HEALTH ALLIANCE MEDICAL PLANS
2015 QUALITY and MEDICAL MANAGEMENT PROGRAM STRUCTURE

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. Note: the following are used interchangeably throughout the document; Health Alliance and Health Alliance Medical Plans; and case and care management.

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 for all products. Activities are monitored according to a variety of quality indicators and regulatory requirements 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 QMM Program include all products and plan types for Commercial HMO/POS, Commercial PPO, Medicare HMO, Medicare PPO, SNP, MMAI, SPD and FHP 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.

GOALS
The goals of the Health Alliance QMM program include:
A. Identify special needs of the target populations served through annual population assessment data.
B. Establish standards of clinical care and service for the target populations and measure performance outcomes adhering to NCQA, HPMS, CMS, and State and health plan requirements.
C. Identify opportunities to enhance clinical care and service for the target populations.
D. Respond with appropriate interventions to prioritized opportunities to improve clinical care and service.
E. 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 the target populations.
B. Develop, refine, and maintain data systems capable of providing systematic, reliable, and meaningful structure and process measures 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, and 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. Measurement of the effectiveness of the model of care for designated populations.

I. Develop and maintain a pharmaceutical management program that includes the development of policies and procedures, processes for restrictions and preferences, patient safety including medication therapy management data, review and update of procedures, participation of pharmacists and physicians, notification to practitioners, and prior authorization processes including denials and appeals.

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

K. 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.

L. 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, 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. Health Alliance also monitors CMS CLAS County Data report based on American Community Survey (ACS) data published by the US Census Bureau which provides notification to health plans meeting the 10% or more threshold of the same non-English language by county.

M. 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.

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

O. 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.

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

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

R. Annually review the program activities to determine effectiveness and focused priorities for the coming year. The QMM department prepares an annual evaluation that is reviewed and approved by the Health Alliance Vice President and Senior Medical Director, Medical Management and Quality; Executive Director, Quality and Medical Management, 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 assessment of effectiveness includes a review of the SPD/MMAI/SNP/FHP Integrated Care Team model and Model of Care. The annual evaluation highlights significant changes in the operation of the Quality Management, Medical Management, Pharmacy and Case and Utilization Management 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. family planning services
   3. clinical quality improvement activities
   4. clinical management criteria and guidelines
   5. disease management
   6. credentialing and recredentialing
   7. inpatient care review for inpatient, surgical and behavioral health care admissions
   8. discharge planning
   9. preauthorization review for medical necessity
   10. case management, 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 by detecting under- and over-utilization
   4. implementation of health management systems that support timely delivery of care
   5. medication management evaluation through case management program

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 has designated the day-to-day accountability of the quality and medical management program to the Health Alliance Vice President and Senior Medical Director, Medical Management and Quality and Executive Director of Quality and Medical Management with reporting accountability to the Quality Improvement Committee (QIC). Subcommittees, workgroups and operational teams of the QIC provide a focus on initiatives involving quality improvement such as 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/SPECIAL NEEDS PLAN (SNP)
In addition to objectives, scope and program structure previously described, the following are specific to the Health Alliance Medicare Advantage/SNP enrollees, defined as a Medicaid subset D-SNP:

1. Implement chronic care improvement programs (CCIP) through methods that identify enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in the program. In addition, establish mechanisms for monitoring these enrollees that are participating in the chronic care improvement program. The program also addresses additional 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.
   a. 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.
   b. The projects assess performance under the plan use quality indicators that are objective, clearly and unambiguously defined, and are based on current clinical knowledge or health services research.
   c. The performance assessments on the selected indicators are based on systematic ongoing collection and analysis of valid and reliable data.
   d. Interventions identified in the annual work plan strive to achieve demonstrable improvement and improvement is documented in the annual evaluation.
   e. Each QIP project status and results of each project are reported to CMS as requested.

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 Star Rating strategy to be consistent with the six priorities in the National Quality Strategy including making care safer by reducing harm caused by the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers and governments by developing and spreading new health care delivery models.

6. Complies with CMS requirements for Medication Therapy Management programs. The goal is to optimize therapeutic treatment of specified chronic disease states by increasing compliance and providing education to enrollees and prescribers.
   a. Health Alliance contracts with Medication Management Systems, Inc. to perform the Medication Therapy Management functions.
   b. Health Alliance policy 1233 – Medicare D Medication Therapy Management Program, outlines the identification of beneficiaries, intervention and reporting processes and policy 1753 for Medicare D Reporting Requirements-Medication Therapy Management further outlines reporting.
   c. Health Alliance provides Medication Management Systems, Inc. eligibility data files as well as beneficiary plan start/end dates. Members are selected based on criteria identified within the policy. All eligible members are included unless the member chooses to opt out of participation.
   d. Medication Management Systems, Inc. provides services including determination of eligibility, telephonic CMR, medication action plan, personal medication list, targeted medication review and other interventions identified in the policy. Health Alliance reviews all interventions and provides feedback and further education/assistance as necessary
   e. Health Alliance stratifies members selected for MTMP into case management per chronic disease state.
   f. CMS data validation standards are used to validate accuracy of reporting data. Data is uploaded to CMS annually via HPMS.

To support CMS regulations Health Alliance maintains a health information system that collects, integrates, analyzes and reports data necessary to implement its QI program:
• Health Alliance has policies and procedures in place on the requirements for reporting data to CMS.
  Updates to the Reporting Requirements are reviewed upon publication and updates to policies, procedures and systems are completed.
• Health Alliance collects data on the following:
a. Provider characteristics – via Visual CACTUS Credentialing System for provider and the MC400 as the primary member system of record for member characteristics.
b. Services furnished to members – via McKesson Compliance Reporter and Risk Manager (HEDIS®), CAHPS® survey process, McKesson Vitals Platform for case management services, MC400 for medical claims, MedImpact for pharmacy data.
c. Data to guide the selection of quality improvement project topics and meet the data collection requirements for quality improvement projects – via McKesson Compliance Reporter and Risk Manager (HEDIS), CAHPS® survey process, McKesson Vitals Platform for case management services, MC400 for medical claims, MedImpact for pharmacy data
   • Health Alliance ensures that information and data received from providers are accurate, timely and complete – via MC400 Claims processing system and MedImpact PBM.
   • Health Alliance has information systems that integrate data from various sources, including member concerns and complaints – via SalesForce.
   • Health Alliance has a formalized process to analyze data – via McKesson Compliance Reporter and Risk Manager (HEDIS), Statistical package for Social Sciences (SPSS), and Access data bases as needed, as reported to QIC.
     • Health Alliance addresses identified deficiencies in reported data through provider feedback or other corrective action – via QMM Program through McKesson Compliance Reporter (HEDIS) and Risk Manager, ambulatory and inpatient reviews.
     • Health Alliance complies with HIPAA and privacy laws and professional standards of health information management through the Compliance Committee (described on page 25).
     • Health Alliance conducts a pre-assessment on the Part C measures and has checks and balances in place for data submission. Corrective actions are put into place for all findings from the data validation audit or CMS notification.

Formal evidence of the impact and effectiveness of the QI program is documented in the quality and medical management annual evaluation. The evaluation includes measurement tools required by CMS and is made available to CMS to enable beneficiaries to compare health coverage options and select among them based on quality and outcomes measures.

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.

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2 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
KEY PERSONNEL

a. Vice President and Senior Medical Director for Medical Management and Quality provides medical leadership for all Health Alliance products in all service areas and oversees the successful implementation of medical management, quality and pharmaceutical programs. The position chairs the Quality Improvement Committee, Medical Director Committee, Adverse Events Committee, Medical Policy Committee and Behavioral Health Workgroup and participates as a member of the Pharmacy and Therapeutics, Compliance, Community Stakeholder and Government Programs Workgroups. All Medical Directors report to the Vice President and Senior Medical Director for Medical Management and Quality and to the Executive Director of Quality and Medical Management for administrative functions.

b. **Medical Directors** are key resources for the quality and medical management team. Medical Directors are represented on the Quality Improvement Committee and obtain feedback on quality and medical management and pharmacy 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:
   - Vice President and Senior Medical Director of Regional Partner Relationships is an emergency room physician and a member of the Quality Improvement Committee, Medical Directors Committee, Medical Policy Committee, MRRC, Star Strategic Plan Workgroup and Government Programs Workgroup. He provides oversight for the Health Alliance joint venture medical directors, devoting 50% of his time to Health Alliance and 50% as an Emergency Department regional outreach physician at Carle.
   - The Senior Medical Director is a Family Practice physician by training, and a 100% medical director. He participates in the Medical Policy Committee, Quality Improvement Committee, Credentialing Committee and 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.
   - 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, Medical Directors Committee and 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 Credentialing Committee, Needs Assessment Committee, and the Springfield Joint Venture team. 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.

c. **Executive Director, Quality and Medical Management** provides oversight for the quality and medical management department and is a key resource to the model of care for the SPD/MMAI/SNP population. 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.

d. **Pharmacy Director** is responsible for drug formulary design and development, implementation and risk management to improve quality, control 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. **Contracting and Provider Services Director** oversees the contracting and provider services department. Responsible for the overall direction and coordination of Network Development, Contracting and Provider Relations functions. 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.

f. **Utilization Management Manager**, for inpatient and outpatient services, 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. Three senior nurse coordinators report to the manager, one leads inpatient and two lead outpatient activities.

g. **QMM Data Reporting Manager** ensures the successful and accurate completion of all HEDIS reporting for all products and the impact on the results to NCQA; develops innovative solutions around disease management reporting and links all affected systems. Manages the HEDIS Supervisor, and key QMM staff for data reporting and system operations for the QMM department.

h. **Corporate Quality Manager** develops implements and monitors a corporate quality improvement plan that includes interventions to improve care and service for all members/enrollees, including expansion areas and products. The position manages applicable staff as well as collaborates with and supports the Data Reporting staff around HEDIS and Star ratings with the goal of attaining excellent NCQA accreditation for all products and 5 Star rating for Medicare Advantage products.

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 and certified rehab counselor who oversees the integration of case and disease management to ensure a focus on the continuum of care. She leads the case management team, which consists of senior case managers, nurses, social workers and administrative staff. Designated case managers lead an integrated care team (ICT) to address specific needs and obtain input from the enrollee’s primary care physician. In addition, a person centered Care Plan is developed and maintained for designated enrollees.

k. **Member Relations Manager** oversees the staff and management of the appeals process, DOI complaints, ERO reviews and Peer reviews for all products and service areas.

l. **QMM Vendor & Medicaid QI Specialist** implements and maintains a Medicaid focus for the corporate quality and medical management program that includes vendor management for QMM core processes. Participates in QI Operational Teams as well as ensures completion and monitoring of the Medicare/Medicaid Duals CCIP and QIP projects and contributes to Medicaid HEDIS and NCQA preparation.

m. **Wellness Administrator** develops implements and oversees all wellness activities internal to Health Alliance as well as offerings and supporting employer groups.

n. **Quality and 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. **Star Coordinators** focus on improving star rating measures. Oversees population disease management programs for all populations and Medicare specific NCQA/CMS requirements.

p. **Systems and Operations Specialist** is the technical resource for the McKesson products that support the quality and medical management department. Primary responsibilities include the analysis, testing and integration of the organization’s software and information systems as it relates to quality and medical management functions. Ensures supplemental products/upgrades within the system, released for production, contain no identified defects. Provides technology expertise to the department and collaborates with other departments for data collections and system upgrades and maintenance. Functions as a liaison and resource to the IT Department related to medical management systems and software.

q. **Utilization Management Coordinators** include inpatient and outpatient nurses. Outpatient focus is on preauthorization of designated medical services and procedures. Inpatient Coordinators 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. Utilization Management Coordinators (previously called medical management coordinators) may determine denials based on benefits only.

r. **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.

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

**TECHNICAL RESOURCES/SYSTEMS**

There are a number of technical resources/systems available to support and implement the QI program:

a. **McKesson Vitals Platform** is a McKesson system that provides, condition identification, program identification/work list, risk levels/risk profile, identification of gaps in care, system alerts and messaging capabilities to support 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. Health Alliance migrated to the McKesson Vitals platform from the McKesson CCMS system in the fall of 2013.

b. **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.

Where vendor guidelines are incomplete or absent, internal medical policies that reflect current standards or medical practice are developed by the Medical Director Committee and reviewed by the Medical Policy Committee. All Health Alliance criteria and medical policies are reviewed annually to determine whether updates/revisions are warranted. The designated Senior Medical Director and the medical management project coordinator receive and research all requests for policy revisions and for new policy development. Annual criteria reviews are conducted through the Medical Directors Committee and Medical Policy Committee as indicated. Coordinators utilize the medical policies to evaluate medical necessity and authorize services if appropriate. Medical Technology reviews are performed on new technologies to ensure that the Health Plan is staying current with the latest standards of care. Medical necessity reviews beyond the scope of current coverage criteria are referred to a Medical Director, who is then accountable for review and determination of coverage. Decisions made using any criteria are based on each members/enrollee’s clinical status and assessment of the local delivery system. Clinical Peers are used as needed. Medical Directors and Coordinators are evaluated at least annually for consistency of applying criteria, and corrective actions are implemented when needed.

c. **McKesson Risk Manager** is an integrated performance platform that enables better management to reduce medical management costs and improve physician efficiency and quality profiling.
d. **McKesson Compliance Reporter** is used to gather and report HEDIS. This includes data reported annually to NCQA, as well as at the provider and employer levels annually and quarterly. The system integrates with VITAL and Risk Manager.

e. **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.

f. **PBM - Pharmacy Benefit Manager** MedImpact for Medicare Advantage and Catamaran for the Commercial and SPD/MMAI populations offers customized products and uses an evidence-based approach to manage costs.

g. **Visual CACTUS** - houses all data for credentialed providers and drives the recredentialing process.

h. **Ambulatory Review Database** – an Access based system developed by Health Alliance staff that enables tracking, documentation and reporting of ambulatory review criteria and results.

i. **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).

j. **Wellness Vendor (Rally)** - available to all Commercial & Medicaid Health Alliance member/enrollees and providers free of charge via the Health Alliance/Health Alliance Connect-SNP website. Rally offers web-based wellness programs using current technologies to engage members in improving their health.

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

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

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

n. **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.

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

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

q. **Salesforce** - a customer relationship management (CRM) service. Broadly, this CRM service is used to manage our customer service, provider relations and member services. Salesforce also provides easy access to complete member information that is used to ensure more “one and done” service calls. The Custom Cloud allows the creation of powerful custom functionality in Salesforce, which works along with other services like Docusign, Conga, etc. to automate many of our manual processes.

r. **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.

s. **Storan** – software used for Medicare Advantage quality and risk management within Health Alliance.

The following pages contain descriptions of the quality improvement program committee structure:
QUALITY IMPROVEMENT COMMITTEE (QIC)

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

b. **Chairperson:** Vice President and Senior Medical Director for Medical Management and Quality, Health Alliance Medical Plans

c. **Membership:**
   - Regional Medical Director, East Central Illinois Region, Health Alliance; Participating Practitioner, Family Medicine
   - Vice President and Senior Medical Director for Regional Partner Relationships and Participating Practitioner, ED, Health Alliance
   - Senior Medical Director, Health Alliance, Family Practice, Iowa
   - Associate Medical Director, Allergy, Carle; Participating Practitioner, Allergy, Carle
   - Chief Medical Quality Officer, Carle
   - Medical Director, Population Health, Carle
   - Vice President of Quality, Carle
   - Vice President Marketing, Plan & Government Relations, Carle
   - Director of Quality, Springfield Clinic
   - Vice President of Corporate Communications, Health Alliance
   - Executive Director, Quality and Medical Management, Health Alliance
   - Executive Director Medicaid, Health Alliance
   - Executive Director Medicare and RARM, Health Alliance
   - Manager of Case and Disease Management, Health Alliance
   - Manager of Utilization Management, Health Alliance
   - Accreditation and Credentialing Manager, Health Alliance
   - Corporate Quality Manager, Health Alliance

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

e. **Responsibilities:**
   - Identify and initiate quality improvement activities for care and service as they relate to the all populations.
   - 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, including resources needed to impact Star ratings and NCQA rankings.
   - Evaluate the quality improvement structure and complete a formal QI Plan and QI Evaluation on an annual basis.
   - Adopt, develop, and implement overall preventive health and clinical guidelines.
   - Oversee all quality improvement initiatives as described in the annual plan.
   - Review reports around pay for performance initiatives.
   - Review new NCQA standards and make recommendations, as needed.
   - Review HEDIS rates by product, reporting findings from the annual HEDIS audit, and assess actions based on results.
   - Review Part C and Part D Report Cards (Star Ratings)
   - Monitor Quality Improvement Project (QIP)
   - Monitor Chronic Care Improvement Program (CCIP)
   - Oversee pay for performance programs
   - Delegate any of the above activities to sub-committees, workgroups or operational teams with appropriate oversight.
   - Monitor sub-committee, work group and operational team activities through review of meeting minutes and reports at least annually.
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.
CREndentialing 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/Iowa Region, Health Alliance; Family Practice
   - Regional Medical Director/Springfield, Health Alliance; Participating Practitioner Internal Medicine
   - Regional Medical Director/Peoria Region, Health Alliance; Participating Practitioner Emergency/Convenient Care
   - Regional Medical Director/Local Service Area, Health Alliance; Participating Practitioner, Board Certified in Otolaryngology
   - A member of the LTSS provider community on an ad hoc basis
   - *Non-Voting:* Credentialing Manager or Designee

d. **Reporting:** Reports to the Quality Improvement Committee (aka Quality Assurance Plan Committee for purposes of MMAI plan.)

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.
   - Oversee quality monitoring deficiencies for all providers outside the recredentialing cycle, including LTSS providers.

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:** Vice President and Senior Quality and Medical Director for Medical Management and Quality, Health Alliance

c. **Membership:**
   
   **VOTING**
   - Vice President and Senior Medical Director for Regional Partner Relationships and Participating Practitioner ED, Health Alliance
   - Senior Medical Director, Health Alliance
   - Regional Medical Directors, Health Alliance
   - Medical Directors, Health Alliance
   - Medical Director, Health Alliance/SNP Health Alliance Northwest Medical Director
   - Executive Director, Quality and Medical Management, Health Alliance
   - Executive Director of Medicare and RARM, Health Alliance
   - Manager, Member Relations, Health Alliance
   - Manager, Utilization Management Health Alliance
   - Manager, Case and Disease Management, Health Alliance

   **NONVOTING**
   - Pharmacist, Health Alliance
   - Senior Case Coordinators/Case Managers, 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.
   - Oversee the review of information involving new technologies and/or treatments.
   - For medical policy and new technology and/or treatment reviews, obtain input from participating providers, as needed.
   - Reviews appeal decisions from External Review Organizations (EROs) to determine if changes in current criteria/medical policies are indicated.
   - 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 and may recommend further review by QMM Leadership and/or UM Committee.

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:** Vice President and Senior Medical Director for Medical Management and Quality, Health Alliance

c. **Membership:**
   - Vice President and Senior Medical Director for Regional Partner Relationships and Participating Practitioner ED, Health Alliance
   - Senior Medical Director, Health Alliance
   - Minimum of five Health Alliance participating practitioners representing primary and specialty care services, including family planning services.
   - Medical Director, Health Alliance/SNP

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 inter-rater reliability reports for applying UM criteria and validity including sampling methodology used when selecting records eligible for inter-rater 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:** Regional Medical Director/Springfield, IL, Health Alliance, Participating Practitioner, Internal Medicine

c. **Membership:**

   **VOTING**
   - Vice President and Senior Medical Director of Medical Management and Quality, Health Alliance
   - Medical Director/East Central Illinois Region, Health Alliance, Allergy
   - Medical Director, Adult Medicine, Ames, IA
   - Medical Director/East Central Illinois Region, ENT
   - Participating Practitioner, Pediatrics, Urbana, IL
   - Participating Practitioner, Family Medicine, Champaign, IL
   - Participating Practitioner, Emergency Medicine, Champaign, IL
   - Participating Practitioner, Rheumatology, Champaign, IL
   - Participating Practitioner, Neurology, Champaign, IL
   - Participating Practitioner, Family Med, Champaign, IL
   - Participating Practitioner, Internal Med, Springfield, IL
   - Participating Practitioner, Convenient Care, Springfield, IL
   - Director of Pharmacy, Health Alliance
   - Long Term Care Pharmacist, Champaign, IL

   **NONVOTING**
   - Compliance Officer or Designee, Health Alliance
   - Pharmacists, Health Alliance
   - Formulary and Communications Manager, Health Alliance
   - Client and Government Programs Manager, Health Alliance
   - 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, 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:** Vice President and Senior Medical Director for Medical Management and Quality, Health Alliance

c. **Membership:**
   - Accreditation and Credentialing Manager, Health Alliance
   - Executive Director, 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/SNP

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:
   - Executive Director of Quality and Medical Management, Health Alliance
   - Director of Quality and Customer Service, Health Alliance
   - Director of Self-Funded Services, Health Alliance
   - Director of Contracting and Provider Services, Health Alliance
   - Director of Communications, Health Alliance
   - Manager of Compliance Programs, Health Alliance
   - Member Relations Manager, Health Alliance
   - Manager of Accreditation & Credentialing, Health Alliance
   - Director of Claims and Recovery, Health Alliance
   - Manager of Self-Funded Account Services, Health Alliance
   - Director of Pharmacy, Health Alliance
   - Senior Quality Management Data Analyst, Health Alliance
   - Director of Consumer Products & Services, Health Alliance
   - Executive Director of Medicaid and Government Relations, Health Alliance
   - Vice President and Senior Medical Director for Regional Relationship Providers and Participating Provider, ED, Health Alliance

d. Reporting: Reports to the Quality Improvement Committee and confidentiality issues to Compliance 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 (annually) to identify trends, provide recommendations for improvement as needed. Monitor development, implementation and tracking of applicable policies and procedures.
   - Ensure member materials contain information needed to understand benefit coverage and how to obtain care.
   - Ensure communication (written and oral) with prospective members clearly outline benefits and provides a description of Health Alliance operating procedures.
   - Ensure privacy and confidentiality of member information across the continuum of care. Work with the Compliance Department to ensure policies and procedures comply with NCQA standards.
   - Ensure cultural and linguistic needs of members/enrollees are assessed annually and addressed to ensure cultural competence of all staff.
   - 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

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, which reports up to the Health Alliance Board of Directors.
CASE MANAGEMENT LEADERSHIP TEAM

a. **Role:** Provides oversight for the case/care 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 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:** Manager of Case and Disease Management, Health Alliance

c. **Membership:**
   - Executive Director, Quality and Medical Management, Health Alliance
   - Senior Case Managers, Health Alliance
   - Ad-Hoc Members, as needed, including the Medical Directors, Manager of Accreditation and Credentialing, Corporate Quality Manager

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

e. **Responsibilities:**
   - Conducts an annual population assessment to identify needs of the population
   - Defines new methods to identify members for case management, as appropriate
   - Develops and implements screening and engagement tools
   - Measures outcomes and 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 (2) 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
   - Vice President and Senior Medical Director of Medical Management and Quality, 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 ADVISORY BOARD

a. **Role:** The Medicare Advisory Board (MAB) for Health Alliance Medicare was established to provide beneficiaries a forum where ideas, concerns, and suggestions could be shared and discussed; and to have input into program planning and product development.

The primary mission of the Board is to facilitate open communication between management and members. The Board is a crucial source of insights about customer issues and concerns, MMAI product development needs and service requirements. Members have the opportunity to influence decision-making by providing feedback to proposed changes in plan policies and procedures which will impact MMAI beneficiaries.

b. **Chairperson:** Director of Consumer Products Service, Health Alliance

c. **Membership:** The Board shall consist of up to 12 members who hold active membership on a Health Alliance Medicare or Medicaid plan. To be selected for the Advisory Board, individuals must be articulate about issues and needs and be willing to commit to participation. There are no set terms of membership. Membership on the MAB will remain in effect until such time as the member or Chairperson deems otherwise. Health Alliance representatives include:
   - Member Relations/Education Coordinator
   - Administrative Office Coordinator
   - Communications Coordinator

   Resources to the Board:
   - Vice President of Medicaid and Medicare Contact Center, and Sales and Retention, Health Alliance

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

e. **Responsibilities:** The Board functions in an advisory capacity only. The Board will serve as a mechanism to:
   - Provide ongoing customer 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
   - Serve as an issues forum
   - Determine customer priorities and needs

f. **Meets:** Quarterly, however meeting frequency may be altered to meet the needs of Board members and Health Alliance staff.

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 members of the Medicare-Medicaid Plan (MMP), Seniors and Persons with Disability (SPD) Plan, and Family Health Plan (FHP) a forum where ideas, concerns, and suggestions are shared and discussed; and to have input into program planning and product development.

b. Chairperson: Director of Client Services or Designee, Health Alliance Connect

c. Membership:
The Board shall consist of up to eight (8) members who hold active membership on a Health Alliance Medicare-Medicaid plan or seniors and Persons with Disability Plan including member’s caregivers/family members that represent the dual and waiver populations, i.e. people 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:
- Vice President of Medicare and Medicaid Contact Center, and Sales and Retention, Health Alliance
- Executive Director of Medicaid, Health Alliance
- Marketing Communications Project Coordinator, Health Alliance
- Medicare-Medicaid Outreach Coordinator, Health Alliance
- Compliance Programs Manager and Privacy Officer, Health Alliance

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:
- Shall recommend program enhancements based on member and community needs.
- Review provider and member satisfaction survey results.
- Evaluate performance levels and telephone response timelines.
- Evaluate access and provider feedback on issues requested by QIP.
- Offer guidance on reviewing member materials and effective approaches for reaching members.
- Identify key program issues; such as racial or ethnic disparities, that may impact community groups.

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/MMAI/SNP/FHP

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:**
   Membership includes eight local representatives from key community stakeholders and advocates (i.e. such as churches, advocacy groups, and other community-based organizations). Representative may not serve on the committee if during the two years preceding service the representative: (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 representatives will serve two-year term and four representatives a one-year term. After the term expires, Health Alliance will re-appoint or appoint a representative to serve on the committee for a two-year term.

   **Resources to the Committee:**
   - Vice President and Senior Medical Director of Medical Management and Quality, Health Alliance
   - Vice President of Medicare and Medicaid contact centers, and Sales and Retention, Health Alliance
   - Consumer Products Sales Manager, Health Alliance
   - Marketing Communications Project Coordinator, Health Alliance
   - Executive Director of Medicaid, Health Alliance
   - Director of Client Services, Health Alliance/SNP

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:**
   - Shall recommend program enhancements based on member and community needs.
   - Review provider and member satisfaction survey results.
   - Evaluate performance levels and telephone response timelines.
   - Evaluate access and provider feedback on issues requested by QIP.
   - Offer guidance on reviewing member materials and effective approaches for reaching members.
   - Identify key program issues; such as racial or ethnic disparities, that may impact community groups.

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**
   - Vice President and Senior Medical Director of Medical Management and Quality, Health Alliance
   - Chief Operating Officer, Health Alliance
   - 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
   - Vice President, Medicare and Medicaid Contact Center, and Sales and Retention, Health Alliance
   - Director, Human Resources, Health Alliance
   - Executive Director, Quality and Medical Management, Health Alliance
   - Executive Director of Medicare and RARM, Health Alliance
   - Director, Internal Audit, Health Alliance and Carle
   - **Non-Voting:**
     - Compliance Program Manager/Privacy Officer, Health Alliance
     - Security Officer, Health Alliance

d. **Reporting:** Reports to the Compliance Committee of the 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 fraud, waste and abuse (FWA) training and education are conducted and appropriately completed by all employees, board members and Medicare Advantage and Part D business partners.
   - Recommend and monitor, in conjunction with internal departments, the development of systems and controls to carry out policies and procedures as part of its daily operations.
   - 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, privacy and information security issues within the

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Health Alliance Medical Plans
2015 Quality Improvement Program
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 activities to ensure compliance with CMS and NCQA requirements for all Medicare-Medicaid products.

b. Chairperson: Executive Director of Medicaid or designee, Health Alliance

c. Membership
   - Vice President and Senior Medical Director of Medical Management and Quality, Health Alliance
   - Vice President and Senior Medical Director for Regional Partner Relationships and Participating Practitioner, ED, Health Alliance
   - Vice President of Medicare and Medicaid Contact Centers, and Sales and Retention, Health Alliance
   - Executive Director, Quality and Medical Management or Designee, Health Alliance
   - Executive Director of Medicare and RARM, Health Alliance
   - Director of Pharmacy or Designee, Health Alliance
   - Director of CPS or Designee, Health Alliance
   - Compliance Program Manager, Health Alliance
   - Communications Manager or Designee, Health Alliance
   - Director of Member Services, Health Alliance
   - Case and Disease Management Manager, Health Alliance
   - Health Alliance Northwest Director of Managed Care Services, as needed

d. Reporting: Reports to the Quality Improvement Committee.

e. Responsibilities:
   - Ensures that the program domains prescribed by Medicare and Medicaid are addressed by the health plan and monitored. Domains include:
     - Safe patient care
     - Patient centered care
     - Effective care coordination
     - Effective prevention and treatment
     - Promotion of healthy living
     - Effective communication
     - Improving affordability
   - Review customer satisfaction, i.e. CAHPS®, complaints and appeals, and make recommendations to MRRC and/or act upon recommendations of the MRRC for Medicare-Medicaid beneficiaries.
   - Review Medicare-Medicaid HEDIS results annually and make recommendations to the QIC.
   - Oversee the HRA process and response rate for all products
   - Review HOS survey results to identify opportunities for quality programs including case manager involvement
   - Keep up-to-date on new Medicare-Medicaid/NCQA regulatory requirements specific to quality.
   - Monitor dashboards monthly for Medicare and Medicaid activities

f. Meets: Quarterly with dashboards distributed 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 any method, including but not limited to Never Event*, Sentinel Event Processes and CMS required events; and provide recommendations for patient safety interventions to QIC.
   *The never events are defined by the National Quality Forum and delineated in provider contracts.

b. **Chairperson:** Vice President and Senior Medical Director of Medical Management and Quality, Health Alliance or Designee

c. **Membership:**
   - Vice President of Corporate Affairs and General Counsel or Designee, Health Alliance
   - Regional Medical Director and Chair for Credentialing Committee, Health Alliance
   - Executive Director for Quality and Medical Management, Health Alliance
   - Executive Director of Medicare and RARM, Health Alliance
   - Director of Contracting and Provider Services, Health Alliance
   - Manager of Claims, Health Alliance
   - Quality Improvement/Member Relations Coordinator, Health Alliance
   - Ad-Hoc Members, as needed

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

e. **Responsibilities:**
   - Oversee the policy and procedure for CMS requirements (SRAE), Adverse and sentinel Events.
   - Trend and track events for annual reporting.

f. **Meets:** Annually

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.
STAR STRATEGIC PLAN WORK GROUP

a. **Role**: Development and implementation of an ongoing quality improvement plan for improving Medicare star ratings

b. **Chairperson**: Star Ratings Coordinator

c. **Membership**
   - Vice President and Senior Medical Director for Regional Partner Relationships and Participating Practitioner, ED, Health Alliance
   - Executive Director, Quality and Medical Management
   - Manager, Clinical Services/Risk Adjustment Revenue Management
   - Manager, Case and Disease Management
   - Senior Case Coordinator, Quality and Medical Management
   - Star Ratings Coordinators
   - Clinical Pharmacist
   - Pharmacy Medicare Specialist
   - Quality Improvement Coordinator
   - Corporate Quality Manager

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

e. **Responsibilities**
   - Develop, implement, and monitor interventions based on:
     - Annual HEDIS data
     - Annual CAHPS® results
     - Annual HOS reports
     - Monthly Storan reports
     - Monthly Accumen data reports (PDE)
     - Other data sources as identified
   - Review Part C and Part D Star Ratings
     - Develop and implement interventions to achieve 5 star rated health plan
     - Review and develop intervention strategies that are directed towards members, providers, and internal staff
     - Monitor and review the CCIP and QIP plans
     - Analyze changes to future Star Ratings and Display Measures
     - Review new Health Plan benefits and analyze the impact to Star Ratings
     - Keep up-to-date on new Medicare/NCQA regulatory requirements specific to quality
     - Promote accountability and collaboration between departments
   - Promote collaboration with Carle, our largest provider network
   - Review and adjust plan and interventions based on market need

f. **Meets**: Monthly

g. **Minutes**:
   - Generated for each meeting and approved by the committee at the next scheduled meeting.
   - Reflect the activity, discussion, analysis and recommendations of the committee as well as follow-up and resolution of prior recommendations.
QI OPERATIONAL TEAMS

Purpose: To review HEDIS, CAHPS and other pertinent data, monitor current interventions, identify areas to target for improvement, recommend specific actions to bring about that improvement and drive discussion to improve care and service to all members. Operational team activities are reported to the QIC as part of the day-to-day QMM program oversight and evaluation process.

Prevention and Screening Team

Focus:
- BMI / Nutrition / Activity (program owner Karen Stefaniak)
  o Adult BMI Assessment
  o Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Immunizations (program owner Season Barrett)
  o Childhood Immunization Status
  o Immunizations for Adolescents
  o Human Papillomavirus Vaccine for Female Adolescents
- Lead Screening in Children
- Women’s Health
  o Breast Cancer Screening
  o Cervical Cancer Screening
  o Chlamydia Screening in Women
- Colorectal Cancer Screening (program owner Karen Stefaniak)
- Prenatal/Postpartum Care; and Prenatal program for FHP
- Medicare Advantage only
  o Improving or Maintaining Physical Health
  o Monitoring Physical Activity

Respiratory Conditions Team

Focus:
- Antibiotic Utilization
  o Appropriate Testing for Children With Pharyngitis
  o Appropriate Treatment for Children With Upper Respiratory Infection
  o Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- COPD
  o Use of Spirometry Testing in the Assessment and Diagnosis of COPD
  o Pharmacotherapy Management of COPD Exacerbation
- Asthma
  o Use of Appropriate Medications for People With Asthma
  o Medication Management for People With Asthma
  o Asthma Medication Ratio
- Osteoporosis Management in Women Who Had a Fracture
- Flu Vaccinations
  o Adults Ages 18-64 (CAHPS)
  o 65 and Older
- Pneumococcal Vaccination Status for Older Adults(CAHPs)
- Medical Assistance With Smoking and Tobacco Use Cessation (CAHPS)
**Chronic Disease/Medication Management Team**

**Focus for Chronic Disease:**
- Cholesterol Management for Patients With Cardiovascular Conditions (HEDIS retired for 2015)
- Controlling High Blood Pressure
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Comprehensive Diabetes Care
- Use of Imaging Studies for Low Back Pain
- Management of Urinary Incontinence in Older Adults (HOS)
- Fall Risk Management (HOS)
- Plan All-Cause Readmissions

**Focus for Medication Management:**
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Annual Monitoring for Patients on Persistent Medications
- Potentially Harmful Drug-Disease Interactions in the Elderly
- Use of High-Risk Medications in the Elderly
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>
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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 agreement
- Pre-delegation evaluation 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 delegates credentialing to entities; the Health Information Line Services to McKesson’s Nurse Advice Line; the HRA and self-assessment tools to Rally; and UM post-acute services for Medicare Advantage to naviHealth.

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.