The Quality and Medical Management (QMM) Program integrates the primary functions of Quality, Medical Management and Pharmacy. These departments work in tandem to establish, coordinate and execute a structure to support Health Alliance members/enrollees as they work to improve their health and assess and evaluate the care and service provided.

**Definition of Quality**
- Purpose
- Goals
- Objectives
- Scope
- Structure

**Medicare Advantage**

**Key Personnel**

**Resources**

**Committee Descriptions**
- Quality Improvement Committee
- Utilization Management Committee
- Credentialing Committee
- Medical Director Committee
- Medical Policy Committee
- Pharmacy & Therapeutics Committee
- Behavioral Health Care Advisory Group
- Members’ Rights and Responsibility Committee
- Case Management Leadership Team
- Consumer Advisory Committee - Commercial
- Medicare-Medicaid Advisory Board
- Community Stakeholder Committee SPD/Dual Eligible
- Compliance Committee
- Government Programs Workgroup
- Adverse Events Committee

**Approval Page**

Appendix
1. 2013 Health Alliance Medicare Program Domains
2. Quality and Medical Management Department organizational chart

**QUALITY MANAGEMENT**

**DEFINITION OF QUALITY:**
- **Clinical quality** is defined as minimum variation from evidence-based practice or expert consensus.
- **Service quality** is defined as meeting or exceeding the valid service requirements of our customers.

**PURPOSE**
Quality Improvement (QI) at Health Alliance is an integrative process of continuous assessment and monitoring that strives to improve care and service provided to Health Alliance members/enrollees. Activities are monitored according to a variety of quality indicators as outlined in the annual QI Plan. These indicators assess the healthcare programs delivered within the Health Alliance system. Based on quality indicator measurements and continuous evaluation of the program components, opportunities for improvement are identified. These opportunities enhance the quality of care and service provided to our members/enrollees by improving efficiency, increasing the span of healthy life and reducing disparities in the healthcare provided. Components of the QI Program include all plan types (Commercial HMO/POS, Commercial PPO, Medicare HMO, Medicare PPO, MMAI and SPD), unless otherwise specified. The Quality and Medical Management Department is committed to ensuring that the care delivered to our members/enrollees is of the highest “value”. Value = Quality + Service/Cost. All utilization management activities are conducted at the health plan, there is no delegation.

GOALS
The goals of the Health Alliance QMM program include:

A. Establish standards of clinical care and service for members/enrollees and measure performance outcomes
B. Identify opportunities to enhance clinical care and service for members/enrollees
C. Respond with appropriate interventions to prioritized opportunities to improve clinical care and service
D. Measure the effectiveness of interventions and implement actions as needed to improve

OBJECTIVES
The objectives of the Health Alliance QMM program include:

A. Utilize a population-based approach to measuring and addressing continuous quality improvement for clinical care and service for members/enrollees
B. Develop, refine, and maintain data systems capable of providing systematic, reliable, and meaningful data for use in the QMM program
C. Facilitate a partnership between practitioners, providers, members/enrollees, and Health Alliance for the purpose of maintaining and improving plan-wide services
D. Annually measure access, availability, and trends in member/enrollee satisfaction for improving service
E. Develop and maintain approaches to providing high-quality clinical care, including disease management, practice guidelines, utilization criteria and guidelines, complex case management, peer review, medical technology review, pharmaceutical management procedures, medical record criteria, and processes to enhance communication and continuity of care between practitioners and providers
F. Involvement of designated behavioral health care practitioners to address behavioral health issues, including continuity and coordination of care, preventive health, clinical practice guidelines, appropriate triage and referral, customer service, clinical care including pharmaceutical management and all aspects of the QMM program. Health Alliance does not have a centralized triage and referral process for behavioral health services.
G. Develop and maintain a utilization management (UM) program that incorporates nationally recognized criteria, use of appropriate clinical professionals, risk management, member/enrollee and practitioner appeal rights, and appropriate handling of denials of service. Through the UM process, each case is evaluated against established medical criteria to determine medical necessity. In the case of Medicare plans, the reviewer complies with national coverage decisions, general Medicare coverage guidelines and written coverage decisions of local Medicare contractors. Individual patient circumstances and the capacity of the practitioner and provider delivery systems are considered. Factors such as age, co-morbidities, complications, progress of treatment, psychosocial situations, and home environment (when applicable) are reviewed when applying criteria. Department policies and procedures further define these processes in detail.
H. Develop and maintain a pharmaceutical management program that includes the development of policies and procedures, processes for restrictions and preferences, patient safety, review and update of procedures, participation of pharmacists and physicians, notification to practitioners, and prior authorization processes including denials and appeals.

I. Develop and maintain a credentialing and recredentialing program for individual practitioners and provider organizations that adheres to federal and state regulations, as well as standards for accreditation.

J. Provide access to information about patient safety to members/enrollees and practitioners through our website while encouraging accountability for patient safety with contracted providers through our Adverse Events and Quality of Care processes.

K. Assess cultural and linguistic needs of member/enrollee population at least annually and report findings to the Members Rights and Responsibilities/Quality Improvement Committee. Annual assessment includes evaluation of CAHPS and new member/enrollee survey demographic data, Language Line translation requests for oral translation services with documentation available upon request, complaint data, CACTUS credentialing system data for provider language spoken, CCMS case management cultural need responses, and data provided by Health Alliance’s four major provider systems.

L. Provide members/enrollees with information regarding rights and responsibilities, health plan policies and procedures, benefit and coverage information, and ensure appropriate oversight of procedures that protects the privacy and confidentiality of member/enrollee information and records.

M. Develop and promote preventive health standards and programs to encourage members/enrollees and practitioners to utilize appropriate guidelines and early detection services for prevention of illness.

N. Provide an appeals process designed to protect the rights of the member/enrollee, physician and hospital as fully as possible. Ensure that any member/enrollee, provider or practitioner who is affected by an adverse determination is given the opportunity to appeal through a verbal or written request for medical and administrative review.

O. Establish standards and processes for maintenance and oversight of delegated activities, if applicable.

P. Establish an annual QMM Plan that describes specific activities undertaken each year to address the components of the QMM program.

Q. Annually review the QMMD program activities for determining effectiveness and focus for the coming year. The QMM department prepares an annual evaluation that is reviewed and approved by the CMO, Department Director, and the Quality Improvement Committee. The annual evaluation contains a summary of the year’s program activities. An assessment of the effectiveness of the various components of the program as well as recommended program modifications and activities planned for the coming year are included. The annual evaluation highlights significant changes in the operation of the Quality Management, Medical Management, Pharmacy and Personal Health Coordination Programs based on review and recommendations from QMM leadership. Member/Enrollee and practitioner satisfaction with program activities is assessed as part of the evaluation. The impact of activities is reviewed by using the program evaluation to identify opportunities for improvement and to revise the programs as needed.

PROGRAM SCOPE
The scope of the Health Alliance QMM program is designed to fulfill the goals and objectives of the program, while efficiently utilizing resources to promote and enhance integration of quality activities internally (within Health Alliance) and externally with practitioners, providers, members/enrollees, employers, state and federal agencies, and appropriate parties. The scope of the QMM program includes, but is not limited to:

A. Clinical Care
   1. preventive health activities
   2. clinical quality improvement activities
   3. clinical management criteria and guidelines
   4. disease management
   5. credentialing and recredentialing
   6. inpatient care review for inpatient, surgical and behavioral health care admissions
   7. discharge planning
8. preauthorization review for medical necessity
9. personal health coordination, including complex case management

B. Service
1. Member/enrollee complaints and appeals
2. trends in member/enrollee dissatisfaction/satisfaction (including CAHPS surveys)
3. appointment and afterhours access monitoring
4. practitioner availability monitoring
5. telephone access
6. written and verbal communications with members/enrollees
7. concurrent review

C. Behavioral Health Services
1. preventive health
2. mental health and substance abuse quality improvement activities
3. behavioral management criteria and guidelines
4. telephone and appointment access monitoring
5. credentialing and recredentialing
6. utilization management
7. care transitions

D. Patient Safety
1. continuity and coordination of care between practitioners and providers
2. tracking and trending of adverse events
3. evaluation of clinical care against aspects of evidence based guidelines that improve safe practices
4. implementation of health management systems that support timely delivery of care
5. medication management evaluation through case management program

The process of integrating the quality improvement initiatives with various Health Alliance departments and committees is accomplished, in part, through appointment of representatives to the committees listed in the structure of the quality improvement program with a diversity of knowledge and skills. These individuals support the development and continuous evaluation of the QMM Program, through the plan, do, study and act cycle. It is the primary responsibility of the QMM Department to diffuse quality initiatives throughout the organization.

STRUCTURE OF PROGRAM
The Quality and Medical Management Program provides a comprehensive structure to identify, evaluate and improve clinical care and service provided to members/enrollees individually and collectively. The Health Alliance Board, through its Quality Committee, oversees the structure with day-to-day accountability designated to the Chief Medical Officer and Quality Improvement Committee (QIC). Subcommittees of the QIC provide a focus on initiatives involving quality improvement such as utilization management, members’ rights and responsibilities, credentialing and pharmacy. In addition to committees, multiple departments and individual staff members/enrollees have key roles and responsibilities in the QMM program.

MEDICARE ADVANTAGE
In addition to objectives, scope and program structure previously described, the following are specific to the Health Alliance Medicare Advantage product:

1. A chronic care improvement program (CCIP) that includes methods for identifying MA enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in the program and mechanisms for monitoring MA enrollees that are participating in the chronic care improvement program. The program must also address populations identified by CMS based on a review of current quality performance.
2. Quality improvement projects (QIP) that can be expected to improve health outcomes, enrollee satisfaction, and addresses areas identified by CMS. The projects are specific initiatives that address
clinical and non-clinical areas and involve measurement of performance, system interventions including
the establishment or alteration of practice guidelines, improving performance and systematic and periodic
follow-up on the effect of the intervention.

3. Encourages providers to participate in CMS and Health and Human Service (HHS) QI initiatives.
4. Contracts with approved Medicare CAHPS vendor to conduct the Medicare CAHPS survey.
5. Complies with and monitors the activities reflected in the Medicare domain program table which includes
(complete domain table found in Appendix 1:

a. Safer Patient Care (Medication Events, Health Care Associated Infections and Other Preventable
Conditions)
b. Patient Centered Care (Cultural Competency, Decision-Marking Partnerships and Integrated
Care Delivery)
c. Effective Care Coordination (Care Management, Effective Discharge Planning and
Multidisciplinary Coordination)
d. Effective Prevention & Treatment (Current Quality Initiatives, Early Detection & Intervention
and Appropriate Treatment Modalities)
e. Promotion of Healthy Living (Evidence Based Medicine, Clinical Preventive Services and
Education & Counseling for Risk Behaviors)
f. Effective Communication (Electronic Health Records, e-Prescribing and Telemedicine)
g. Improving Affordability (Utilization of Products & Services, Payment and Service Models and
Administrative Simplification)

KEY PERSONNEL

a. **Chief Medical Officer (CMO)** provides medical leadership for all Health Alliance products in all service
areas. Oversees the successful implementation of medical management, pharmaceutical, Medicare Advantage
revenue management and quality programs. The pharmacy, quality and medical management, Medicare
Advantage revenue management, and contracting/provider network directors report to the CMO. The Senior
and Regional Medical Directors report to the CMO; and to the director of quality and medical management
for administrative functions. The CMO chairs the Medical Director Committee and Adverse Events
Committee; and participates on the Quality Improvement, Medical Policy, Pharmacy and Therapeutics,
Compliance and Members’ Rights and Responsibilities committees.

b. **Senior and Regional Medical Directors** are key resources for the quality and medical management team.
These four medical directors are members of the Quality Improvement Committee and obtain feedback on
quality and medical management initiatives throughout the Health Alliance network. Physicians and
pharmacists make all UM denial determinations for medical necessity through daily reviews for medically
necessary services at all levels and appeal reviews, they are key to the following areas:

a. The Senior Medical Director is an Adult Medicine/Geriatric Provider by training, and a 100% medical
director. He chairs the Medical Policy Committee, participates in the Quality Improvement Committee,
Medical Director Committee and leads the preauthorization review process, medical policy development
and annual review, tech topic reviews, out of area concurrent review, and supports the CCMS system
enhancements and embedded criteria, including the provider portal link to Clear Coverage.

b. A Regional Medical Director, a Psychiatrist, is a 50% medical director and practices 30% for Carle. He
chairs the Quality Improvement Committee, is a member of the Behavioral Health Workgroup,
Credentialing Committee, Medical Director Committee and is integral in the management of acute care
for mental health and case management to integrate behavioral with medical needs. He leads meetings
with the providers in the local service area to share utilization reports and obtain feedback on
improvements in the reporting/feedback process.
c. Two Regional Medical Directors are Family Practice Physicians. One is an 85% medical director for the Bloomington/Peoria and surrounding markets. He chairs the Credentialing Committee, participates in the Adverse Event Committee, OSF Joint Venture team, leads acute and non-acute concurrent review activities and interrater reviews. The other leads initiatives in the Springfield market and chairs the Pharmacy and Therapeutics Committee, participating in the Needs Assessment Committee, and the Springfield Joint Venture team. Four additional Medical Directors provide day-to-day support at least 20% time for medical necessity reviews. Their specialties include Allergy, Emergency Medicine, Pediatrics and Otolaryngology/Head and Neck Surgery.

d. **Pharmacy Director** is responsible for drug formulary design and development, implementation and risk management to improve quality, control cost and contain costs. Responsible for the supervision of the pharmacy network, pharmacy staff, pharmacy related contracting and pharmacy benefit manager. Evaluates and implements interventions that address clinical, administrative, financial and regulatory challenges involved in managing pharmaceutical costs and utilization.

e. **Quality and Medical Management Director** provides oversight for the quality and medical management department. Responsible for identifying, implementing monitoring and evaluating quality and medical management activities to improve care and service provided to all Health Alliance members/enrollees. Responsible for overseeing the areas of credentialing and re-credentialing for all providers (individual and facilities); wellness; enhance Joint Venture and community partnerships; member/enrollee appeal and grievance monitoring to meet regulatory agency requirements; clinical guidelines for acute, chronic, preventative and behavioral health services; population-based disease management programs with the goal of improving health outcomes; case management to ensure engagement and improvement in quality of life; utilization management to focus on reducing medical spend while maintaining or improving quality; and ensuring appropriate document and reporting systems are utilized to maximum efficiency.

f. **Medicare Advantage Revenue Manager** is responsible for the overall development, implementation and operational oversight of a dedicated unit ensuring adequacy and appropriateness of Medicare Advantage revenue, clinical care and star ratings. Direct strategic planning and standardization of Medicare Advantage reimbursement and clinical processes throughout multiple business units and departments.

g. **Utilization Management Manager** is a registered nurse who oversees the utilization management activities for all products. She oversees the preauthorization process using established criteria to determine coverage. Ensures that questionable cases or any potential denials based on medical necessity are forwarded to a Medical Director for review. Ensures utilization management coordinators determine denials based on benefits only; and support the Intake Coordinators who are the front line staff for the preauthorization process.

h. **Contracting and Provider Service Director** oversees the contracting and provider services department. Responsible for the overall direction and coordination of Network Development, Contracting and Provider Relations. Duties include planning, directing, organizing, controlling, and evaluating the implementation of strategic and tactical plans that ensure effective provider interactions and network development, and their continued viability to the organization.

i. **Accreditation and Credentialing Manager** oversees the day-to-day credentialing and re-credentialing for all practitioners and providers, as well as manages the delegated credentialing program. Key contact to coordinate NCQA activities and facilitates completion of NCQA onsite activities.

j. **Case and Disease Management Manager** is a registered nurse who oversees the integration of case and disease management to ensure a focus on the continuum of care that with wellness, move through population management of disease and individualized case management. She leads a team of three senior case managers, two case management representatives (assistants) and case management coordinators.

k. **Wellness Administrator** develops, implements and oversees all wellness activities internal to Health Alliance as well as offerings and supporting employer groups.
1. **Member Relations and Intake Manager** oversees the staff and management of the appeals process, DOI complaints, and front line preauthorization process for Intake Coordinators. Intake Coordinators may only approve specific services for which there are explicit criteria working closely with the Utilization Management Manager.

m. **Quality and Medical Management Reporting Manager** oversees HEDIS data retrieval and analysis, works with clinical reporting tools, provides reports for quality and medical management interventions that ensure NCQA and regulatory compliance.

n. **Quality Health Management Services Coordinators**, through accountability for assigned quality initiatives, facilitate solutions to improve care and service through population based disease management and patient safety programs, HEDIS data collection, complete tasks that support activities defined in the QI work plan and prepare routine reports to the Quality Improvement Committee (QIC).

o. **Medicare Advantage Star Specialist** leads the Medicare workgroup and focuses on improving star rating measures. Oversees population disease management programs for all populations and Medicare specific NCQA/CMS requirements.

p. **Data Analysts** provide statistical comparisons and analysis for quality improvement studies and supplies data for multiple initiatives, including access, various components of member/enrollee satisfaction, clinical guideline surveys, and inter-rater reliability analysis.

q. **Systems and Operations Analyst** is responsible for development and maintenance of medical management reports that support the department activities. Participates in analysis, testing and integration of the organization’s software and information systems as it relates to medical management functions. Provides technology expertise to the department and collaborates with other departments for data collections and system upgrades and maintenance.

r. **Manager for Acute and Non-Acute Care** is a registered nurse who oversees acute and non-acute care processes. Two senior nurse managers report to the manager, one leads acute care and one leads non-acute care; and two intake coordinators support these areas, reporting to the designated senior manager.

s. **Medical Management Coordinators** include Utilization Management Coordinators, Outpatient and Inpatient Case Managers. Utilization Management Coordinators perform preauthorization. Inpatient Case Managers perform concurrent review, with a key focus on discharge planning, in the inpatient acute setting and at non-acute skilled nursing facilities. Retrospective reviews are conducted within each area, as appropriate. Established clinical criteria are used to determine coverage based on medical necessity. Questionable cases or potential denials based on medical necessity are forwarded to a Medical Director for review. Medical Management Coordinators may determine denials based on benefits only. Outpatient Case Managers facilitate care transitions and complex member/enrollee needs through motivational interviewing techniques and approved scripting. An initial clinical assessment, screening for changes in health status, care transitions, and coaching and monitoring behavior changes for improved self-management are the performance expectations. Members/Enrollees are also reminded about necessary testing and follow-up care as determined by clinical guidelines. Patient information sources include medical and pharmacy claims, medical record documentation, discussion with appropriate physicians and information gleaned from the member/enrollee.

t. **The Communications Specialist** is dedicated to quality management to provide consultation for material presentation and coordinate material distribution, as needed.

The organizational charts for the Quality and Medical Management and Medicare Advantage Revenue Management departments depict the reporting structure for the majority of the key personnel integral to the quality improvement program.

**RESOURCES**

There are a number of technical resources available to support the initiatives and programs offered to members/enrollees and providers including, but not limited to:
1. **CareEnhance Clinical Management Software (CCMS)** is a McKesson system that provides full medical management services including utilization management, case management, disease management, management of members/enrollees at risk (complex case management) and documentation of appeals. The system allows evaluation of care management by tracking and measuring goals, interventions and outcomes.

2. **InterQual** is embedded in CCMS and is an industry-leading evidence-based tool for determining the appropriateness of health care interventions and levels of care across the continuum. This program supports preauthorization, concurrent review and retrospective analysis of clinical appropriateness. The following guidelines are used:

   - **Inpatient Services**
     - InterQual® Level of Care: Acute Criteria, Adult
     - InterQual® Level of Care: Acute Criteria, Pediatric
     - Prest & Associates, Inc. Review Criteria - Mental Health

   - **Outpatient Services**
     - InterQual® Care Planning: Procedures Criteria, Adult and Pediatric
     - InterQual® Care Planning: Imaging Criteria, Adult and Pediatric
     - InterQual® Care Planning: Molecular Diagnostics

   InterQual is a nationally respected vendor with clinical criteria based on best practice, clinical data and medical literature. Prest & Associates, Inc. is a nationally respected independent review organization that provides Behavioral Health criteria along with consultation and review services with board certified physicians in Mental Health and Substance Abuse. ASAM guidelines are a nationally accepted standard of care for the treatment of substance abuse disorders.

3. **McKesson Health Solutions Care Enhance Resource Management Software (CRMS™)** has been used to support our HEDIS® program with their ChartReview Manager (CRM) and Health Plan Reporter (HPR) tools; as well as physician profiling in utilization and quality patterns. In 2013 Health Alliance will transition to a new McKesson product called the Compliance Reporter for HEDIS and Analytics Advisor for physician and utilization data. McKesson Analytics Advisor™ connects payers and providers with flexible tools to manage and improve costs, physician efficiency, profiling results, HEDIS reporting, and quality.

4. **MC400 – Managed Care 400** is a claim processing system from OAO Healthcare Solutions retains member/enrollee eligibility information, applies provider contract and payment terms and adjudicates claims based on specific rules established for employer benefit packages.

5. **PBM - Pharmacy Benefit Manager** MedImpact for Medicare Advantage and Catamaran for Commercial offers customized products and uses an evidence-based approach to manage costs.

6. **Visual CACTUS** - houses all data for credentialed providers and drives the recredentialing process.
7. **Ambulatory Review Database** – an Access based system developed by Health Alliance staff that enables tracking, documentation and reporting of ambulatory review criteria and results.

8. **Adverse Events Database** – an Access based system developed by Health Alliance staff enables to tracking, documentation and reporting of adverse events (never events and sentinel events).

9. **WorldDoc** - available to all Health Alliance member/enrollees and providers free of charge via the Health Alliance website. WorldDoc offers around-the-clock access to information that can make challenging health decisions a little easier. Tools and information on health risks, illnesses, treatment options and medications are included.

10. **MEDai, Inc. /Risk Navigator** Financial predictive modeling software - predicts future expenditures by analyzing patterns of service utilization and diagnosis codes to identify at high risk for clinical events in the near future.

11. **SPSS- Statistical Package for the Social Sciences** allows users to sample, manipulate, and analyze data including statistical testing, correlations, and regression analysis

12. **SQL Query Analyzer**- Allows users to query data from the database for reporting or producing mailing lists.

13. **Crystal Reports**- Allows users to query data from the data warehouse for reporting or producing mailing lists

14. **MCNet** - pulls member/enrollee information for the customer service representative from the member/enrollee number entered into the Cisco Systems IVR by the caller or when accessed manually by the representative. MCNet combines access to a call tracking process from another system by Onyx called Customer Center with data housed in the MC400. Calabrio’s Work Force Management and Quality Management software are used for staff scheduling, call recording, and call monitoring. They are fully integrated with the phones by Cisco Systems.

15. **Cisco Systems** - phone system that provides reporting on telephone utilization.

16. **Onyx Customer Center** tracks complaints and feeds into our data warehouse. Reports are run using Crystal Enterprises.

17. **CMS** – Medicare coverage guidelines. For Medicare plans, national coverage decisions, general Medicare coverage guidelines and written coverage decisions of local Medicare contracts is used. Individual patient circumstances and the capacity of the practitioner and provider delivery system are considered. This includes the consideration of alternate settings when needed. Factors such as age, co-morbidities, complications, progress of treatment psychosocial situations, and home environment (when applicable) are reviewed when applying criteria.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
QUALITY IMPROVEMENT COMMITTEE (QIC)

a. Role: Primary responsibility is to provide direction, implementation, oversight and coordination of quality improvement initiatives throughout Health Alliance.

b. Chairperson: Regional Medical Director, Health Alliance, and Participating Psychiatrist

c. Membership:
   - Chief Medical Officer
   - Regional Medical Director, East Central Illinois Region, Health Alliance; Participating Practitioner, Family Medicine
   - Senior Medical Director, Health Alliance, Family Practice, Board Certified
   - Associate Medical Director, Allergy, Carle; Participating Practitioner, Allergy, Carle
   - Chief Medical Quality Officer, Carle
   - Vice President of Quality, Carle
   - Director of Individual and Medicare Services or Designee, Health Alliance
   - Director of Quality and Medical Management, Health Alliance
   - Director of Medicare Advantage Revenue Management, Health Alliance
   - Administrative Director, Primary Care and Pediatric Subspecialties/Carle
   - Director of Primary Care, Carle
   - Manager of Case and Disease Management
   - Communications Manager, Health Alliance
   - Wellness Administrator, Health Alliance
   - Director of Care Management, Health Alliance Connect
   - Director of Pharmacy, Health Alliance Connect
   - Quality Manager, Health Alliance Connect

d. Reporting: Reports to the Health Alliance Medical Plans Board.

e. Responsibilities:
   - Identify and initiate quality improvement activities as they relate to the enrolled Health Alliance population.
   - Reports activities to the Carle Quality Systems Oversight Committee.
   - Continuously monitor data from quality improvement activities as outlined in the annual work plan and recommend appropriate action.
   - Evaluate and allocate resources for quality improvement activities.
   - Evaluate the quality improvement structure and complete a formal QI Plan and QI Evaluation on an annual basis.
   - Monitor sub-committee and task group activities through review of meeting minutes and reports.
   - Delegate any of the above activities to sub-committees with appropriate oversight.
   - Adopt, develop, and implement overall preventive health and clinical guidelines.
   - Oversee all quality improvement initiatives as described in the annual plan.
   - Review new NCQA standards and make recommendations, as needed.
f. **Meets:** Monthly  
g. **Minutes:**  
  - Generated for each meeting and approved by the committee.  
  - Reflect the activity, discussion, analysis and recommendations of the committee, as well as follow-up and resolution of prior recommendations.
a. **Role:** To assure the appropriate management of healthcare services for the elderly and disabled population utilizing up to date clinical criteria and guidelines. Collaborate with other committees such as the Medical Policy Committee, the Pharmacy & Therapeutics Committee, the Behavioral Health Committee and the Consumer Advisory Committee. Function as the Grievance Committee to review member grievances.

b. **Chairperson:** Medical Director/Quality Manager

c. **Membership:** Quality Manager,  
   - Medical Director  
   - Director of Care Management (RN)  
   - Director of Client Services (SW)  
   - Director of Pharmacy  
   - member of the Behavioral Health Committee

d. **Reporting:** Reports to the Health Alliance Quality Improvement Committee and Health Alliance Connect Board.

e. **Responsibilities:**
   a. Review utilization patterns and trends for inpatient, outpatient and LTSS services  
   b. Evaluate for over/under utilization of services  
   c. Evaluate and analyze inpatient LOS  
   d. Types of services  
   e. Review appeal overturn decisions for comparison against the guidelines and or criteria used to make the initial determination  
   f. Review member grievances that cannot be handled informally and are not appropriate for standard internal processing

f. **Meets:** Bimonthly

g. **Minutes:**
   a. Generated for each meeting and approved by the committee.  
   b. Reflect the activity, discussion, analysis and recommendations of the committee, as well as, follow-up and resolution of prior recommendations.  
   c. Reported to the Health Alliance quality improvement Committee and Health Alliance Connect Board.
CREDENTIALING COMMITTEE

a. **Role:** Primary responsibility is to review all credentialing and recredentialing files and determine approval or denial of individual practitioners and facilities at the time of initial credentialing and recredentialing.

b. **Chairperson:** Regional Medical Director/East Central Illinois Region, Health Alliance; Participating Practitioner, Family Medicine

c. **Membership:**
   - Senior Medical Director, Health Alliance
   - Regional Medical Director/Springfield Region, Health Alliance; Participating Practitioner Internal Medicine
   - Medical Director/Local Service Area, Health Alliance; Participating Practitioner, Psychiatry
   - Regional Medical Director/Peoria Region/Participating Practitioner, Adult Medicine-Urgent Care
   - **Non-Voting:** Credentialing Manager or Designee

d. **Reporting:** Reports to the Quality Improvement Committee for informational purposes.

e. **Responsibilities:**
   - Review all materials, including patient safety/quality issues, relevant to an applicant regarding credentialing and recredentialing issues as identified in the Health Alliance credentialing policies and procedures.
   - Determine approval or denial status as a Health Alliance participating practitioner or facility.
   - Review and revise all policies and procedures related to credentialing and recredentialing activities at a minimum annually.

f. **Meets:** Bimonthly

g. **Minutes:**
   - Generated for each meeting and approved by the committee.
   - Reflect the activity, discussion, analysis and recommendations of the committee, as well as, follow-up and resolution of prior recommendations.
MEDICAL DIRECTORS’ COMMITTEE (MDC)

a. **Role:** Primarily responsible for oversight and review of medical management activities and strategic planning for initiatives that will enhance the provision of care.

b. **Chairperson:** Chief Medical Officer, Health Alliance

c. **Membership:**
   
   **VOTING**
   - Senior Medical Directors, Health Alliance
   - Three Regional Medical Directors, Health Alliance
   - Four Medical Directors, Health Alliance
   - Wenatchee Valley Medical Director, Health Alliance Northwest
   - Director of Quality and Medical Management, Health Alliance
   - Director of Medicare Advantage Revenue Management, Health Alliance
   - Manager, Member Relations and Intake, Health Alliance
   - Manager, Utilization Management, Health Alliance
   - Manager, Case and Disease Management, Health Alliance
   - Manager, Inpatient and Subacute, Springfield Health Alliance
   - Medical Director, Health Alliance Connect
   
   **NONVOTING**
   - Pharmacist, Health Alliance
   - Project Coordinator, Medical Management, Health Alliance
   - Senior Case Coordinators/Case Management, Health Alliance
   - Project Assistant, Medical Management, Health Alliance

d. **Reporting:** Reports to the Quality Improvement Committee for informational purposes only.

e. **Responsibilities:**
   - Review medical policies at least annually.
   - Identify, evaluate and recommend actions for utilization issues.
   - Oversee the review of information involving new technologies and/or treatments.
   - Reviews appeal decisions from External Review Organizations (EROs) to determine if changes in current criteria/medical policies are indicated.
   - Reviews utilization reports to assist joint venture partners in identifying opportunities to improve service and quality of care as related to cost.
   - Oversees review of inter-rater reliability reports for applying UM criteria and validity including sampling methodology used when selecting records eligible for inter-rater reliability testing
   - Reviews and approves department policies presented for new or changed UM activities or processes
   - Discusses UM issues that are appropriate for the Leadership level of review

f. **Meets:** Monthly. Reports summary of activities to QIC.

g. **Minutes:**
- Generated for each meeting and approved by the committee.
- Reflect the activity, discussion, analysis and recommendations of the committee as well as follow-up and resolution of prior recommendations.
MEDICAL POLICY COMMITTEE (MPC)

a. **Role:** Primary responsibility to review and provide practitioner input on new and updated criteria, medical policies, and policies and procedures.

b. **Chairperson:** Senior Medical Director, Health Alliance

c. **Membership:**
   - Chief Medical Officer, Health Alliance
   - Minimum of five Health Alliance participating practitioners representing primary and specialty care services.
   - Medical Director, Health Alliance Connect

d. **Reporting:** Provides feedback to the Medical Directors’ Committee, as needed.

e. **Responsibilities:**
   - Review case requests for new technology based on literature with recommendations based on area of expertise
   - Review and updates to policy and procedures with recommendations based on area of expertise
   - Review interrater reliability reports for applying UM criteria and validity including sampling methodology used when selecting records eligible for interrater reliability testing.

f. **Meets:** Monthly

g. **Minutes:**
   - Generated for each meeting and approved by the committee.
   - Reflect the activity, discussion, analysis, and recommendations of the committee as well as follow-up and resolution of prior recommendations.
   - Reviewed by Corporate Medical Directors’ Committee monthly and shared with the Quality Improvement Committee.
PHARMACY AND THERAPEUTICS COMMITTEE

a. **Role:** Provides guidance for pharmacy utilization for Health Alliance providers.

b. **Chairperson:** Chief Medical Officer or Designee, Health Alliance

c. **Membership:**

   **VOTING**
   - Chief Medical Officer, Health Alliance
   - Medical Director/Springfield, IL, Health Alliance, Participating Practitioner, Internal Medicine
   - Medical Director/East Central Illinois Region, Health Alliance, Allergy
   - Participating Practitioner, Geriatrics, Urbana, IL
   - Participating Practitioner, Nephrology, Springfield, IL
   - Participating Practitioner, Psychiatry, Champaign, IL
   - Medical Director, Adult Medicine, Ames, IA
   - Participating Practitioner, Pediatrics, Urbana, IL
   - Participating Practitioner, Family Medicine, Champaign, IL
   - Participating Geriatric Pharmacy Manager, Monticello, IL
   - Participating Practitioner, Emergency Medicine, Champaign, IL
   - Participating Practitioner, Rheumatology, Champaign, IL
   - Participating Practitioner, Neurology, Champaign, IL
   - Participating Director of Pharmacy, Health Alliance
   - Participating Director of Pharmacy, Health Alliance Connect

   **NONVOTING**
   - Compliance Officer, Health Alliance
   - Pharmacist, Health Alliance
   - Pharmacist, Health Alliance
   - Pharmacist, Health Alliance
   - Pharmacist, Health Alliance
   - Pharmacist, Health Alliance
   - Pharmacist, Health Alliance
   - Pharmacist, Health Alliance
   - Pharmacy Manager, Health Alliance
   - Pharmacy Rebate Contract Analyst, Health Alliance
   - Pharmacy Medicare Specialist
   - Director of Pharmacy, Carle Hospital, Champaign, IL
   - Clinical Peers (consulted as needed, determination based on agenda)

d. **Reporting:** Reports to Medical Directors Committee for informational purposes only.

e. **Responsibilities:**
   - Annual review of the pharmacy program.
   - Maintain and establish a formulary.
   - Reviews and updates pharmaceutical management policies and procedures annually based on new technologies.
   - Approves or disapproves medications including biotechnology and medications. Medication on the formulary may be removed or have its status changed.
   - May, from time to time, determine that a prior approval guideline should be developed and implemented.
- May establish guidelines for criteria based medications.
- Establish and implement a Drug Utilization Evaluation (DUE) program.
- Designate a Task Force or Subcommittee to study particular prior approval guideline.
- Ensure an appeal process for pharmacy issues is maintained.

f. **Meets:** Bimonthly

g. **Minutes:**
   - Generated for each meeting and approved by the Chairman.
   - Reflects the activity, discussion, analysis, and recommendations of the committee as well as follow-up and resolution of prior recommendations.
   - Distributed to the Medical Director Committee and key directors and managers at Health Alliance.
   - Provided to Communications Department to include a summary of minutes to all Health Alliance practitioners.
BEHAVIORAL HEALTHCARE ADVISORY GROUP

a. **Role:** Identifies opportunities to improve the quality of behavioral health care delivered to members/enrollees of Health Alliance throughout all service areas. Reaches out to high volume behavioral health providers on a regular basis to identify interventions and coordinate efforts for medical and behavioral health care.

b. **Chairperson:** Senior Medical Director, Health Alliance/Practicing Psychiatrist

c. **Membership:**
   - Accreditation and Credentialing Manager, Health Alliance
   - Director of Quality and Medical Management, Health Alliance
   - Case and Disease Management Manager, Health Alliance
   - Senior Case Manager, Social Worker, Health Alliance
   - Inpatient Case Management for Behavioral Health, Health Alliance
   - Director of Care Management, Health Alliance Connect

d. **Reporting:** Reports to the Quality Improvement Committee.

e. **Responsibilities:**
   - Advise Health Alliance on issues related to improving continuity and coordination of care between medical care and behavioral health care
   - Review HEDIS results for measures related to behavioral health care and advise Health Alliance on improvement opportunities and action plans
   - Addresses any identified patient safety improvement opportunities around behavioral health.
   - Identify and recommend actions to improve access to behavioral health services

f. **Meets:** Monthly (or as needed).

g. **Minutes:**
   - Generated for each meeting and approved by the committee
   - Reflect the activity, discussion, analysis and recommendations of the committee
MEMBERS’ RIGHTS AND RESPONSIBILITIES COMMITTEE (MRRC)

a. **Role:**
   To assist in maximizing the value of our members’/enrollees’ health care by monitoring available reports and information and making recommendations for improvement to the Quality Improvement Committee. Information reviewed includes but is not limited to: complaints and appeals data, policies and procedures, member/enrollee communications, prospective member/enrollee communications, member/enrollee satisfaction survey results (CAHPS and new member/enrollee surveys), provider satisfaction survey results, employer satisfaction survey results, disenrollment survey results, cultural and linguistic service needs, service-related HEDIS measures, provider access data, and service-related Key Performance Indicators.

b. **Chairperson:** Senior Vice President of Corporate Communications, Health Alliance

c. **Membership:**
   - Chief Medical Officer, or designated Medical Director, Health Alliance
   - Director, Quality & Medical Management, Health Alliance
   - Director, Customer Service, Health Alliance
   - Director, Medicare & Individual Plans, Health Alliance
   - Director, Contracting and Provider Services, Health Alliance
   - Director, Communications, Health Alliance
   - Manager, Regulatory Compliance, Health Alliance
   - Manager, Member Relations, Health Alliance
   - Quality Improvement Coordinator, Health Alliance
   - Operations Management Representative, Health Alliance
   - Marketing Manager-Client Development, Health Alliance
   - Pharmacy Director, Health Alliance
   - Senior QM Data Analyst
   - Director of Client Services, Health Alliance Connect

d. **Reporting:** Reports to the Quality Improvement Committee.

e. **Responsibilities:**
   - Facilitate mutually respectful relationships with members/enrollees and providers through an established statement of members’ rights and responsibilities.
   - Review member/enrollee complaints and appeals data and provider appeals (at least semi-annually) to identify trends, provide recommendations for improvement as needed. Monitor development, implementation and tracking of applicable policies and procedures.
   - Ensure member/enrollee and prospective member/enrollee communications clearly outline benefits and contain information needed to understand benefit coverage and how to obtain care via review of survey results.
   - Ensure cultural and linguistic needs of members/enrollees are assessed and addressed annually
   - Review findings of member/enrollee and practitioner satisfaction surveys (at least annually) to identify trends and opportunities for improvement.
• Support development and implementation of action plans and monitor progress and subsequent data to determine effectiveness.
• Monitor service-related HEDIS measures and service-related organizational Key Performance Indicators to identify opportunities for improvement. Support development and implementation of action plans and monitor progress and subsequent data to determine effectiveness.

f. **Meets:** Every other month starting June 2003 (quarterly prior to this time).

g. **Minutes:**
   - Generated for each meeting and approved by the committee
   - Reflect the activity, discussion, analysis and recommendations of the committee
   - Shared with the Quality Improvement Committee
CASE MANAGEMENT LEADERSHIP TEAM

a. **Role:** Provides oversight for the case management to ensure an integrated member/provider approach in the coordination of quality and cost effective health care services in the most appropriate setting. To identify differentiation for Commercial and Medicare Advantage plan members’/enrollees’ needs, when applicable. To support NCQA standards around complex case management to members/enrollees following a critical event, have a diagnosis with the potential to require the extensive use of resources, or have a high forecasted risk index.

b. **Chairperson:** Director of Quality and Medical Management or designee, Health Alliance

c. **Membership:**
   - Director of Medicare Advantage Revenue Management, Health Alliance
   - Manager of Case and Disease Management, Health Alliance
   - Senior Case Coordinators, Case and Disease Management (x3)
   - Ad Hoc Members as needed
   - Director of Care Management, Health Alliance Connect

d. **Reporting:** Reports to the Quality Improvement Committee for activities around complex case management.

e. **Responsibilities:**
   - Defines new methods to identify members for case management, as appropriate
   - Develops and implements screening and engagement tools
   - Measures program effectiveness
   - Integrates activities with provider specific initiatives
   - Ensure call monitoring of all case managers and action plans developed, if appropriate
   - Monitor CTI process and metrics
   - Ensure compliance with NCQA complex case management standard

f. **Meets:** Monthly

g. **Minutes:**
   - Generated for each meeting and approved by the committee.
   - Reflect the activity, discussion, analysis and recommendations of the committee, as well as follow-up and resolution of prior recommendations.
CONSUMER ADVISORY COMMITTEE – COMMERCIAL PRODUCTS

a. **Role:** Identifies and reviews consumer concerns and makes advisory recommendations to Health Alliance. In addition, Health Alliance makes requests of the committee to provide feedback to proposed changes in plan policies and procedures, programs, materials and processes, which will affect enrollees.

b. **Chairperson:** Elected by the committee.

c. **Membership:**
Eight enrollees selected as required by law. An enrollee may not serve on the committee if during the two years preceding service the enrollee: (1) has been an employee, officer, or director of the plan, an affiliate of the plan or a provider or affiliate of a provider that furnishes health care services to the plan or affiliate of the plan; or (2) is a relative of a person specified in item (1). Four enrollees will serve a two-year term and four enrollees a one year term. After the term expires, Health Alliance will re-appoint or appoint an enrollee to serve on the committee for a two-year term.

*Resources to the Committee:*
Director of Compliance, Health Alliance
Marketing Communications Specialist, Health Alliance
Chief Medical Officer or Designee, Health Alliance

d. **Reporting:** Reports to the Members’ Rights and Responsibilities Committee.

e. **Responsibilities:**
   - Identify and review consumer concerns and make advisory recommendations.
   - Provide feedback to proposed changes in plan policies and procedures which will affect enrollees.
   - Identify and recommend improvement of Health Alliance membership and educational materials.
   - Provide input and recommendations for coverage issues.

f. **Meets:** Quarterly

g. **Minutes:**
   - Generated for each meeting and reviewed/approved by the committee.
   - Reflects the activity, discussion, and decision of the committee, as well as follow-up and resolution of prior recommendations.
   - Reported to the Members’ Rights and Responsibilities Committee.
MEDICARE-MEDICAID ADVISORY BOARD

a. **Role:** Provides beneficiaries and a forum where ideas, concerns, and suggestions are shared and discussed; and to have input into program planning and product development.

b. **Chairperson:** Manager of Medicare Member Services.

c. **Membership:**
The Board shall of up to 12 members who hold active membership on a Health Alliance Medicare or Medicaid plan, including members with disabilities. To be selected for the Advisory Board, individuals must be articulate about issues and needs and be willing to commit to participation.

**Resources to the Committee:**
- Director of Medicare and Individual Services
- Consumer Products Sales Manager
- Marketing Communications Project Coordinator
- Education Coordinator
- Medicare Administrative Office Coordinator

d. **Reporting:** Reports to the Members’ Rights and Responsibilities Committee (MRRC); MRRC reports to the Quality Improvement Committee (QIC); and QIC reports to the Health Alliance Board of Directors.

e. **Responsibilities:**
   - Facilitate open communication between management and members.
   - Provide insight about customer issues and concerns, product development needs and service requirements.
   - Influence decision-making by providing feedback to proposed changes in plan policies and procedures to impact beneficiaries.
   - Provide ongoing customer (provider and member) feedback on services, regulations, policies and procedures.
   - Evaluate current products and services.
   - Identify new/alternative services and products.
   - Determine areas, products, or services that may need to be changed and/or improved.
   - Determine customer priorities and needs.
   - Evaluate performance levels and telephone response timeliness.
   - Identify key program issues that may impact community groups.
   - Offer guidance on reviewing member materials and effective approaches for reaching members.

f. **Meets:** Quarterly

g. **Minutes:**
   - Generated for each meeting and reviewed/approved by the committee.
   - Reflects the activity, discussion, and decision of the committee, as well as follow-up and resolution of prior recommendations.
   - Reported to the Members’ Rights and Responsibilities Committee.
COMMUNITY STAKEHOLDER COMMITTEE SPD/DUAL ELIGIBLE

a. **Role:** Provide feedback on the performance from community perspectives. Identify regional community health education opportunities, improve outreach and communication with community-based organization members, and actively promote healthy lifestyles such as disease prevention and health promotion.

b. **Chairperson:** Elected by the Committee

c. **Membership:**
Eight local representation from key community stakeholders and advocates. An enrollee may not serve on the committee if during the two years preceding service the enrollee: (1) has been an employee, officer, or direct of the plan, an affiliate of the plan or a provider or affiliate of a provider that furnishes health care services to the plan or affiliate of the plan; or (2) is a relative of a person specified in (1). Four enrollees will serve two-year term and four enrollees a one-year term. After the term expires, Health Alliance will re-appoint or appoint an enrollee to serve on the committee for a two-year term.

*Resources to the Committee:*
Director of Medicare and Individual Services
Consumer Products Sales Manager
Marketing Communications Project Coordinator

d. **Reporting:** Reports to the Members’ Rights and Responsibilities Committee (MRRC).

e. **Responsibilities:**
- Identify and review consumer concerns and make advisory recommendations.
- Provide feedback to proposed changes in plan policies and procedure which will affect enrollees.
- Identify and recommend improvement of Health Alliance membership and educational materials.
- Provide input and recommendations for coverage issues.
- Review provider and member satisfaction survey results.
- Evaluate performance levels and telephone response timeliness.
- Identify key program issues that may impact community groups.
- Offer guidance in reviewing member materials and effective approaches for reaching members.

f. **Meets:** Quarterly

g. **Minutes:**
- Generated for each meeting and reviewed/approved by the committee.
- Reflects the activity, discussion, and decision of the committee, as well as follow-up and resolution of prior recommendations.
- Reported to the Members’ Rights and Responsibilities Committee.
COMPLIANCE COMMITTEE

a. Role: Provide direction and support in the ongoing oversight of the Compliance Program. The Compliance Committee acts on behalf of the Health Alliance Board of Directors to review and approve policies, procedures and activities of the Compliance Program.

b. Chairperson: Director of Compliance, Compliance Officer, Health Alliance

c. Membership
   ▪ Chief Medical Officer, Health Alliance
   ▪ Chief Operating Officer/Chief Financial Officer, Health Alliance
   ▪ Chief Sales and Marketing Officer, Health Alliance
   ▪ Senior Vice President, Corporate Affairs and General Counsel, Health Alliance
   ▪ Senior Vice President, Corporate Communications, Health Alliance
   ▪ Vice President, Operations and Information Technology, Health Alliance
   ▪ Director, Human Resources, Health Alliance
   ▪ Director, Quality and Medical Management, Health Alliance
   ▪ Director, Medicare and Individual Services, Health Alliance
   ▪ Director, Internal Audit, Health Alliance and Care
   ▪ Director of Compliance, Heath Alliance Connect
   ▪ Non-Voting:
     o Compliance Program Manager/Privacy Officer, Health Alliance
     o Security Officer, Health Alliance

d. Reporting: Reports to the Compliance Committee of the Health Alliance Board of Directors through meeting minutes and updates from the Compliance Officer or designee.

e. Responsibilities:
   ▪ Assist with the development of the Compliance Program, which includes creation and implementation of standards, policies and procedures; effective training and education; effective lines of communication; effective system for auditing and monitoring, reports of non-compliance, the investigation process and well publicized disciplinary standards.
   ▪ Develop strategies to promote compliance and the detection of any potential violations.
   ▪ Review and approve standards of conduct and ensure up-to-date compliance policies and procedures are in place.
   ▪ Ensure compliance and FWA training and education are conducted and appropriately completed by all employees and Medicare Advantage and Part D business partners.
   ▪ Review and approve the compliance risk assessment model.
   ▪ Review and approve the monitoring and audit work plan(s).
   ▪ Ensure a system is in place for employees and business partners to ask compliance questions and report suspected misconduct, compliance violations and potential instances of fraud, waste or abuse confidentially or anonymously without fear of retaliation.
- Review reports of suspected misconduct and compliance violations, the investigation conducted and ensure corrective action plans are implemented and monitored.
- Review and address at risk areas of fraud, waste or abuse and ensure that corrective action plans are implemented and monitored.
- Support the Compliance Officer’s needs for sufficient staff and resources to carry out his or her duties.
- Review effectiveness of internal controls and policies and procedures developed to ensure compliance with Medicare regulations and guidelines in daily operations.
- Provide oversight and guidance for confidentiality and privacy issues within the organization including but not limited to:
  - Confidentiality, privacy and security policies for the organization.
  - Review and approve policies and procedures with material changes, as determined by the Compliance Officer.
  - Mechanisms to ensure application of confidentiality and privacy policies
  - Opportunities for reducing collection of unnecessary member data or using blinded and/or aggregate data
  - Levels of user access to data across the delivery system, including practitioners and their staff as well as Health Alliance staff, i.e. claims, utilization management and customer service departments
  - Mechanisms for adhering to specific requests to limit access to data
  - Formal complaint process to address member/enrollee concerns regarding confidentiality, privacy and security of their information.
  - Ensure detection of potential identify theft and appropriate mitigation.

The committee may also address other functions, as the compliance concept becomes a part of the overall operating structure and daily routine.

f. **Meets:** The committee shall meet on a quarterly basis and may hold special meetings as may be called by the Chairperson.

A majority of the Committee shall constitute a quorum and the majority of a quorum is necessary for committee action.

g. **Minutes:**
- Generated for each meeting and approved by the committee
- Reflect the activity, discussion, analysis and recommendations of the committee, as well as follow-up and resolution of prior recommendations.
GOVERNMENT PROGRAMS WORKGROUP

a. **Role:** Identifies and reviews quality activities to ensure compliance with CMS and NCQA requirements for the HMO and PPO products and Medicare Deeming.

b. **Chairperson:** Medicare Advantage Star Rating Coordinator, Health Alliance

c. **Membership**
   - Director, Medicare and Individual Services, Health Alliance
   - Manager, Medicare and Individual Services, Health Alliance
   - Director, Quality and Medical Management, Health Alliance
   - Director, Medicare Advantage Revenue Management, Health Alliance
   - Manager of Case and Disease Management, Health Alliance
   - NCQA/HEDIS specialist, Health Alliance
   - Director of Pharmacy or Designee, Health Alliance
   - QI Coordinator, Health Alliance
   - Compliance Program Manager, Health Alliance
   - Compliance Medicare Analyst, Health Alliance
   - Provider Network Manager, Health Alliance
   - Member Relations and Intake Manager, Health Alliance
   - Medicare Advantage Coding Consultant, Health Alliance
   - Nurse Practitioner, Health Alliance
   - Communications Manager or Designee, Health Alliance
   - Clinical pharmacist, Health Alliance
   - Pharmacy Medicare Specialist, Health Alliance
   - Wenatchee Valley Director of Managed Care Services

d. **Reporting:** Reports to the Quality Improvement Committee.

e. **Responsibilities:**
   - Ensures that the program domains prescribed by Medicare are addressed by the health plan and monitored. Domains include:
     - a. Safe patient care
     - b. Patient centered care
     - c. Effective care coordination
     - d. Effective prevention and treatment
     - e. Promotion of healthy living
     - f. Effective communication
     - g. Improving affordability
   - Review annual population assessment to identify opportunities for new programs and make recommendations to the QIC.
   - Review customer satisfaction, i.e. CAHPS, complaints and appeals, and make recommendations to MRRC and/or act upon recommendations of the MRRC for Medicare beneficiaries.
   - Review and/or facilitate Medicare HEDIS results annually and make recommendations to the QIC.
   - Oversee the HRA process and response rate.
   - Review HOS survey results to identify opportunities for quality programs including case manager involvement
   - Review Part C and Part D Report Cards (Star Ratings)
- Keep up-to-date on new Medicare/NCQA regulatory requirements specific to quality.
- Monitor Member Call Center data
- Monitor Quality Improvement Project (QIP)
- Monitor Chronic Care Improvement Program (CCIP)

f. **Meets:** Monthly

g. **Minutes:**
- Generated for each meeting and reviewed/approved by the committee.
- Reflects the activity, discussion, and decision of the committee, as well as, follow-up and resolution of prior recommendations.
ADVERSE EVENTS COMMITTEE

a. **Role:** Reviews aggregate adverse events identified through the Serious Reportable Adverse Event (CMS), Never Event and Sentinel Event Processes. The never events are defined by the National Quality Forum and delineated in provider contracts. Provide recommendations for patient safety interventions to QIC.

b. **Chairperson:** Chief Medical Officer, Health Alliance or Designee

c. **Membership:**
   - Chief Medical Officer, Health Alliance
   - VP of Corporate Affairs and General Counsel or Designee, Health Alliance
   - Regional Medical Director and Chair for Credentialing Committee, Health Alliance
   - Director for Quality and Medical Management, Health Alliance
   - Director of Medicare Advantage Revenue Management, Health Alliance
   - Director of Contracting and Provider Services, Health Alliance
   - Manager of Claims, Health Alliance
   - Medicare Advantage Coding Consultant, Health Alliance
   - Quality Improvement/Member Relations Coordinator, Health Alliance
   - Ad-Hoc Members, as needed
   - Quality Manager, Health Alliance Connect

d. **Reporting:** Reports events to Credentialing Committee, as needed; and annually to the Quality Improvement Committee.

e. **Responsibilities:**
   - Oversee the policy and procedure for SRAE and Adverse Events.
   - Trend and track events for annual reporting.

f. **Meets:** Biannually

g. **Minutes:**
   - Generated for each meeting and approved by the committee.
   - Reflect the activity, discussion, analysis and recommendations of the committee, as well as, follow-up and resolution of prior recommendations.
APPROVAL
The Quality Improvement Committee (QIC) approved the first QI Program on May 24, 1994. The QIC reviews and revises the QI/QMM Program document at least annually. After review and approval by the QIC, the program is submitted to the Health Alliance Medical Plans Board for final approval. As of August 2001, the Health Alliance Board designated this function to the newly formed Quality Committee. Approval dates are reflected in the following chart.

<table>
<thead>
<tr>
<th>QI/QMM Program</th>
<th>QIC Annual Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 (revised)</td>
<td>June 13, 2013</td>
</tr>
<tr>
<td>2013</td>
<td>December 21, 2012</td>
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<tr>
<td>2012</td>
<td>December 16, 2011</td>
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<tr>
<td>2011</td>
<td>November 19, 2010</td>
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<td>2010</td>
<td>November 20, 2009</td>
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<td>2009</td>
<td>November 6, 2008</td>
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<td>2008</td>
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<td>2007</td>
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<td>2006</td>
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<td>2002</td>
<td>January 16, 2002</td>
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<tr>
<td>2001 (revised)</td>
<td>May 16, 2001</td>
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<tr>
<td>2000</td>
<td>November 15, 2000</td>
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<tr>
<td>1999 (revised)</td>
<td>May 21, 1999</td>
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<td>November 15, 1995</td>
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<td>1995 (revised)</td>
<td>April 19, 1995</td>
</tr>
<tr>
<td>1995</td>
<td>January 18, 1995</td>
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<tr>
<td>1994</td>
<td>May 24, 1994</td>
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</tbody>
</table>

DELEGATION
If quality improvement, utilization management, or credentialing activities are delegated to another organization or provider group, strict procedures for assessing and monitoring the delegation relationship are followed, including:
- Pre-delegation site visit to determine scope and current capabilities
- Formal, written contract and description of roles and responsibilities for both parties
- Specified regular reporting by delegate to Health Alliance
- Annual oversight audit with appropriate follow-up for deficiencies
- Review and approval of delegates’ pertinent program descriptions, policies and procedures

At present, Health Alliance does not delegate any other functions except Credentialing.
CONFIDENTIALITY AND CONFLICT OF INTEREST
QI information is considered confidential and handled in accordance with Health Alliance confidentiality policies and procedures. Health Alliance employees and committee members/enrollees sign a confidentiality and conflict of interest statement, as applicable, on an annual basis.
2013 Health Alliance Medicare Program Domains

<table>
<thead>
<tr>
<th>Health Care Associated Infections</th>
<th>Decision-Making Partnership</th>
<th>Effective Discharge Planning</th>
<th>Early Detection &amp; Intervention</th>
<th>Clinical Preventive Services</th>
<th>Improvement of Products &amp; Services</th>
<th>Payment and Service Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug-disease interactions</td>
<td>PHC working with members, families, providers to promote informed decisions</td>
<td>Complex case management</td>
<td>Promote yearly exams.</td>
<td>Partnering with providers for education sessions</td>
<td>Large clinic groups have EMR</td>
<td>SNF Pay for Performance</td>
</tr>
<tr>
<td></td>
<td>Advanced care and education materials</td>
<td>Care Transition Initiative</td>
<td>Routine screenings and preventive care guidelines promoted in member publications</td>
<td>e-Prescribing</td>
<td>MYCARLE</td>
<td>Capitated Risk Arrangements</td>
</tr>
<tr>
<td></td>
<td>Translators availability.</td>
<td>Inpatient case management</td>
<td>Smoking Cessation program</td>
<td></td>
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<tr>
<td></td>
<td>Education materials are aimed at 6th grade reading level or lower</td>
<td>Windsor pilot</td>
<td>Comprehensive Disease Management Program which includes: Member and provider education via newsletters, web content and case management; gap reports to providers and members</td>
<td></td>
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<tr>
<td></td>
<td>Updated information available to case managers regarding all available community resources</td>
<td>In home visits by nurse practitioners</td>
<td></td>
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<tr>
<td></td>
<td>Collaboration with provider joint ventures</td>
<td>NaviHealth</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Preventable Conditions</th>
<th>Integrated Care Delivery</th>
<th>Multidisciplinary Coordination</th>
<th>Appropriate Treatment Modalities</th>
<th>Education &amp; Counseling for Risk Behaviors</th>
<th>Telemedicine</th>
<th>Administrative Simplification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug-disease interactions</td>
<td>Support Medical Home/Accountable Care models</td>
<td>Working with high volume SNFs to decrease readmission</td>
<td>Medical Policies Oversight by Medical Director Committee</td>
<td>Available at contracted facilities</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Monitor all readmissions Support of imbedded case management models and efforts by providers to reduce readmissions</td>
<td></td>
<td>Support provider initiatives and determine how to augment</td>
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<thead>
<tr>
<th>Medication Events</th>
<th>Cultural Competency</th>
<th>Care Management</th>
<th>Current Quality Initiatives</th>
<th>Evidence Based Medicine</th>
<th>Electronic Health Records</th>
<th>Utilization of Products &amp; Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease HRM in MA population</td>
<td>Education materials available on request in various languages</td>
<td>Complex case management</td>
<td>Preventive guidelines are available for members addressing:</td>
<td>Promote national treatment guidelines:</td>
<td>Large clinic groups have EMR</td>
<td>Net work adequacy reviewed by CPS</td>
</tr>
<tr>
<td></td>
<td>Krames hard copy education materials</td>
<td>Care Transition Initiative</td>
<td>• Vaccines</td>
<td>• ADA</td>
<td></td>
<td>Clear coverage utilized for approval of procedures</td>
</tr>
<tr>
<td></td>
<td>EMMI web based education</td>
<td>Inpatient case management</td>
<td>• Screenings</td>
<td>• JNC VIII</td>
<td></td>
<td>Oversight by Medical Director Committee</td>
</tr>
<tr>
<td></td>
<td>Translators availability.</td>
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<tr>
<td></td>
<td>Education materials are aimed at 6th grade reading level or lower</td>
<td>In home visits by nurse practitioners</td>
<td>Comprehensive Disease Management Program which includes: Member and provider education via newsletters, web content and case management; gap reports to providers and members</td>
<td>• Osteoporosis-ICSI:</td>
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<tr>
<td></td>
<td>Updated information available to case managers regarding all available community resources</td>
<td>Collaboration with provider joint ventures</td>
<td></td>
<td>• NIAA National Institute of Alcohol Abuse and Alcoholism</td>
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</tbody>
</table>

Reduce the risk of negative outcomes from errors in care delivery

2013 Health Alliance Medical Plans
2013 Quality Improvement Program

Reduce healthcare costs in conjunction with the promotion of quality care

Oversight by Medical Director Committee

Support provider initiatives and determine how to augment

Automated prior authorization process

CM updates directly into EMR of highest volume provider
<table>
<thead>
<tr>
<th>Safer Patient Care</th>
<th>Patient Centered Care</th>
<th>Effective Care Coordination</th>
<th>Effective Prevention &amp; Treatment</th>
<th>Promotion of Healthy Living</th>
<th>Effective Communication</th>
<th>Improving Affordability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the risk of negative outcomes from errors in care delivery</td>
<td>Improve health outcomes through partnerships among providers, patients and families</td>
<td>Improve efforts to result in seamless care coordination</td>
<td>Improve the prevention and treatment of the most common chronic conditions and leading causes of mortality</td>
<td>Promote healthy lifestyles through community partnerships, patient education and the adoption of national standards of care</td>
<td>Incorporate technology to promote communication among health care providers</td>
<td>Reduce healthcare costs in conjunction with the promotion of quality care</td>
</tr>
</tbody>
</table>

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