standards is measured using a variety of techniques, including but not limited to:

A. <u>Standards of Practice</u>

1. The standards of practice used as criteria, measures, indicators, protocols, practice guidelines, review standards or benchmarks in the Quality Improvement process are based on professionally recognized standards. Sources for standards include but not limited to:
   a. National and local medical professional associations
   b. Local professionally recognized practices
   c. Review of applicable medical literature
   d. Available medical knowledge
   e. State and federal requirements
2. Standards are used to evaluate quality of care of Practitioners.
3. Standards are incorporated into policies and procedures.
4. Thresholds and targets derived from these standards/norms and accepted for will be:
   a. Measurable
   b. Achievable
   c. Consistent with national/community standards
   d. Consistent with requirements of regulatory agencies and legal guidelines
   e. Valuable to the assessment of quality or the potential improvement of quality for our member population.
5. Standards are communicated to Practitioners through the Plan in a systematic manner in ways that may include but not limited to:
   a. Care1st Provider Manual
   b. Newsletters
   c. Bulletins

B. Access to Service

Care1st has established standards and mechanisms to assure the accessibility of primary care, specialty care, and behavioral health and member services. Standards include but not limited to:

1. Preventive care appointments
2. Regular and Routine care appointments
3. Urgent care appointments
4. Emergency care
5. After-hours care
6. Wait times
7. Telephone service

Care1st conducts an annual access to care audit using the standards to implement and measure improvements made in performance. (Refer to QI Policy and Procedure for Access to Service).

Behavioral Health Access to Care and Availability

Care1st contracts with an NCQA Accredited MBHO and delegates the following functions to ensure BH access to care and geographical availability to ensure access and availability of BH Practitioners:

a. BH Access to Care
b. BH Telephone Access to Care
c. BH Geographical Availability
d. Annual BH CAHPS (Member Experience)
e. Annual BH CAHPS opportunities for improvement

C. Member Satisfaction

1. Grievance Process

Under the QI departmental structure the Appeals and Grievance and PQI Departments adheres to the following process:

The Grievance and Appeals Department receives from Member Services a typed call text of every call-in grievance to the company. A grievance is described as any indication of dissatisfaction from a member. These grievances can also be submitted in writing. A Registered Nurse in the PQI department reviews each grievance as they are received by the Grievance and appeals department for clinical urgency and if indicated, forwards the case information to the CMO or QI Medical Director for review and further direction. The RN assigns an Issue code based on the content of the grievance. This process is housed in the Grievance Database.

A RN in the PQI Department then evaluates each closed grievance utilizing available information and determines if there is a potential quality of care issue. All of those that receive that determination are forwarded to the PQI department where a nurse reviews and prepares the case to be reviewed by the QI Medical Director and is ultimately assigned a Severity Level.

Care1st‘s grievance process provides members a means by which they can report and seek resolution of concerns regarding practitioners’ or Care1st’s ability to provide appropriate health care services, access to care, cultural and linguistic issues or quality of care or service issues. (Refer to the Quality Improvement Policy and Procedure for Grievance Process.)

2. Member Satisfaction Survey (CAHPS)

The CAHPS survey is completed by a certified vendor in accordance with CMS rules and regulations. CMS administers the Medicare Managed Care CAHPS survey, which consists of the core CAHPS questions plus additional questions specific to Medicare. These CAHPS surveys are conducted to monitor members' satisfaction with health care services, accessibility of care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunities to improve member satisfaction and the processes which impact satisfaction. CAHPS surveys are conducted at least annually and presented to the Medical Services Committee. Care1st evaluates the survey results annually and develops an improvement plan to address areas identified. Care1st also does a drill down analysis (e.g. root-cause, trend analysis, etc) of the CAHPS results. Care1st will also review CAHPS survey results at the medical group and IPA level to identify high and low performing groups. This analysis helps Care1st to learn best practices form high performing groups and work with low performing groups to improve performance. Care1st evaluates the survey results annually and develops an improvement plan to address areas identified. Care1st annually presents the survey results to the Medical Services Committee. .

Care1st is going to share the results of the CAHPS survey with the groups to they can assess their performance. Care1st also plans to hold joint operations meetings with the large groups to address quality related issues and identify opportunities for improvement. (Refer to the Member Satisfaction Survey Policy and Procedure.)

3. CAHPS Disenrollment Reasons Survey

CMS administers the CAHPS Disenrollment Reasons Survey, which asks beneficiaries about their reasons for leaving their Medicare managed care plan. The survey is administered by both mail and phone follow-up. Care1st reviews these results to identify areas for improvement and develops an improvement plan to address identified issues. (Refer to the Member Satisfaction Survey Policy and Procedure.)

4. Public Policy Meetings

Our Care1st Member Services Department holds a quarterly Public Policy meeting where members have the opportunity to voice any opinions or concerns about the services provided to them. This meeting is an open forum and has educational purposes for the members who attend. This meeting was developed to educate members about the health plans processes and elicit input on these processes from enrollees. (Refer to the Member Services Program for a more detailed description).

D. Disease State Management

Care1st Health Plan has developed its own proactive Disease Management Program which is overseen by the Utilization Management Department. Additionally, all related policies and procedures and clinical measurements can be found in the Utilization Management Department.

In addition, Care1st participates in a CCIP Program and a brief description is provided below:

1. Chronic Care Improvement Program (CCIP) and Quality Improvement Projects (QIP):

A CCIP is a clinically-focused initiative designed to improve the health of a specific group of enrollees with chronic conditions. Started in 2012, Care1st's CCIP is conducting a 5-year program focusing on reducing and/or preventing cardiovascular disease.

The Chronic Care Improvement Program (CCIP) describes all aspects of the CCIP initiative, including, but not limited to: targeted members, goal, opportunity for improvement, interventions, and expected results. The Medical Services Division has a written process for identifying enrollees with multiple or sufficiently severe chronic conditions that meet the criteria for participation in the program. All Medicare members have an annual risk assessment completed where an individualized care plan for that member is generated and completed. The criteria are developed through the MOC Subcommittee and reviewed and approved through our Medical Services Committee. The program details what chronic conditions are monitored, types of services offered and the types of measures that are used to assess performance.

Quality Improvement Projects (QIP) are initiatives focused on one or more clinical or non-clinical areas with the aim of improving health outcomes and beneficiary satisfaction. In 2012, Care1st's QIP was initiated and is focused on reducing 30-day all cause readmission rates.

The quality improvement model adopted by CMS for the CCIP and QIP is based on the Plan-Do-Study-Act (PDSA) model. PDSA is an iterative, problem-solving model used for improving a process or carrying out change.

- Plan: Describes the processes, specifications, and output objectives used to establish the CCIP/QIP;
- Do: Describes the progress of the implementation and the data collection plan;
- Study: Describes the analysis of data to determine what impact the program has had on members;
- Act: Summarizes action plan(s) based on findings; describes, in particular, the differences between actual and anticipated results, and describes specific actions or steps taken or planned based on current results.

a) Reporting to CMS

Care1st follows the required components of CCIP Plan:

- Basis for Selection – an overall description of the CCIP and rationale for selection that includes impact on the member, anticipated outcomes, and rationale for selection.
- Program Design – description of the process used to identify the target population, risk stratification, and enrollment method.
- Evidence-Based Medicine – includes the clinical practice guidelines and standards of care to be employed.
- Care Coordination Approach - describes the expected collaboration and communication among a multidisciplinary team that may include providers, staff and targeted member.
- Education – describes the method of education and the topics that will be addressed, including the education directed to applicable providers and/or targeted members.
- Outcome Measures and Interventions – setting objectives in measurable terms; identifying the appropriate data source(s) to measure; and the methodology used to analyze the data to determine whether the initiative impacted the health status of the targeted population.
- Communication Sources – methods used to inform patients, physicians, and other providers on what is occurring in the CCIP and any changes over time.

b) Annual Update

The CCIP Plan will be submitted to CMS for approval. Annually, an Annual Update will be submitted for both CCIP and QIP that comprise of the following components:

- Educational Components - includes the actual method of education and the topics that were covered.

- Interventions – describes the specific actions/approaches implemented to achieve the goal.
- Barriers – describes the barriers encountered, and if applicable, the specific actions to mitigate those barriers.
- Findings and Analysis of Results – discussion of results in relation to established goal, benchmark, timeframe, and identification of steps based on the evaluation and ongoing assessment of the CCIP, revisions to the interventions, methodology, goals or other aspects of the initiative.
- Best Practices – any identified approaches proven to be reliable and appear to contribute to the success of the CCIP.
- Lessons Learned – description of pertinent knowledge gained through CCIP experience.

E. Health Management Processes

Care1st identifies members with chronic conditions such as hypertension, asthma and diabetes and offers appropriate services and programs to assist in the management of these conditions. The Quality Improvement Department identifies these conditions through several ways but not limited to:

1. Clinical Practice Guidelines

Care1st adopts nationally recognized Clinical Practice Guidelines (CPGs), which are reviewed and approved annually through our committees and overseen by our Utilization Management Department.

2. Health Risk Assessment

As part of the Quality Improvement Program, the QI Department works to ensure that all Medicare members have timely access to a Health Risk Assessment ("HRA") within 90 days of enrollment. The HRA is to evaluate all new Medicare members and to establish a process for identifying members' medical needs and status. The risk assessment consists of a health history, assessment of needs and initiates the process for members getting needed care and services. Care1st outreach staff contact all new Medicare members and complete a risk survey and work to schedule the member with the assigned physicians to establish care and complete a full risk assessment, which consists of a comprehensive health history, assessment of health education needs, physical assessment, and specific evaluations, tests, immunizations, counseling, follow-up, behavioral assessment, and treatments.

3. Potential Quality Issues (PQI)

A major component of the Quality Improvement Program is the identification and review of potential quality issues and the implementation of appropriate corrective action to address confirmed quality of care issues. (Refer to Quality Improvement Policy and Procedure for identification and handling of PQIs.)

A PQI is a deviation or suspected deviation from expected Practitioner performance, clinical care or outcome of care that cannot be determined to be justified without additional review. Such issues must be referred to the Quality Improvement Department for review and investigation.

4. Peer Review

- Peer review is conducted in any situation where peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific practitioner or to review aspects of care, behavior or practice, as may be deemed inappropriate.
- The Chief Medical Officer is responsible for authorizing the referral of cases for peer review.

- All Peer Review consultants (including members of the Credentials/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in active practice.
- At least one consultant will be a Practitioner with the same or similar specialty training as the Practitioner whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty.
- The Chief Medical Officer can send cases out for a specialty review and consultation to be used for the peer review process.
- The Chief Medical Officer will confirm that the peer review consultants have the necessary experience and qualifications for the review at hand.
- The AVP and Quality Improvement Manager prepare all materials for review by the Peer Review Committee and conduct all follow-ups, as required by the Committee. (Refer to Peer Review Policy and Procedure.)

5. Continuity and Coordination of Care

Our Care1st Quality Improvement Department ensures the continuity and coordination of care that our members receive. This is measured through routine medical record reviews potential quality of care reviews, grievance reviews and member satisfaction surveys. This collaborative information is tracked and analyzed to identify opportunities for improvement. When a Practitioner discontinues a contract with Care1st, the member can continue with that Practitioner for care for the remainder of active treatment or 90 days, whichever is shorter. Members with a second or third trimester pregnancy have access to their discontinued practitioner through the post-partum period. (Refer to Continuity and Coordination of Care Policy and Procedure.)

6. Sentinel Events

A major component of the Quality Improvement Program is the use of sentinel events to monitor important aspects of care, accessibility and service. (Refer to the Sentinel Events Policy and Procedure).

7. Patient Safety Program

Care1st's Quality Improvement Department has developed a patient safety program which identifies supports and facilitates patient safety throughout our network operations. This program evaluates multiple aspects of the patient care process, such as hospital safety, health education, Practitioner office safety and drug utilization safety.

Programs are in place through our Pharmacy Department to identify members who are on medications that are contraindicated (such as drug interactions) or when warnings have been issued. All members that prescribed 10 or more medications are reviewed for patient safety, drug to drug interactions and drug-disease interactions.

The Quality Improvement Department has initiated new facility site review criteria aimed at improving patient safety in the offices and provide our members with added information that can help them make a decision on what office is best for them. This Physical Accessibility Review Survey (PARS) looks at the general areas of Parking, Exterior Building, Interior Building, Restroom, Exam Room(s), and Exam Table/Scale. The facility site review sub-department performs these safety audits when conducting on-site review of the Practitioners. This information is now being used to provide offices with an accessibility level for physically challenged members. The levels are posted in our practitioner directory both hard copy and on the web, giving members the opportunity to know if the office site meets their individual needs.

The Facility Site Review Department also looks at percentage of yes answers in Facility criteria with the initial and periodic reviews for the following criteria which directly impact patient safety: Disabled Parking, Accessible Restroom, Diagramed Evacuation Routes, and Personnel Trained in Medical Emergency procedures, Emergency Equipment, Emergency Medications and documented preventive equipment maintenance.

The member's grievance system has codes identified to track grievances relating to safety issues. Care1st actively encourages hospitals to have a Leap Frog patient safety survey completed. When hospitals have the Leap Frog survey done, results are disseminated on our web site. Care1st strives to include patient safety specific education in our intervention and program mailings and have educational material available to members through multiple sources. Our Provider Manual documents specific patient safety issues and policies. A full description of our patient safety program can be found as QI P&P # 70.1.1.49.

F. Clinical Measurement Activities and Quality Performance Reporting

Care1st Health Plan's Quality Improvement Department adheres to all CMS and DHCS standards in accordance with Title 42 CFR Part 422, Subpart D, Social Security Act, Title 22, CCR, Section 53860 (d) and Title 42, USC, Section 1396a(30)(C) for quality performance reporting. Care1st will cooperate and assist CMS and the Quality Improvement Organization (QIO) contracted by CMS.

Care1st uses data collection and analysis to track clinical issues that are relevant to our population. At a minimum, Care1st will adopt and establish quantitative measures to assess performance and to identify and prioritize areas for improvement annually, in at least (2) Quality Improvement Projects (QIPs).

1. Health Plan Effectiveness Data and Information Set (HEDIS®)

Care1st Health Plan actively takes part in annual Health Plan Effectiveness Data and Information Set (HEDIS) measures. HEDIS Studies are conducted for all lines of business and are in accordance with CMS, DHCS, DMHC and NCQA standards. Care1st cooperates and assists the QIO in the review of quality outcomes and timeliness of services provided. (Refer to QI Policy and Procedure for HEDIS.) Patient-level data will be reported to the CMS designated patient-level data contractor. Care1st uses a certified auditor to certify the HEDIS results. Care1st also uses a certified software solution to report HEDIS results.

2. Health Outcomes Survey (HOS)

The Health Outcomes Survey (HOS) is conducted in accordance with CMS requirements. Each year a baseline cohort will be drawn and 1,000 eligible members per reporting unit will be surveyed. The survey is designed to achieve a 70 percent response rate. Each year a cohort drawn two years previously will be resurveyed. The results of this re-measurement will be used to calculate a change score for the physical health and emotional well being of each respondent. (Refer to HEDIS Policy and Procedure for Health Outcomes Survey Process). The HOS survey is completed by a certified vendor in accordance with CMS rules and regulations.

3. **Quality Improvement Projects (QIPs)**
   Care1st will conduct and/or participate in at least one (1) Quality Improvement Projects (QIPs) and one (1) Chronic Care Improvement plan each year. In addition to plan-specific QIP's, Care1st will also consider collaborative QIP's with CMS, through the QIO, and other Health Plans in statewide collaborative. Among the QIPs, at least one (1) will be non-clinical and one (1) clinical. All QIPs must meet guidelines for preventive care standards. The guidelines include Advisory Committee on Immunizations Practices, U. S. Preventive Services Task Force and all other nationally recognized practice guidelines as appropriate (Refer to QI Policy and Procedure for Quality Improvement Projects). Care1st will implement the PDCA cycle to make improvements. The QIPs and CCIPs will be reported to CMS in a timely manner and according to the requirements set forth by CMS.

4. **Quality Improvement Organization (QIO)**
   CMS contracts with a QIO in each State to fulfill provisions in Title XI of the Social Security Act as amended by the Peer review Improvement Act of 1982. These provisions relate to improving the quality of care for Medicare beneficiaries, protecting the integrity of the Medicare Trust Fund by ensuring that payments for services are reasonable and medically necessary and protecting beneficiaries by addressing care related complaints and other beneficiary issues. Care1st will adhere to the reporting requirement set forth by CMS through the QIO.

5. **Practitioner/Provider Performance Data**
   To ensure compliance with regulatory agencies (e.g., National Committee of Quality Assurance, (NCQA), Practitioners and Providers must comply with Cares1st policies and procedures and allow the health plan to use their performance data (i.e., HEDIS, clinical performance data).

G. Other Quality Improvement Activities

Care1st conducts quality improvement studies and programs to assess quality of service to our members, including the following:

1. **Practitioner Satisfaction Surveys**
   Practitioner satisfaction surveys are conducted to monitor practitioners' satisfaction with the Plan's delivery of services and to identify and pursue opportunities for improvement. Practitioner satisfaction surveys are conducted at least annually. Care1st annually presents the survey results to the Medical Services Committee. Care1st evaluates the survey results annually and develops an improvement plan to address areas identified. (Refer to the Practitioner Satisfaction Survey Policy and Procedure.)

2. **Facility Site Review (FSR)**
   Policy change: Medicare Initial and Periodic Site Review is no longer a Care1st Requirement. Medicare site reviews are triggered by member complaints and/or Care1st internal concerns.

3. **Credentialing**
   Care1st conducts a Credentialing process that is in compliance with all regulatory and oversight requirements. Care1st will credential and recredential all contracted independent practitioners and mid-level practitioners employed in contracted practitioners' offices who see Care1st members. Care1st does not credential hospital-based practitioners, i.e., anesthesiologists, Emergency Medicine physicians, pathologists and radiologists, who see Care1st members solely as patients of the hospital. Care1st does delegate Credentialing functions to contracted IPA/MSOs but retains ultimate responsibility and authority for all credentialing activities. (Refer to the Credentialing Program, Policies and Procedures for details.)

H. Quality Improvement Interventions

The Quality Improvement Department will implement opportunities to improve the delivery and quality of care through the design and implementation of quality improvement interventions. Wherever possible, these interventions are designed to achieve systemic or procedural improvements affecting multiple members, Practitioners or services. Such interventions may include but not limited to:

- Developing and adopting clinical standards, practice guidelines or administrative standards, with subsequent dissemination of the standards to Practitioners, members or staff as appropriate.
- Educating Practitioners about clinical standards and practice guidelines.
- Monitoring the receipt of and compliance with standards and guidelines by practitioners.
- Providing feedback to practitioners to inform them of specific findings of Quality Improvement reviews pertaining to the Practitioner in question.
- Providing health promotion and health education programs to inform members of ways to improve their health or their use of the health care delivery system.
- Modifying administrative processes to improve quality of care, accessibility and service. These processes may include, but are not limited to, customer services, utilization management and case management activities, preventive services and health education.
- Modifying the practitioner and provider network, including adding practitioners or providers to improve accessibility.
- Taking disciplinary action against practitioners and providers.
- Conducting Joint Operations Committee (JOC) meetings with the delegated IPA/PMGs for the purpose of education and dissemination of new materials, tools and standards.
- Providing information to members in the threshold languages.

1. Severity Levels

The Quality Improvement Department has adopted a system of severity levels to be assigned to PQI cases as reviewed by QI nurses and the QI Medical Director. Any severity level that reveals a borderline quality of care issue, or above, is required to have a corrective action plan developed (refer to the Quality Improvement Policy and Procedure for Severity Levels).

2. Corrective Action Plans

The Quality Improvement Department when conducting any activity that reveals any opportunity for improvement will have a corrective action plan developed. The corrective action plans can be developed from issues arising from but not limited to:

- Member/Practitioner satisfaction surveys
- Access to care audits
- Availability studies
- Potential or actual quality of care issues
- Grievances focused review studies

3. Dissemination of Information

All Quality Improvement activities are presented and reviewed by the Medical Services Committee. Communication to the Medical Services Committee may include but not limited to:

- Member grievance statistics and trends
- Sentinel events
- HEDIS Summary
- CAHPS Summary
- Access to Care (Appointment Availability, After Hours & Ancillary)
- Study outcomes (GeoAccess Distance and Language)

- Policies and Procedures
- Medical record and facility audit reports and trends
- Delegation audit results
- Satisfaction survey results
- Utilization Management referral statistics and trends
- Quality Improvement activities
- Quality Improvement Program, Work Plan, Annual Evaluation and Quarterly Reports
- Regulatory and legislative information

Results of Quality Improvement activities are communicated to Practitioners in the most appropriate manner, including but not limited to:

- Correspondence with the Practitioner showing individual results and a comparison to the group
- Correspondence with the IPA/PMGs showing results and comparisons to the net-work
- Newsletter articles
- Fax updates
- Provider Manual updates

The Quality Improvement Program description is made available to all practitioners and members. Members and Practitioners are notified of the availability of the Quality Improvement Program through the Member Handbook and Provider Manual, respectively. The results and intervention analysis is available on our web site for all practitioners and members and written notification of this availability is sent to them annually.

I. Language Services

Care1st demonstrates compliance with DMHC Title 28, Section 1300.67.04 Language Assistance Programs. For specific details on the Language Assistance requirements, please refer to the C & L policies and procedures**.**

J. Quality Outreach Program

The Quality Outreach Program will have the responsibility of reaching out to practitioners and their office staff by a site visit that provides intensive education and incentives. In addition, practitioners can obtain the Quality Outreach Program tools/information via the recently implemented Provider Portal. The Quality Outreach Program was implemented to make change at the “point of care” and ensure members received required annual services.

A key component of the Quality Outreach Program is to develop strong and collaborative relationships with Practitioners and office staff through the outreach efforts. In addition, through this educational mechanism staff will emphasize compliance as it relates to Healthcare Effectiveness Data and Information Set (HEDIS) Measures and the completion of encounter forms; improve patient care, and overall improvement of medical record documentation practices.

As part of the Quality Outreach Program, staff will routinely visit the office site offering intensive education in the following areas:

1. Provider Portal Orientation
2. Healthcare Effectiveness Data and Information Set (HEDIS).
3. Improving documentation practices.
4. Providing tools that focus practitioners’ office on specific members requiring services and the use of HEDIS specific encounter forms.

5. Suggestions and assistance in the development of office processes that limit the possibility of these services being missed.
6. Identify opportunities to limit barriers between the physician and the health plan.
7. Clinical care resources such as Disease Management Programs and how to refer patients.
8. Collaborate on the collection of important diagnosis and service information to limit the intrusion on the physician office.
9. Inform the physician that you are the resource to get questions answered and issues resolved quickly.
10. Work toward improvement in access to care for our members.
11. Offer practice management suggestion that would limit barriers to care.
12. Look for opportunities to free up physician time so additional time can be spent with the patient.
13. Provide in-service reminders that will be placed on the member's medical record (i.e., on the next visit this member needs a Mammogram and Colorectal Cancer Screening completed).

Quality Outreach Tool-Kit consists of:

Physician Profile Report:	The report details their specific rates compared to their peers (i.e., pediatricians are compared to pediatricians), national benchmarks and health plan's overall rates.
Member Listing:	Physicians are supplied a listing of their assigned members that based on administrative data, have not obtained the required services.
Health Risk Assessment	This Progress Note Form contains a complete comprehensive Risk, functional, pain and health history assessment, including meeting several other HEDIS related components. Providers are offered incentives for completing these assessments on our Medicare members.

Provider Web Portal

In 2010, our web based Provider Portal was implemented and contains the essential Quality Outreach Program tools which are available to practitioners. By integrating the tools electronically for practitioners to use that include: Physician Profile Report, Assigned Members Listing and other tools; these will improve data collection from provider offices. Due to new requirements by NCQA pertaining to encounter data, Care1st has revised our web site.

K. <u>Care1st Pay For Performance Program</u>

A new Quality Incentive Bonus Grant program was planned to be implemented in 2015. The new program created a bonus program based on how well each IPA/MG's measured rates for 6 HEDIS measures compared with their peers and how they compared with the county wide rates.

L. <u>Serving Members with Complex Needs</u>

The Complex Case Management Program Description outlines the organization's approach to address members with complex needs. Members with complex needs can include individuals with physical or developmental disabilities, multiple chronic conditions and severe mental illness.

M. <u>Behavioral Health Program</u>

Care1st Health Plan is contracted with Managed Behavioral Healthcare Organizations (MBHOs) that have a comprehensive Behavioral Health Program (BHP). The MBHOs are fully delegated coordinate and administer Care1st behavioral health benefits.

Behavioral Health Program for the Medicare Population

The Medicare Behavioral Health Benefits are defined in accordance with the Centers for Medicare and Medicaid Services (CMS) and include services and programs to help diagnose and treat mental health conditions. These services and programs may be provided in outpatient and inpatient settings. Medicare helps cover outpatient and inpatient mental health care, as well as prescription drugs needed to treat a mental health condition.

Care1st's Behavioral Health Director's responsibilities:

Care1st's BH Director is a doctoral-level behavioral healthcare practitioner involved in all the behavioral health aspects of the QI and UM Programs and is responsible for, but not limited to, the following functions:

- Ensuring that the process by which the MBHO reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of behavioral health services to enrollees, complies with the requirements in State Federal regulatory and accrediting entities, as they apply to LOB.
- Providing substantial involvement in MBHO's QI and UM Program operations through significant time devoted to UM activities, clinical oversight, and guidance to QI staff.
- Providing substantial involvement in Care1st's Medical Services Committee and other sub-committees through collaboration with MBHO's Behavioral Health Director. .
- Establishing QI and UM policies and procedures relating to behavioral healthcare
- Participating in activities related to continuity and coordination of care between medical and BH practitioners

11. EFFECTIVENESS OF THE QUALITY IMPROVEMENT PROGRAM

A. Quality Improvement Work Plans

Quality Improvement Work Plan is developed annually outlining Quality Improvement activities for the year. The Work Plans will include all activities not completed during the previous year, unless identified in the Annual Evaluations as issues that are no longer relevant or feasible to pursue. The Work Plans are reviewed by the Chief Medical Officer Medical Director, Quality Improvement and submitted to the Medical Services Committee and Board of Directors for review and comment.. The Quality Improvement Work Plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement.

B. Quarterly Reports

Quarterly reports are an evaluation of the progress of the Quality Improvement activities, as outlined in the Work Plan, and are submitted to the Medical Services Committee and Board of Directors for review and comment each quarter.

C. Annual Plan Evaluation

Quality Improvement activities, as defined by the Quality Improvement Work Plan, will be evaluated annually to measure the Plan's performance for the year and to assist in revising the Quality Improvement Program and preparing the following year's Work Plan. The Evaluations are reviewed by the Chief Medical Officer and Medical Director, Quality Improvement and submitted to the Medical Services Committee and Board of Directors for review and approval.

12. RESOURCES, QI PERSONNEL AND INTERDEPARTMENTAL INTERFACE

A. Pharmacy Department

The Pharmacy Department and Quality Improvement Department work collaboratively on disease management and study projects. The Pharmacy Department supports the process of obtaining grants and conducting pharmacy reports.

B. Utilization Management Department

The Utilization Management and Quality Improvement Departments are part of the Medical Services Department. The Utilization Management Department frequently identifies potential risk management and quality of care issues and health education needs through case management, inpatient review, utilization review, referrals, etc. The Quality Improvement Department can refer cases to the Utilization Management Department for active Case Management of members with identified chromic conditions.

C. Member Services Department

When a Member Services representative identifies a potential quality of care issue from a members call, it is forwarded to the Quality Improvement Department for investigation and resolution. The Member Services Department records all incoming calls by specific indicators for tracking, trending and reporting.

D. Credentialing Department

The Credentialing Department is part of the Quality Improvement Department. Quality Improvement information is provided to the Credentialing Department for inclusion in the Credentialing/recredentialing process. The Quality Improvement Department provides the Credentialing Department with Facility Site Review and Medical Record audit scores and any sanction activity related to those reviews and with identified QCIs, as appropriate. The Quality Improvement Manager works with the Credentialing Department to take peer review cases, as directed by the Chief Medical Officer, to the Peer Review Committee for review and action.

E. Provider Relations/Contracting Department

The Provider Relations/Contracting Department assists the Quality Improvement Department in obtaining Quality Improvement information from and disseminating information to practitioners. In addition, the Provider Relations/Contracting Department:

- Serves as a liaison between the Quality Improvement Department and Practitioners to facilitate education and compliance with approved Care1st standards.
- Schedules Joint Operating Committee meetings.
- Serves as a liaison with delegated IPA/PMGs.
- Assists the Quality Improvement Department with Practitioners who do not comply with requests from the Quality Improvement Department.
- Ensures contracted ancillary providers and facilities meet regulatory and accreditation requirements.

F. Health Education Department

The goal of the Health Education Program is to improve the health status of members and to educate Practitioners and Providers in a variety of modalities to help them educate their patients. Education modalities may include preventive health literature, educational classes and wellness programs (Refer to the Health Education Program and Policies and Procedures).

The Health Education Department and Quality Improvement Department work together on projects related to Practitioner and member education. The Health Education Department is part of the Medical Services Department. Educational opportunities identified through grievances, quality of care issues, facility site review audits, focused review studies, etc., are forwarded to the Health Education Department. The Quality Improvement Department also works with the Health Education Department on preventive service guidelines, 120-Day Initial Health Assessment and Staying Healthy Assessment compliance.

G. Claims Department

The Quality Improvement Department utilizes claims data to identify potential quality of care issues and sentinel diagnosis. The Quality Improvement Department is able to obtain certain medical records from the Claims Department as available.

H. Cultural and Linguistic Department (C&L)

The Quality Improvement Department utilizes the Health Education and C&L Department to review materials for reading level and cultural appropriateness before submitting to members. Additionally, C&L coordinates the process of sending materials to qualified vendors for translation. All materials must be approved by CMS prior to utilization. The C&L Department uses QI to analyze studies and identify any areas for improvement by using cultural and linguistic breakdowns. In addition, the C & L Department has objectives for serving a culturally and linguistically diverse population.

I. Appeals and Grievances

The QI department utilizes data from the appeals and grievances databases to analyze for patterns of complaints and problems being reported by members. These analyses are done the A&G Division that is part of the QI department. The A&G division works with other departments to resolve grievances and appeals and for preventing reoccurrences.

J. HCC

The HCC Department is responsible for assessing all Medicare, Special Needs Plan (SNP) Medicare, and Cal Medi-Connect Medicare populations to assure that all members have had a complete assessment each year and all conditions have been evaluated and documented. Care1st HCC process is built as a quality improvement process aimed at assuring data completeness and quality of care. We assess care gaps (i.e. member has not been seen, member has conditions that have not been assessed in current year, member has a lab result that requires follow-up, HEDIS related gap, etc.) and collect the record for review. We code and collect any data or information that meets the care gaps we have identified. If after this review the member still has a remaining gap we outreach to them and schedule them in for a complete evaluation with their provider.

All diagnosis codes are captured in a database and used to for submission to CMS for payment reimbursement. All members who require Case Management or special services we provide are referred for these services at that time. The HCC Department uses vendors to collect and code medical records. The HCC department audits all the vendors work to assure accuracy. The HCC department also does specific audits comparing record to encounter data submitted by providers to verify data correctness. If a code was submitted and is not substantiated by the medical record documentation we will delete that code from our system by submitting to CMS a delete file for that date of service identified. The HCC Department and the Quality Improvement Department work collaboratively to improve HCC and HEDIS scores, boost Medicare Advantage (MA) Star ratings, and reduce redundancy.

The HCC Department is responsible for preparing for CMS RADV audit process, by proactively auditing records for diagnosis that are not substantiated and retrospectively auditing and preparing charts when in a RADV audit process. Care1st HCC department also conducts educational outreach to providers with an aim at improving the completeness of assessments, improving the documentation, and communicating gaps and needs in a collaborative process.

13. SNP MODEL OF CARE

The SNP Model of Care describes the processes that provide the fundamental foundation on which a comprehensive program is developed to promote quality, care management and care coordination for SNP population.

Model of Care Elements

1. Description of SNP Population

The SNP Model of Care describes the profile of the medical, social, cognitive, environmental living conditions and co-morbidities associated with the D-SNP population. It includes characteristics that affect health, such as average age, gender, ethnicity and potential health disparities such as language barriers, deficits in health literacy, poor socioeconomic status, cultural barriers, and others.

- **Most Vulnerable Beneficiaries**

  Care1st Health Plan utilizes Optum's predictive modeling software, Impact Pro (Version 7.1), to identify members for complex case management and the most vulnerable D-SNP members. Using a combination of Medi-Cal claims and encounters, pharmacy claims, laboratory results, member enrollment files, and the integration of Care1st Complex Case Management criteria, members with the greatest need for case management services and the most vulnerable are identified through a variety of risk models.

  The predictive modeling software quantifies the relative risk between members, based on a variety of factors and takes into account demographic information, such as age and gender, healthcare episode treatment groups from Medi-Cal and pharmacy claims, and lab results. These episode treatment groups describe a member's observed mix of diseases and conditions and underlying co-morbidities and complications. The software then compiles a set of risk markers for each member. It considers complications and co-morbidities, as they increase risk; it assigns risk factors and provides a numeric score of relative risk.

  Identification of most vulnerable population is also based on multiple hospital admissions, high pharmacy utilization, high cost, or combination of medical, psychosocial, cognitive, and functional challenges.

  Through the HRA process, Care1st identifies high risk members and refer them for further assessment with a case manager to identify if members meet Complex Case Management or Disease Management criteria.

2. Care Coordination

The following components are essential in the development of a comprehensive care coordination program to ensure SNP beneficiaries' healthcare needs, preferences for health services and information sharing across healthcare staff and facilities are met over time. Care1st has policies and procedures describing the following sub-elements in detail:

- SNP Staff Structure – defines staff roles and responsibilities across all health plan functions that directly or indirectly affect care coordination of beneficiaries enrolled in SNP.
- Health Risk Assessment Tool (HRAT) – addresses the medical, functional, cognitive, psychosocial and mental health needs of each beneficiary.
- Individualized Care Plan (ICP) – includes beneficiary's self-management goals and objectives, personal healthcare preferences, description of services specifically tailored to beneficiary's needs, roles of the caregivers, and identification if goals are met or not met.
- Interdisciplinary Care Team (ICT) – describes the composition of the ICT and the roles and responsibilities of each member.
- Care Transition Protocols – explains how care transition protocols are used to maintain continuity of care for SNP beneficiaries, how beneficiary's ICP are transferred between healthcare settings when a transition in care happens, how the beneficiary and caregivers are informed about the point of contact during the transition process.

3. SNP Provider Network

Care1st has procedures that ensure the following are implemented in its Provider Network:

- Specialized Expertise
- Use of Clinical Practice Guidelines & Care Transition Protocols
- MOC Training for the Provider Network

4. MOC Quality Measurement and Performance Improvement

Care1st has a comprehensive quality improvement program to measure the level of performance and determine if systems or processes need to be modified. Care1st's goal is to deliver a high quality health care services and benefits to its beneficiaries. Care1st's quality improvement plan includes:

- MOC Quality Performance Improvement Plan – Care1st's quality performance improvement plan is designed to detect whether the overall MOC structure effectively accommodates beneficiaries' unique healthcare needs.

- Measurable Goals and Health Outcomes for the MOC – Care1st uses specific measures, benchmarks and timeframes to determine achievement of goals that address access and affordability of health care needs; appropriate delivery of services that align with HRA, ICP, and ICT; care transition across all healthcare settings; and appropriate utilization for preventive health and chronic conditions. Actions are formulated if goals are not met.

- Measuring Patient Experience of Care – surveys are used to assess SNP member experience. Standardized methodology is used to collect patient experience surveys, including sample size used.

- Ongoing Performance Improvement Evaluation of MOC – results of performance indicators and measures are used to continuously assess and evaluate quality, support ongoing improvements in the MOC, and incorporate lessons learned.

- Dissemination of SNP Quality Performance Related to MOC - results of the performance evaluation and outcomes analysis will be communicated to key stakeholders, including but not limited to:

    - SNP leadership (Committees and Board of Directors)
    - SNP personnel and staff

- SNP provider network
- Beneficiaries and caregivers
- Regulatory agencies
- Public

SNP-Specific Care Management Measurement: Measuring the Effectiveness of the Model of Care

Care1st uses the following internal quality processes and methodologies for collecting data and reporting quality measures:

a. Healthcare Effectiveness Data Information Set (HEDIS)
b. Consumer Assessment of Healthcare Providers and Systems (CAHPS)
c. Grievance and Appeals Data
d. Health Risk Assessment and Individual Care Plan Data
e. Member Eligibility and Enrollment Data
f. Access to Care Survey Results
g. Geo Access Study Reports
h. Provider Network Adequacy Reports
i. Delegation Oversight Audit Results
j. Staff and Provider Training Completion Data

Measurable Goals and Health Outcomes for the MOC

Care1st has indentified a comprehensive list of process and outcome measures that help the organization assess both quality of clinical care and services received by the member. These measures are based on HEDIS, CAHPS, internal surveys, grievance and appeals data, and other relevant elements that make up health plan operations. Care1st recognizes the importance monitoring and evaluating the outcome and process measures at least annually. This process helps Care1st cultivate an environment where quality of care for its SNP members is the top priority. Please see Appendix A.

Care1st establishes goals and benchmarks for all these measures and evaluates performance against these benchmarks, which are based on NCQA thresholds, CMS Star thresholds, accepted industry standards, and internally-established goals.

Corrective Actions:

The QI Department staff members identify measures that are not meeting the thresholds and communicate this information to business owners for corrective actions. Improvement activities are implemented in various ways, including formal CCIPs/QIPs, process improvements, and/or written specific action plans. Updates from business owners are documented on the MOC work plan and reported to the MOC Subcommittee.

Minutes of the MOC Subcommittee meetings and the MOC work plans will be available to CMS and other regulatory entities during onsite audits, or as requested.

Health Information System

Identifying Eligible D-SNP Beneficiaries

Care1st has Medicare D-SNP plans approved by CMS in the counties of Los Angeles, San Diego, Orange, San Bernardino, Alameda, San Francisco and Santa Clara. This is done through four plan benefit packages H5928-001 (Los Angeles), H5928-009 (San Diego), H5928-005 (Orange and San Bernardino), and H5928-025 (Alameda, Santa Clara, San Francisco). All D-SNP members must be eligible for Medicare managed care and also be a full-dual eligible with State's Medicaid program (known as Medi-Cal).

Care1st determines eligibility for DNSP enrollment, in accordance with the most recent guidance provided by CMS and DHCS.

Care1st uses "Chapter 2 - Medicare Advantage Enrollment and Disenrollment", as updated as its source for CMS guidance on enrolling D-SNP members.

In addition, the State of California Department of Health Care Services (DHCS), All Plan Letter 14-007, provides additional guidance on DSNP eligibility requirements. The State of California is participating in the CMS Financial Alignment Demonstration, in certain counties. The Financial Alignment Demonstration in California is called the "Cal MediConnect Program" (CMC).

- In counties where Care1st has a CMC plan, the DSNP policy restricts enrollment in the DSNP to CMC-excluded beneficiaries only. This applies to Care1st's Los Angeles and San Diego DSNPs.
- In counties where Care1st is not a CMC plan, but the county is one of the counties included in the State's Financial Alignment Demonstration, the DSNP policy permits the plan to retain all members enrolled as of 12/31/2014; however, new enrollment is limited to CMC-excluded beneficiaries. This applies to Care1st's San Bernardino, Santa Clara, and Orange (when the CMC launches in Orange county) DSNPs.

Excluded Beneficiaries include the following:

- Individuals under the age of 21;
- Individuals with other private or public health insurance;
- Individuals receiving services through the State's regional centers or developmental centers or intermediate care facilities for the developmentally disabled;
- Individuals with a share of cost that do not meet the requirements outlined above;
- Individuals residing in one of the Veterans' Homes of California; and
- Individuals residing in an excluded zip code per the Memorandum of Understanding between the State and the Centers for Medicare and Medicaid Services (CMS

In counties not participating in the CMC program, there are no additional restrictions impacting DSNP enrollment. This applies to Care1st's Alameda and San Francisco DSNPs.
D-SNP beneficiary applicants must live in one of the approved zip codes in their respective counties and must be verified as a full-dual eligible in the State of California Department of Health Care Services online eligibility verification system on the effective date of their requested D-SNP enrollment. Beneficiary applicants with spend down share of cost requirements must have completed their spend down amounts before enrolling with the Care1st D-SNP plan. Applicants that are not eligible for Medi-Cal or have unmet spend down requirements are denied enrollment by Care1st per CMS guidelines.

Care1st has online login access to check Medi-cal eligibility and uses it for each application to its D-SNP plans. In addition, the Department of Health Care Services will be including information in the Medi-Cal eligibility system that enables plans to determine the beneficiaries' eligibility for the Cal MediConnect program. A printout of this verification is filed with each application by the Medicare enrollment staff. Care1st accepts applications on paper, fax, telephonically, or through its CMS-approved online web site. These applications are stored in a secure database and then loaded to a third-party Medicare enrollment system known as "**EAM**".

After manually verifying each applicants Medicare claim number, name, birthdate and sex, as well as checking for Part A and Part B enrollments and the absence of ESRD on the CMS MARX user interface, and validating the member's residence zip code as an approved zip code for the county of residence, Care1st staff creates an upload file to CMS known as the BEQ file (batch eligibility query). The BEQ return file is loaded back into the EAM system and the system marks each application as either "accepted" or "rejected" by CMS. After all other key data fields are validated, the staff creates a transaction upload file to CMS requesting the enrollment to the D-SNP plan. Only the BEQ accepted applications can be uploaded.

At this point, the member's enrollment is passed to the Care1st **MHC** eligibility system where the member is enrolled and the process for sending the members and ID card, welcome letter, welcome packet and making an Eligibility Verification call is triggered. That same evening, the member's eligibility is sent to the Care1st pharmacy benefits manager "**MedImpact**" and enrolled as active for pharmacy benefits.

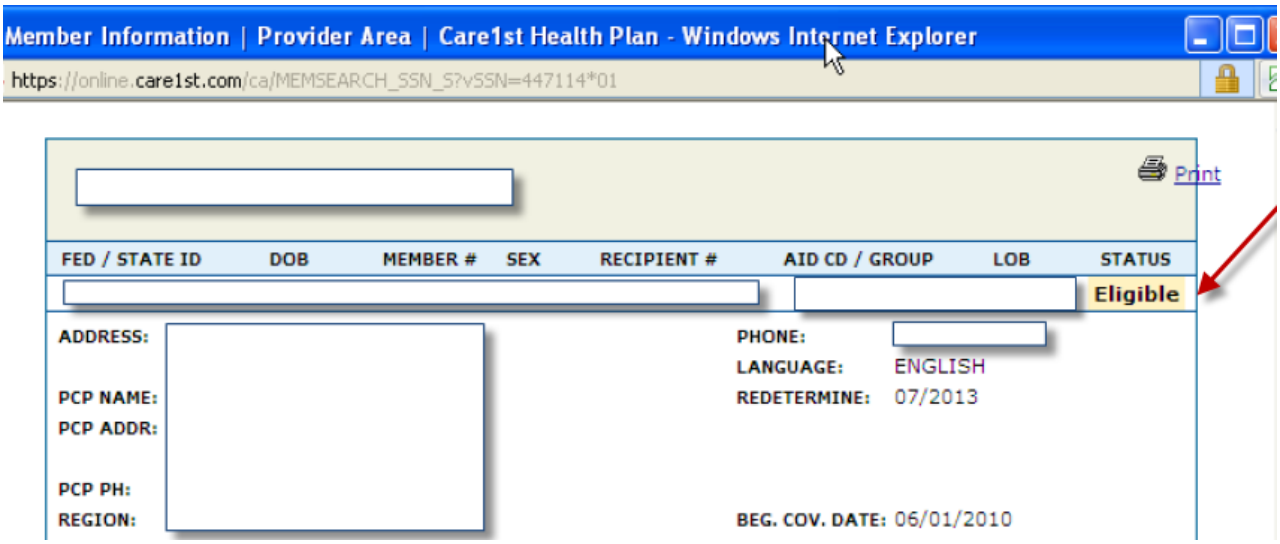
The CMS return file known as the "TRR" or transaction reply file is loaded into the EAM system which updates the applications status as either "accepted" or "rejected". The TRR file is also reconciled daily against the MHC eligibility system and actions to enroll, update or disenroll members are transacted by Enrollment staff. Any changes made during the day are also sent to the PBM vendor MedImpact. The working of the daily TRR file is considered a high priority activity to complete each day.

The member is also enrolled in Care1st medical management systems known as **CCMS** (Care Enhanced Case Management System) and **MCG** (Milliman Care Guidelines) and into its predictive risk system (**Optum Impact Pro**, aka **IPro**).

To maintain SNP eligibility, Care1st sends a file of all SNP members to the California Department of Health Care Services Medi-cal program (**DHCS Medi-Cal Verification**). The state sends this file back with Medi-cal eligibility information for each member in the file. Members that are no longer eligible for Medi-cal are flagged and a notice of potential disenrollment is sent to the member by Care1st per CMS guidelines. Members that continue to show loss of Medi-cal eligibility and are not within their appeal rights time period are mandatorily disenrolled by Care1st with the proper notification sent the member.

Care1st also participates in the CMS TBT system that electronically transfers member out of pocket costs from one health plan to another. All discrepancies reported out of this system are reviewed daily and fixes made as needed. Most often, discrepancy issues are due to timing issues among the various systems.

For communicating member eligibility to contracted providers and medical groups, Care1st sends eligibility data (**Medical Groups Eligibility**) weekly and also makes eligibility information available to providers 24 hours a day through a provider portal.

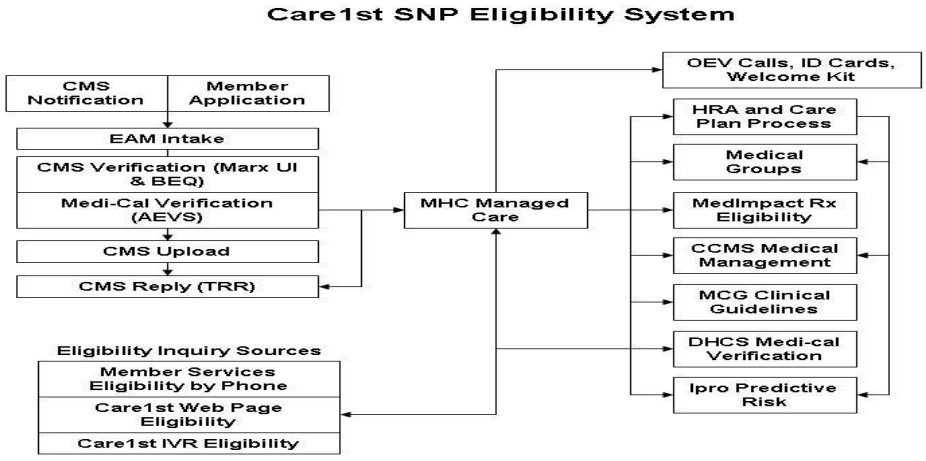


A data flow schematic chart follows that shows the major parts of the Care1st Eligibility and Verification System that includes data flow to providers (medical groups), clinical data systems (CCMS and MCG) and predictive modeling (Ipro).

Eligibility Inquiry Sources

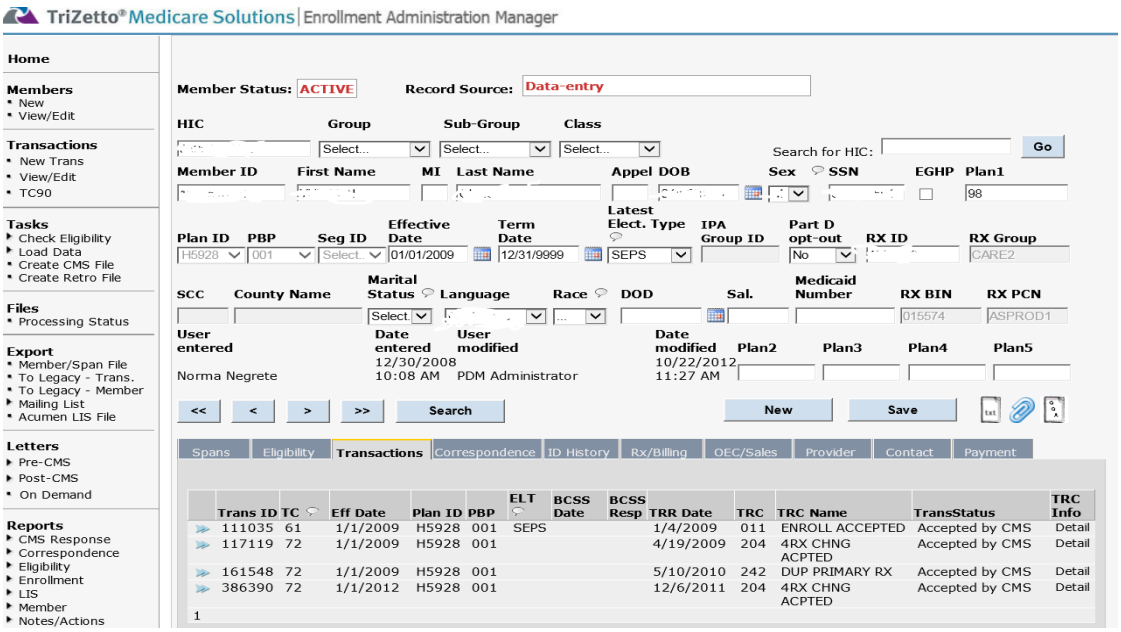
Members and Providers can also check on SNP eligibility by calling our Member Services phone line 24 hours a day. Providers can also use our automated phone IVR system or web page eligibility lookup.

Based on the multiple resources available to internal staff and providers, the ability to check eligibility is widely available and contributes to the provision of coordinated care without interruption.



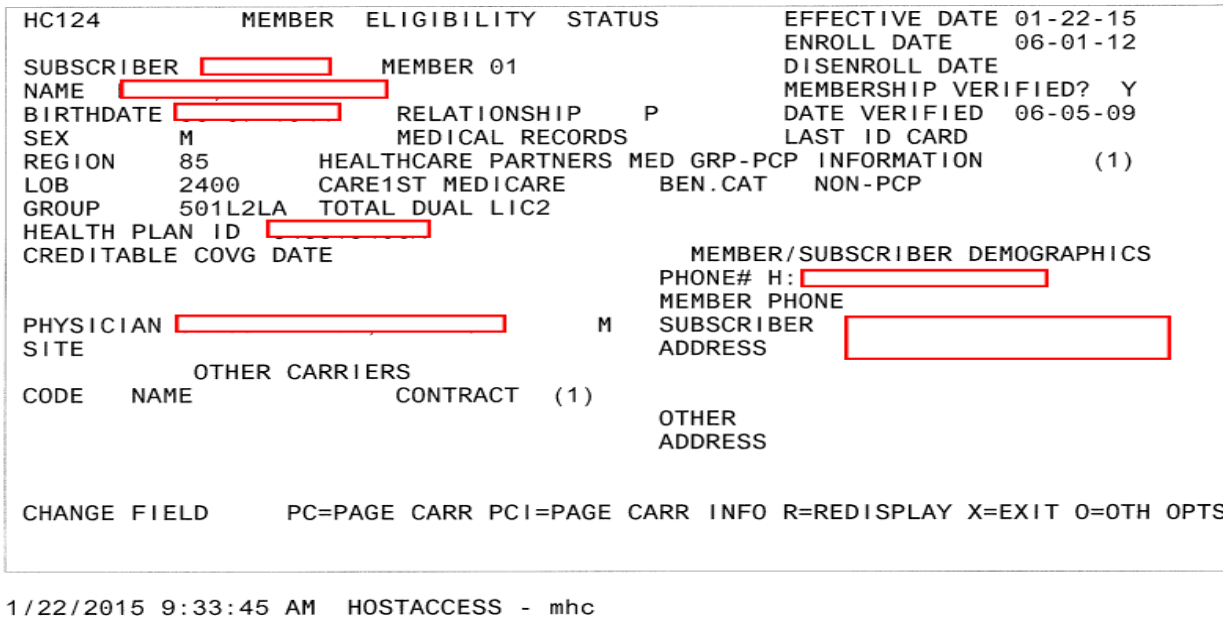
Screen Shot from EAM Enrollment System

Member applications are data entered into a system that is used to validate eligibility, capture and code all CMS-required codes and for sending eligibility request transaction to CMS. This system also accepts and process the CMS return file and generates CMS-required letters to the enrollees.



Screen Shot from MHC Managed Care System

Members that are approved by the CMS return file are enrolled in the main eligibility and claims system. From this main system, eligibility files are extracted and sent to other data systems such as the Pharmacy Benefit Manager, Medical Management (CCMS), etc.



Screen Shot from MHC Managed Care System Showing Enrollment History

Part 2 showing the members can and do have multiple enrollment segments, particularly when the Low Income Subsidy levels change.

```
HC129.2              MEMBER EFFECTIVE DATES HISTORY INQUIRY
SUBSCRIBER NUMBER

     * ENROLLMENT *       ***          T R A N S F E R S                ***
   GROUP    DATES         PCP       TR.DATES REG    TR.DATES MDC       TR.DATES
MEMBER:  01                                                  RELATIONSHIP: P
   501L2LA E-06-01-12    32235    I-06-01-12 85    I-06-01-12

   504L2LA E-07-01-09    32235    I-08-01-09 85    I-08-01-09
           D-05-31-12             O-05-31-12       O-05-31-12
   504L0LA E-07-01-09    28781    I-07-01-09 740   I-07-01-09
           D-07-01-09             O-08-01-09       O-08-01-09
                         28781    I-07-01-09 740   I-07-01-09
                                  O-07-01-09       O-07-01-09




    CHANGE FIELD          X=EXIT     P=PAGE     R=REDISPLAY    O=OTHER OPTIONS

1/22/2015 9:33:56 AM  HOSTACCESS - mhc
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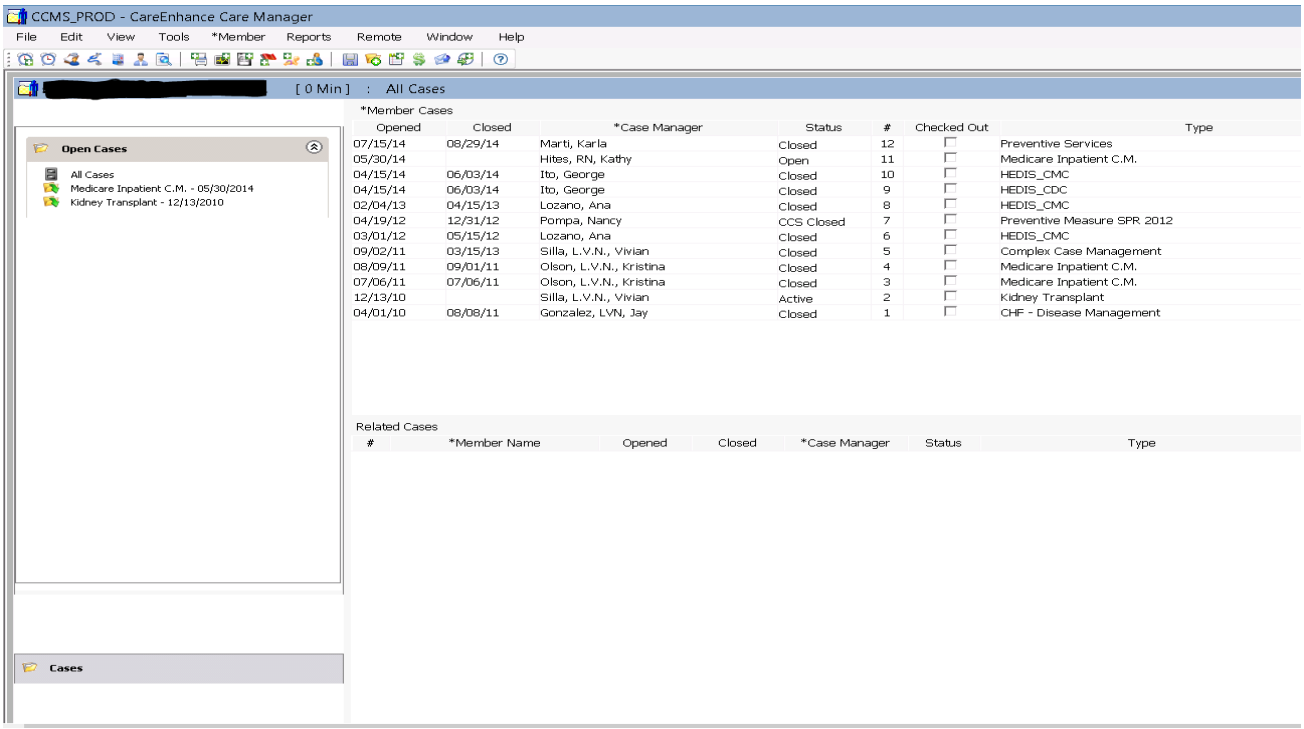
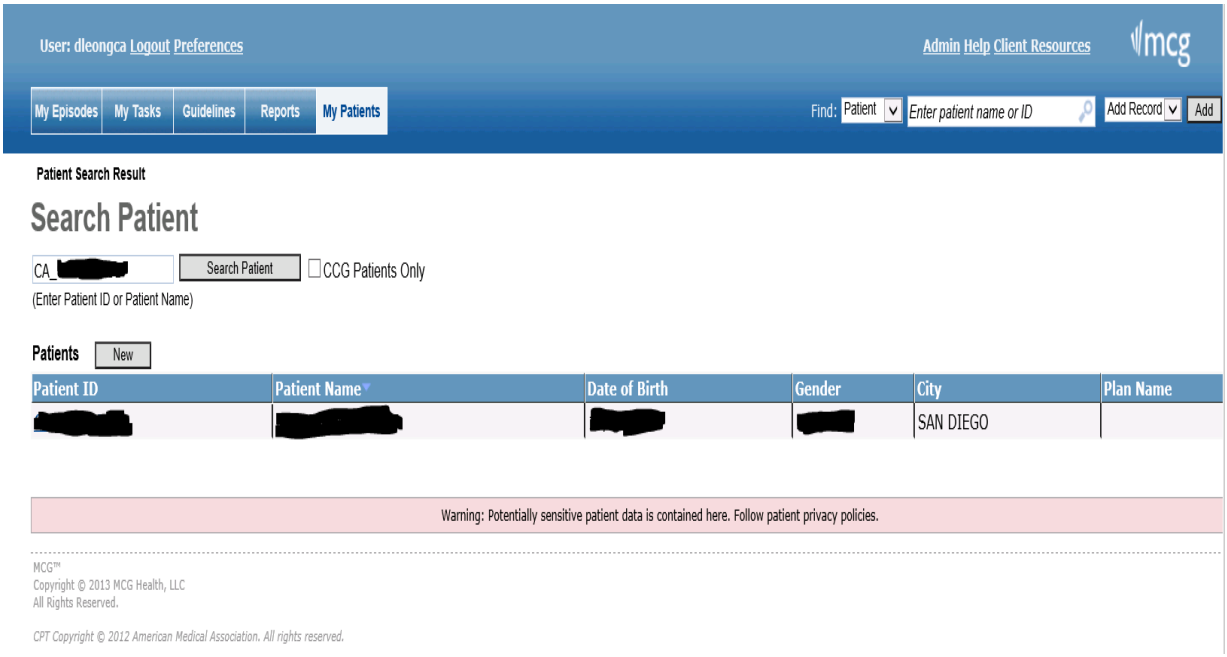
Screen Shot from CCMS Medical Management System

All members are loaded to the CCMS Medical Management system which is used by utilization management, case management, risk assessments, and quality outreach.



Screen Shot from MCG (Clinical Guidelines) System

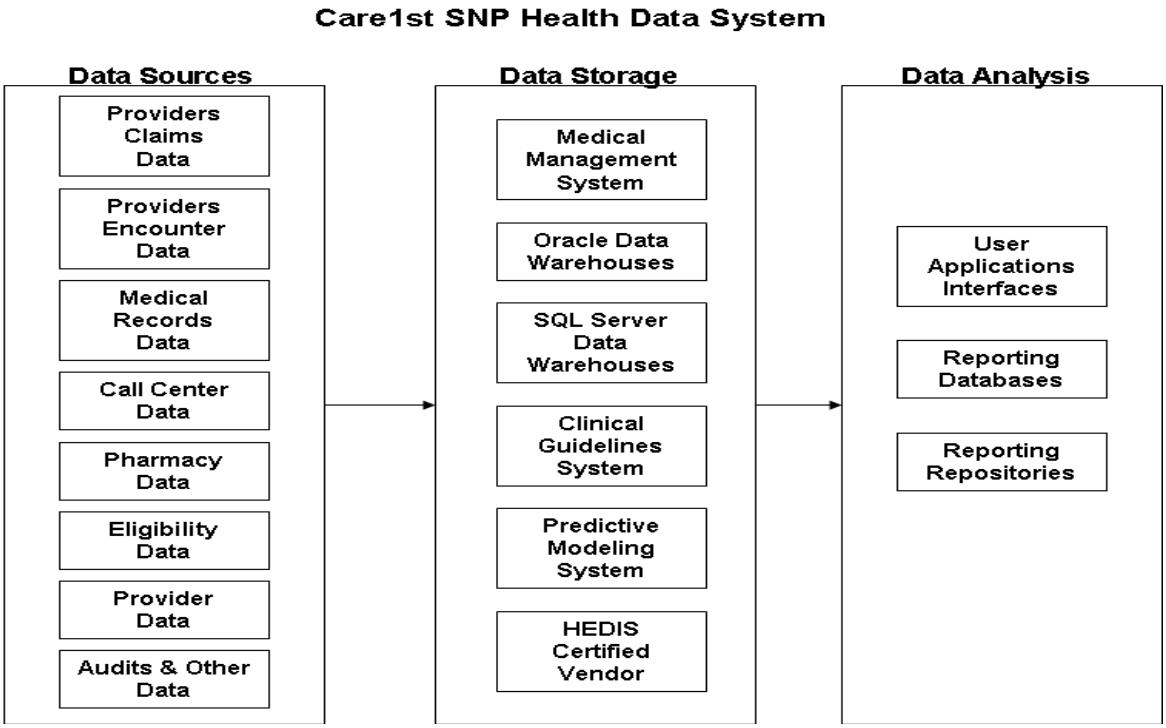
All members and certain inpatient events are loaded to this system which for using clinical guidelines based on the member's condition.



Health Data System Overall Schematic

Care1st maintains a robust interactive hierarchical system that collects data from providers and other sources, stores and manages the data in multiple data warehouses, loads data to medical management, clinical guidelines, and predictive modeling data bases, and uses application interfaces to the data ware house as well as reporting databases and data report repositories to all key users to analyze and monitor the health and health outcomes of each SNP member.

Data analyses are done for various Care1st operational units including quality improvement, utilization management, member services, grievance and appeals, provider networks, credentialing, quality site reviews, quality investigations, delegation oversight, compliance, marketing, and other units.



PART C and D REPORTING ELEMENTS

Care1st Health Plan utilizes the Medicare Part C and Part D Plan Reporting Requirements Technical Specifications Document and associated guidance (CMS User Group Calls, HPMS memos, etc.) to develop reporting protocols that clearly identify the required data elements and corresponding source data. Care1st's data team develops these protocols in collaboration with the business owner so that the information reported accurately represents the required measure. The structured protocols ensure consistency and reproducibility of the information that is reported. Additionally, as per CMS guidance, Care1st will engage the services of a third party entity to perform data validation.

Care1st participates in the annual data validation audit for its Part C and Part D reporting.

The Care1st Medical Services Committee and the Care1st Compliance Committee are responsible for reviewing the results of the Part C Reports and identifying trends or issues that require intervention. Action items identified by the Committees will be carried out by the appropriate Care1st team. For example, with regards to "Provider Network Adequacy", if a network deficiency is identified, Care1st's Medical Services Committee will request that Care1st's Provider Network Team obtain contracts with the necessary providers and report back the outcome of their actions to the Medical Services Committee.

Another example of how Care1st utilizes data to monitor and identify trends is illustrated by Care1st's Special Investigation Unit process of conducting timely review of sales-related complaints and presenting summary reports that include the Part C "Plan Oversight of Agents" reporting elements to Care1st's Compliance Committee. The Compliance Committee reviews the trends and makes recommendations to the Compliance Officer and Marketing team, as necessary. Similarly, results of these action items are reported back to the Compliance Committee. Minutes of the Care1st's Medical Services Committee and Compliance Committee reflect recommendations and actions generated by review of the Part C Reports.

(PART D) MEDICATION THERAPY MANAGEMENT PROGRAM (MTMP)

Care1st's clinical pharmacists are responsible for conducting the Care1st Part D Medication Therapy Management Program (MTMP). The pharmacists utilize pharmacy claims data to identify beneficiaries who meet the program criteria. Medication profiles associated with these beneficiaries are reviewed by a Care1st pharmacist to identify opportunities to improve the pharmaceutical regimen. Examples of the clinical observations include, but are not limited to, identification of duplicate therapy, harmful drug-drug interactions, inappropriate dosing, ensuring that the drug regimen is consistent with national treatment guidelines, etc. Clinical recommendations are based on nationally-recognized protocols and guidelines approved by Care1st's Pharmacy & Therapeutics Committee. The pharmacist provides their observations and treatment modification recommendations to the beneficiary's primary care physician. Physician response to the recommendations is tracked by monitoring responses returned to Care1st and information obtained from prescription claims data. Additionally, for high-risk situations, the pharmacist will contact the provider by phone and will monitor the resolution. If the high-risk issue is not resolved, the matter is reported to Care1st's Medical Director for peer-to-peer discussion. Care1st integrates a direct beneficiary interaction component to the MTMP. Care1st recognizes that by actively engaging the beneficiary in understanding the appropriate use of their medication, MTMP outcomes may be further enhanced.

Data associated with Care1st's MTMP is obtained directly from Care1st's MTMP database and pharmacy claims data. Care1st's Pharmacy Director is responsible for evaluating the accuracy of the data and providing overall program oversight in collaboration with the plan's clinical pharmacists. The MTMP activity and outcomes are presented to Care1st's Pharmacy & Therapeutics Committee. The Committee is responsible for reviewing the program's effectiveness and identifying program modifications or issues and trends that require action. See Appendix A.

14. MEDICARE – MEDICAID PLAN (MMP) / (CAL MEDICONNECT)

Model of Care

Medicare Medicaid Plan is a chronic care initiative that begins the process of integrating delivery of medical, behavioral, and long-term care services and provides a road map to integrate Medicare and Medi-Cal for people in both programs, called "dual-eligible" beneficiaries. The goals are to (a) improve quality of care; (b) maximize the ability of beneficiaries to remain safely in the homes and communities; (c) coordinate Medi-Cal and Medicare benefits across health care settings and improve continuity of care using a person-centered approach; and (d) promote a system that is both sustainable and enables beneficiaries to attain or maintain personal health goals.

Care1st implements an evidence-based Medicare-Medicaid (MMP) Model of Care (MOC) with explicit components consistent with the SNP Model of Care.

Care1st's MMP assures continuity of care for medical, mental and behavioral, and long term services and supports (LTSS) upon new enrollment. Policies and procedures are in place to ensure members get uninterrupted care with their previous physicians during their transition to the new plan.

Measurable Goals and Health Outcomes for the MOC

Care1st has indentified a comprehensive list of process and outcome measures that help the organization assess both quality of clinical care and services received by the member. These measures are based on HEDIS, CAHPS, internal surveys, grievance and appeals data, and other relevant elements that make up health plan operations. Care1st recognizes the importance monitoring and evaluating the outcome and process measures at least annually. This process helps Care1st cultivate an environment where quality of care for its MMP members is the top priority. See Appendix A.

Performance and Health Outcome Measurement

- **HEDIS Measures:**
  HEDIS data is collected through encounter data, claims data, pharmacy data, lab repositories and direct medical record reviews. Care1st proactively monitors HEDIS measures and actively contacts members and providers in attempts to get member scheduled for these services. The Quality Improvement department has outreach coordinators and nurses who visit providers continuously throughout the year to educate physicians and office staff on details about these measures. The QI department provides physicians with incentives for completing these specific services and the office staff small incentives for using our web portal and filing the reminders in the charts. The outreach staff collect gap data when out in the physicians' offices (they are equipped with secure laptops and scanners). Physician offices are educated about encounter submission processes and Care1st has a process for submission of encounter data through the web portal.

  HEDIS data is analyzed annually through the NCQA HEDIS Technical Specifications process. Care1st utilizes NCQA Certified HEDIS software programs to produce samples and enter medical record abstraction data. All HEDIS measures are compared against National benchmarks distributed by NCQA. All HEDIS measures are also compared to previous results to document statistical significance of rate changes. All HEDIS data has a quantitative and qualitative analysis completed and documented through the QI process. Providers are provided individual profile reports every six months that detail their HEDIS rates compared to their peers, Care1st overall and National benchmarks. Ongoing analysis and monitoring is done to track each measure proactively and interventions are done to encourage member to complete specific services.

  HEDIS analysis results are compared to national benchmarks and previous rates to establish statistical significance of changes. These results are submitted through the NCQA web site and an NCQA HEDIS Auditor who audits the results. The auditor performs an on-site audit of how data is used, an audit of the medical record abstraction process and the HEDIS result submission to NCQA. When the auditor signs-off on the results they are considered official results. When results are official the QI department summarizes all results, details statistical changes, completes a report of the quantitative and qualitative analysis, establishes new goals, and they are reported to the Medical Services Committee for recommendations. The QI department will recommend specific interventions and goals aimed to improve rates and through this committee these results are reported to the Board of Directors.

  Care1st acts upon these results through the same process. Each measure is reported with key findings, quantitative and qualitative analysis, goals and benchmarking, interventions and follow-up actions.

- **Health Outcomes Survey:**
  Health Outcomes Surveys (HOS) will be conducted annually with a baseline survey one year and a follow-up survey the following year. This survey compares specific member responses on a baseline survey and compares them to the same member follow-up responses the following year. The survey evaluates the member's physical functioning, fall risk, urinary incontinence, health status, pain, social functioning, and mental health. This is an NCQA survey and will be conducted using the HEDIS Technical Specifications Volume 6 for HOS.

- **Access to affordable health care services and essential services such as medical, behavioral health, drug and alcohol rehabilitation and social services:**
  Care1st collects data to evaluate access to care for appointment availability, after hours availability, geographical distribution and coverage (for PCPs, specialist, hospitals and ancillary services), and physical site accommodations for members with disabilities. Care1st also monitors the drug and alcohol rehabilitation access and monitors this through HEDIS measures. Data for appointment availability and after hours availability is collected through provider survey and secret shopper contact calls. and is compared to the Adults' Access to Preventive/Ambulatory Health Services (AAP).
  HEDIS Measure Data for the geographical distribution and coverage analysis is collected from our provider directory and is matched with our members home addresses to map out coverage within 15 miles of each member home. Physical site accommodations data is collected through on-site audits by our FSR Nurse. Drug and alcohol rehabilitation data is collected through encounter and claims data. The Care1st Quality Improvement department also reviews member grievance and CAHPS data as it relates to access to care issues, which gives validity to our access to care results. Behavioral Health access to care data is collected by our NCQA Accredited MBHO and distributed to QI for reporting to the Medical Services Committee.

  Care1st analyzes all the data collected from surveys and secret shopper contact calls and calculates each provider compliance rate. These rates are compared to overall averages and prior year rates to document improvements or changes. Care1st analyzes geographical mapping studies to document and establish specific geographical areas where additional coverage is needed. The geographical studies are completed from all PCPs, specialist, hospitals and ancillary services. We also conduct language mapping to assure we have enough providers who speak specific languages that our members need. These results are compared to previous results to document improvements, which are completed every six months. Data is supplied in writing to our Provider network Operations (PNO) department to work on contracting additional providers in coverage gap areas. Physical Site Accommodations data is not scored and a CAP is not done but data is analyzed and placed in the provider directory for members to use when selecting provider who best meet their needs. The Care1st Quality Improvement department also analyzes member grievance and CAHPS data as it relates to access to care issues, which gives validity to our access to care results. The MBHO is delegated the responsibility to analyzes and provide interventions and follow-up for access to care as it relates to behavioral health providers.

  Care1st reports all the data and analysis to our Medical Services Committee for recommendations and through this committee to the Board of Directors. Physicians who fall below the benchmark goals are given results and are required to submit a written CAP. PNO department obtains report of coverage gaps to work on contacting additional providers. Physical accessibility reports are used for provider directories so members can be better informed about the sites ability to meet their needs. Behavioral health access to care reports is supplied by our NCQA Accredited MBHO and is reported through our Medical Services Committee.

Care1st acts on all the access to care related studies and reports by first reporting all analysis to our Medical Services Committee for recommendations and through this committee to the Board of Directors. All providers who fall below the 95% compliance rate for appointment availability and after hours are required to submit a written CAP and follow-up evaluation is planned to document improvements. Geographical mapping is acted upon through contracting additional providers need to cover any identified gap areas. If a gap area cannot be covered we have a written plan to address the issue. An example; we have a rural area where specific specialty types are not available within the required distance. Care1st addresses this issue by providing these member free transportation to out of area specialists.

- **Member Satisfaction, Grievances and Potential Quality Issue Reviews:**
  Care1st collects data to evaluate member satisfaction through the CAHPS and a Proactive CAHPS process. The Quality Improvement department conducts a proactive member satisfaction survey mid-year where every SNP member gets a survey form to complete. The Member Services department also offers the survey to member when they contact us. At the beginning of each year Care1st will conduct an official CAHPS survey through an NCQA Certified CAHPS vendor. Care1st does not delegate any QI activities to any entity (with exception for the MBHO) so all member grievances and PQIs are reviewed and processed at Care1st. We keep a centralized database giving us ability to track and trend this data multiple ways.

  Care1st will also collect data from the Health Outcomes Survey, Specialized Disease management and Complex case Management surveys to identify opportunities for improvements.

  Care1st analyzes proactive member satisfaction data through calculating each question rates, which are compared to previous studies for improvement. Actual CAHPS studies will be completed by an NCQA certified vendor and analysis and benchmarking will be report to us in summary reports. Member grievances and PQIs are annualized per 1000 members and the QI department profiles providers and medical groups to identify trends. Each individual grievance is investigated and if a quality issue is identified an individual corrective action plan will be written and completed. The contracted MBHO collect, analyzes and reports behavioral health related grievances.

  Care1st reports all data collected and analyzed for member satisfaction, grievances and potential quality issues to the Medical Services Committee for recommendations. Individual grievances or PQIs where an actual quality issue is identified are reported through the Peer Review Committee for corrective actions prior to the Medical Services Committee. From the Medical Services Committee all reports are then supplied to the Board of Directors.

Care1st acts upon these reports in various ways. Individual grievance or PQI issues are addressed directly with the physician or medical group and all documentation and corrections are documented. Trending reports are supplied to the medical groups during Joint Operation Meetings (done at least annually). CAHPS reports are distributed to internal departments and interventions are developed. The MOC Sub Committee (MOCSC) has developed internal action teams to identify additional opportunities for improvements. An example of this process is as follows: We had lower CAHPS scores two years ago and brought the issues to the MOCSC for discussion and action. The committee agreed to establish a post grievance survey to document if the member was satisfied with our resolution of their grievance issue. Through this committee the Primer Member Services department was recommended so we had the ability to personalize our services to our members. The proactive CAHPS survey process was also recommended and established. Quality issues identified from grievances and PQIs are reported through the Peer Review Committee (PRC). The PRC takes specific actions to address the issues identified and can range from education, proctoring, to termination of contractual agreement.

Effectiveness of the Model of Care

- **Work Plans**
  Quality Improvement Work Plans
  Quality Improvement Work Plan is developed annually outlining Quality Improvement and Model of Care activities for the year. The Work Plans will include all activities not completed during the previous year, unless identified in the Annual Evaluations as issues that are no longer relevant or feasible to pursue. The Work Plans are reviewed by the Chief Medical Officer and submitted to the Medical Services Committee and Board of Directors for review and comment. The Quality Improvement Work Plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement.

- **Utilization and Case Management Work Plans**
  Utilization and Case Management departments develop annual Work Plans that outline all Utilization, Case Management, and Model of Care activities for the year. The Work Plans will include all activities not completed during the previous year, unless identified in the Annual Evaluations as issues that are no longer relevant or feasible to pursue. The Work Plans are reviewed by the Chief Medical Officer and submitted to the Medical Services Committee and Board of Directors for review and comment. These Work Plans are fluid documents and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement

Measuring Effectiveness of Care Management Programs

Care Management Programs, such as Model of Care, QIPs, CCIP, Disease Management Programs, Complex Case Management, HEDIS, CAHPS, HOS, grievances and PQIs, are Care1st Dual Demo MOC (C) measured on a consistent basis to demonstrate effectiveness of the interventions established. These measurements are established through the QIA Steering Committee and Medical Services Committee and specific timeframes for re-measurement and methodology vary. All measurements and studies are presented to the Medical Services Committee and summarized on the annual evaluations, which are available for regulatory agency review. Quarterly reports are an evaluation of the progress of the Quality Improvement activities, as outlined in the Work Plan, and are submitted to the Medical Services Committee and Board of Directors for review and comment each quarter.

- **Quarterly Reports**
  Quarterly reports are an evaluation of the progress of the Quality Improvement and Model of Care activities, as outlined in the Work Plan, and are submitted to the Medical Services Committee and Board of Directors for review and comment each quarter

- **Annual Plan Evaluation**
  Quality Improvement and Model of Care activities, as defined by the Quality Improvement Work Plan, will be evaluated annually to measure the Plan's performance for the year and to assist in revising the Quality Improvement Program and preparing the following year's Work Plan. The Evaluations are reviewed by the Chief Medical Officer and submitted to the Medical Services Committee and Board of Directors for review and approval

Dissemination of QI and Model of Care Program, Activities and Outcomes to Network Practitioners

- All network Practitioners will be informed of the Quality Improvement and Model of Care Program, activities and outcomes in accordance with DHCS, CMS, and NCQA, and DMHC requirements. Care1st Health Plan will update Practitioners on any revisions or changes to the QI program. The QI Department will disseminate information on its activities and outcomes from studies or surveys.

- All Care1st Network Practitioners will be given a Practitioner Manual, which describes in detail the Quality Improvement and Model of Care standards, goals, objectives and guidelines.

- Periodically the Quality Improvement Department will write articles in the Practitioner newsletter highlighting specific standards and guidelines (i.e., Access to Care, Member Satisfaction, HEDIS Results, etc.).

- Any immediate change in standards the Practitioner network will be notified in writing and via broadcast fax. This will be followed up with newsletter articles and revisions to the Practitioner Manual.

- Practitioners will be mailed at least every six months a profile report, which details their compliance with several QI and Model of Care indicators. These indicators include but are not limited to:
  - Encounter data submission
  - Compliance rates of Access to Care studies, FSR.
  - Current HEDIS rates

- Practitioners are provided through the web portal monthly a list of their assigned members needing preventive care services (i.e., Colorectal cancer Screening, Mammograms, medication reconciliation, functional assessments, etc.)

- Practitioners will be notified of any grievance issue and they are required to respond in writing. They will be notified of all determinations in writing.
- Study outcomes are disseminated to Practitioners through the Practitioner Newsletter, direct mailings and our web site.

Dissemination of QI and Model of Care Program, Activities and Outcomes to Members
All members will be informed of the Quality Improvement and Model of Care Program, activities and outcomes. Care1st Quality Improvement department will disseminate information on its activities and outcomes from studies or surveys.

- All Care1st members will be mailed at least two times a year a member newsletter that details Quality Improvement and Model of Care activities and where to find additional details and analysis on the web site (i.e., Access to Care, Member Satisfaction, HEDIS Results, etc.).

- Members will have access to the provider directory on line, which will detail physical accessibility information.

- Members will be mailed reminders for services they are due to complete.

- Member Service screens are populated with HEDIS reminder data so when they contact Care1st they will be reminded.

- Members will be mailed and informed of the contact information if they wish to request a hard copy of specific study results or information.

- Members will be mailed an acknowledgement of any grievance issue within 5 days of receipt and a closure letter within 30 days of receipt.

15. POLICIES AND PROCEDURES

Quality Improvement

70.1.1.1 Confidentiality of QI Information
70.1.1.3 Internal Quality Improvement Projects (IQIP's)
70.1.1.5 Assigning a Quality Improvement Severity Level
70.1.1.7 Clinical Grievance Process
70.1.1.8 Access to Care Standards and Monitoring Process
90.1.1.8 Access to Care Standards and Monitoring Process
70.1.1.9 Potential Quality of Care and Quality of Care issues
70.1.1.10 Peer Review
70.1.1.11 Sentinel Events
90.1.1.11 Sentinel Events
70.1.1.12 Practitioner Request to Terminate Patient/Practitioner Relationship
70.1.1.14 Initial Health Assessment – IHEBA's
70.1.1.22 Confidentiality and Release of Patient Medical Information
70.1.1.24 Medical Record Keeping
70.1.1.25 Member Satisfaction Survey – CAHPS and ProActive CAHPS
90.1.1.25 Member Satisfaction Survey – CAHPS and ProActive CAHPS
70.1.1.26 Practitioner Satisfaction Survey
70.1.1.28 Cultural and Linguistic in QI
70.1.1.29 Availability of Practitioners (PCP, SPEC, Hospitals & Ancillary)
70.1.1.30 Continuity and Coordination of Care
70.1.1.31 Over and Under Utilization
90.1.1.38 Availability of Specialty Care Practitioners
70.1.1.44 Reporting Diseases and Conditions to Public Health Agencies
70.1.1.45 Dissemination of QI Activities and Outcomes to Network Practitioners
70.1.1.49 Patient Safety Program
80.1.1.50 Interactive Voice Response (IVR) System
70.1.1.51 QI Outreach Program
70.1.1.52 Over and Under Utilization of Specific Services
90.1.1.52 Over and Under Utilization of Specific Services
50.1.1.55 Reporting to CMS
90.1.1.55 Reporting to CMS
80.1.1.56 Reporting to DHCS
70.1.1.57 Grievance Tracking Process
70.1.1.58 Provider Portal Data/QI Data Information Exchange
70.1.1.59 Continuity and Coordination between Medical and Behavioral Health Care
90.1.1.59 Continuity and Coordination between Medical and Behavioral Health Care
50.1.1.60 CMS Chronic Care Improvement Program (Clinical Initiative)
50.1.1.61 CMS Quality Improvement Project (QIP)
90.1.1.63 Community Based Adult Services (CBAS) and LTSS Quality Monitoring

HEDIS

70.1.2.1 HEDIS Studies and QISMC Studies Reporting
90.1.2.1 HEDIS Studies and QISMC Studies Reporting
70.1.2.2 HEDIS Medical Record Abstraction Process
70.1.2.3 HEDIS Oversight Audit Process
90.1.2.3 HEDIS Oversight Audit Process
70.1.2.4 HEDIS Reporting and Dissemination of Results
70.1.2.5 HEDIS Corrective Actions and Interventions
90.1.2.5 HEDIS Corrective Actions and Interventions
70.1.2.6 Internal HEDIS Tracking Database and Collection Process
70.1.2.7 Healthy Start Program
70.1.2.8 HEDIS Provider Incentive

Credentialing

70.1.3.1 Credentialing Committee
70.1.3.2 Minimum Credentialing Criteria for Practitioners
90.1.3.2 Minimum Credentialing Criteria for Practitioners
70.1.3.3 Credentialing Verification
90.1.3.3 Credentialing Verification
70.1.3.4 Re-Credentialing Cycle Length
90.1.3.4 Re-Credentialing Cycle Length
70.1.3.5 Sanction Review
90.1.3.5 Sanction Review
70.1.3.7 Adverse Events
70.1.3.8 Practitioner Rights
70.1.3.9 Confidentiality of Credentials Information
70.1.3.10 Fair Hearing Plan
90.1.3.10 Fair Hearing Plan
70.1.3.11 Non-Physician Medical Practitioner Initial Credentialing
90.1.3.11 Non-Physician Medical Practitioner Initial Credentialing
70.1.3.12 Non-Physician Medical Practitioner Re-Credentialing
70.1.3.13 Credentialing Policies
90.1.3.13 Credentialing Policies
70.1.3.14 Delegation of Credentialing
90.1.3.14 Delegation of Credentialing
70.1.3.15 PCP Practice Requirements
70.1.3.16 Chief Medical Officer's Responsibilities for Credentialing
70.1.3.17 Reporting Sanction Activity to State and Federal Agencies
90.1.3.17 Reporting Sanction Activity to State and Federal Agencies
70.1.3.18 Credentialing of Health Delivery Organizational Providers
90.1.3.18 Credentialing of Health Delivery Organizational Providers
70.1.3.19 Provider Database Modification Changes
70.1.3.20 HIV Specialist Credentialing Criteria
90.1.3.20 HIV Specialist Credentialing Criteria
70.1.3.21 Guidelines for Physicians Supervising Non-Physician Medical Practitioners
90.1.3.21 Guidelines for Physicians Supervising Non-Physician Medical Practitioners
50.1.3.22 Medicare Opt-Out Practitioners
90.1.3.22 Medicare Opt-Out Practitioners
70.1.3.23 Mid Cycle License and Expired Documents
70.1.3.24 LOA Credentialing Process

Facility Site Review

70.1.4.12 Member Complaint-Related Office Visit

HCC

50.1.5.1 HCC Internal Staff Audit
50.1.5.2 HCC Contracted Vendor Audit Process
50.1.5.3 HCC Vendor Data and Chart Retrieval
50.1.5.4 Hierarchical Condition Category (HCC)
50.1.1.5; Medicare Risk Adjustment Process

16. APPENDIX

Appendix A Population Description
Appendix B QI MOC Performance Improvement Measures
Appendix C Committee Structure
Appendix D Meeting Minutes
Appendix E Quality Improvement Calendar/Work Plan (sample)
Appendix F Quarterly Reports (sample)