Care1st Health Plan

2015 Quality Improvement Program

Special Needs Plan - SNP Medicare
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Care1st Health Plan’s Quality Improvement Department has a mission of providing the highest quality of service and excellence in satisfaction of all members, providers and employees, with an assurance of basic and ethical values driven by integrity, honesty and respect.

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

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

II. PURPOSE/PROGRAM DESCRIPTION
The QI Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcomes of services delivered to our SNP members. The QI Program provides mechanisms that continuously pursue opportunities for improvement and problem resolution. In addition, the QI Program utilizes a population management approach to eligible members and collaborates with local, state and federal public health agencies and programs, as well as with providers and other health plans.

III. SCOPE OF PROGRAM
The scope of the QI Program is focused on monitoring quality of care and identifying opportunities for improvement on the services we provide to our members and practitioners. Through early identification and investigation of issues, Care1st continuously measures, implements actions and evaluates processes and activities to determine accomplishment of its goals.

The Quality Improvement Program covers all Special Needs Plan members. In the State of California, the Special Needs population includes the D-SNP or members that are eligible for Medicare and Medicaid. Care1st serves the dual-eligible members in the following Counties:

I. Los Angeles County – All Dual-Eligible
II. Orange and San Bernardino Counties – All Dual-Eligible
III. San Diego County – All Dual-Eligible
IV. Alameda, San Francisco, and Santa Clara Counties – Full Benefit Dual-Eligible Without Share of Cost

The QI Program also focuses on the most vulnerable members, such as the frail, disabled, near end of life, multiple complex chronic conditions, developing ESRD, etc., that are at highest risk of poor health outcomes.

A. Supplemental Services for the SNP Population
Currently, the following supplemental services are offered to SNP population:
- Dental
- Vision
- Over the Counter Medications
- Hearing Aids
Specific components of the Quality Improvement Program include, but are not limited to:

- Practitioner accessibility and availability
- Member satisfaction
- Member Safety
- Continuity and coordination of care
- Clinical measurement and improvement monitoring of the SNP model of care and all quality improvement activities
- Analysis, re-measurement and improvement monitoring of member health outcomes
- Chronic Care Improvement Program (CCIP)
- Quality Improvement Projects
- Collection and reporting of Healthcare Effectiveness data and Information Sets (HEDIS)
- Participation and Analysis of the Health Outcomes Survey (HOS)
- Participation and Analysis of the CAHPS Survey
- Credentialing and Recredentialing
- Peer Review
- Grievance Case Review
- Oversight of Delegated Entities
- Clinical practice guidelines
- Under and over utilization monitoring
- Adverse outcomes/sentinel events
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- High risk and high volume services
- Complex Case Management
- Disease Management
- Medication Therapy and Management
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- Compliance with regulatory requirements and reporting

IV. GOALS AND OBJECTIVES

A. Goals

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

B. Objectives
• Ensure timely, quality, medically necessary and appropriate care and services that meet professionally recognized standards of practice are available to members through identification, investigation and resolution of problems, focusing on known or suspected issues that are revealed through monitoring, trending and measuring of specific clinical indicators, promoting preventive health services, accessing services that will result in increased member satisfaction, through the use of a total quality improvement philosophy.
• Systematically collect, screen, identify, evaluate and measure information about the quality and appropriateness of clinical care and provide feedback to IPA/PMG’s and Practitioners about their performance and also the network-wide performance.
• Maintain a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity and performance.
• Objectively and regularly evaluate professional practices and performance on a proactive, concurrent and retrospective basis through Credentialing and peer review.
• Ensure our members are afforded accessible health care through continuous assessment of access to care and availability of our network of Practitioners and specialists.
• Design and develop data systems to support Quality Improvement monitoring and measurement activities.
• Assure compliance with the requirements of accrediting and regulatory agencies, including but not limited to Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA).
• Appropriately oversee Quality Improvement activities of our contracted delegated medical groups and independent practice associations (IPA).
• Ensure that at all times the Quality Improvement structure, staff and processes are in compliance with all regulatory and oversight requirements.
• Actively work to maintain standards for quality of care and accessibility of care and service.
• Establish and conduct focused review studies, with an emphasis on preventive services, high-volume practitioners, and services on high-risk services, with implementation of processes to measure improvements.
• Ensure that mechanisms are in place to support and facilitate continuity of care within the healthcare network and to review the effectiveness of such mechanisms.
• Identify potential risk management issues.
• Effectively interface with all interdisciplinary departments and practices for the coordination of quality Improvement activities.
• Provide a confidential mechanism of documentation, communication and reporting of quality Improvement issues and activities to the Medical Services Committee, Board of Directors and other appropriate involved parties.
• Assess the effectiveness of the Quality Improvement Program and make modifications and enhancements on an ongoing and annual basis.
• Ensure that Care1st is meeting the members cultural and linguistic needs at all points of contact.
• Ensure members have access to all available services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
• Ensure mechanisms are in place to identify, support and facilitate patient safety issues within the network and review the effectiveness of these mechanisms.

V. CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

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

A. Governing Body
The Plan’s Governing Body is the Care1st Board of Directors (BOD). The BOD is responsible for the establishment and implementation of the Plan’s Quality Improvement Program. The BOD appoints the Chief Medical Officer and Medical Services Committee as accountable entities for oversight of the Quality Improvement Program. The Chief Medical Officer reports all Quality Improvement activities monthly and the Medical Services Committee reports all Quality Improvement activities to the Board at least three (3) times a year. The BOD formally reviews and approves all Quality Improvement activities quarterly and directs these operations on an ongoing basis.

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

Responsibilities include, but are not limited to:

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

The Medical Director oversees the operations of the Quality Improvement Department and is responsible for the administrative execution and coordination of all Quality Improvement activities. The Medical Director of Quality Improvement reports to the Chief Medical Officer (CMO). The Medical Director helps to administratively plan, develop, organize, monitor, communicate, and recommend modifications to the Quality Improvement Program and all policies and procedures. The Medical Director reports any areas of concern to the CMO and/or the Medical Services Committee. Other responsibilities include, but are not limited to:

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

D. Assistant Vice President, Quality Improvement
The Quality Improvement Director is a Registered Nurse with a current California licensure and oversees the managers in the administrative daily operations of the Quality Improvement Department. The position is responsible for the execution of Quality Improvement activities. The position is also responsible for interfacing with other departments on daily Quality Improvement processes and issues. The Quality Improvement Director reports to the Medical Director Quality Improvement. Additional responsibilities include, but are not limited to:
• Writing the Annual Evaluation and Work Plan and presenting for review and approval.
• Assisting in collecting information for quarterly QI activity progress reports.
• Overseeing the management of Facility Site Review Program
• Overseeing the managing of the Credentialing process.
• Assuring that all staff members are adhering to company standards of conduct.
• Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
• Ensuring that staff collects and monitors data and report identified trends to the CMO and Medical Services Committee.
• Ensuring appropriate resources and materials are available and ordered to meet the department’s needs.
• Overseeing the Managers in reviewing daily staff time clock logs and ensuring compliance with company standards.
• Assisting in the development of Focused Review Studies.
• Interfacing with the Medical Director, QI and Chief Medical Officer for clinical quality of care and service issues.
• Ensuring the maintenance of the PQI/QCI database to track pertinent case data that facilitates capture, tracking and trending of quality data.
• Overseeing member clinical grievance case files and the process for the Medical Director of Quality Improvement and Chief Medical Officer.
• Overseeing the preparation of peer review case files for the Chief Medical Officer’s action.
• Collecting, monitoring and reporting data for tracking and trending.
• Serving as a Liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues.
Overseeing the preparation of PQI/QCI and grievance reports for management, Board of Directors, Medical Services Committee, Joint Operating Committee and Delegated Oversight Committee meetings.

Overseeing the collaboration with Member Services Administrative Grievance Coordinator to identify quality of care issues.

Reporting IPA/PMG findings of non-compliance to the QI Medical Director and CMO.

E. HEDIS Team
A senior team composed of members trained and experienced in HEDIS reporting provides support, expertise, and supervision of the HEDIS processes. The primary responsibilities range from oversight of medical record review, data extraction, maintenance of data systems, leading the physician/physician office staff as it relates to HEDIS, Risk Assessment and other intervention programs initiated through the Quality Management Department.

Additional responsibilities include but are not limited to:

- Providing oversight, support and expertise for interventions initiated by the Quality Management Department and Quality Outreach programs, including medical record abstraction for HEDIS, Outreach Education, Medicare HCC, STAR rating, and Risk Assessment projects.
- Collaborating with HCC Director or vendor to ensure that there is synergy in the physician outreach and the use and abstraction of medical records.
- Managing and overseeing QI Outreach team including nurses, coordinators, data entry clerks and physician office staff.
- Effectively leveraging available resources (financial, people, time) to accomplish project objectives and contributes to the successful implementation of QI Outreach programs.
- Overseeing the field teams’ educational and data collection efforts with possible traveling to assigned Physician/IPA office sites.
- Overseeing the annual HEDIS Compliance audit including submission and dissemination to HSAG and CMS and other regulatory agencies, extensive education, validation, and documentation of physician and physician’s office staff regarding HEDIS measures, Medicare HCC Risk adjustment and Risk assessment requirements/ compliance guidelines.
- Overseeing HEDIS data abstraction processes to ensure we adhere to NCQA standards for data abstraction.
- Possessing the knowledge and experience with HEDIS Technical Specifications, NCQA Survey and Outcome Measures and be able to write a HEDIS Road Map.
- Having the skills and knowledgeable of the Minimum Performance Levels (MPL’s).
- Ensuring physicians and physician’s office staff meet the HEDIS, Medicare HCC, and Risk assessment requirements by concurrent and ongoing evaluation.
- Teaching nurses and coordinators how to educate physician and physician’s office staff to use various QI Outreach incentive programs.
- Empowering physician/physician’s office staff, promotes physician/physician’s office staff relationships, and ensures client satisfaction.
• Performing concurrent and ongoing assessment of physician offices’ current practices and streamlining the process as per the QI Outreach implementation project plans.
• Developing new interventions and corrective action plans for physician office sites that fall below the QI Outreach measurement benchmarks.
• Promoting team environment, positive work environment, and quality assurance of QI Outreach team.
• Making appropriate decisions in the face of ambiguity, and anticipating the resolution of barriers while managing multiple priorities.
• Providing support to the CMO and QI Medical Director, as part of the Quality Improvement Management Team on projects pertaining to HEDIS.
• Overseeing the PCP and IPA QI report card mailings.
• Attending annual HEDIS and Medicare HCC/Coding certification classes.
• Assisting in the annual preparation of the Baseline Assessment Tool and audit process.
• Preparing audit result reports, graphs and presentations.
• Performing other duties, as assigned by the Medical Director, Quality Improvement and as need to assist the Quality Improvement Department with HEDIS related Accreditation Projects.

F. Other Quality Improvement Staff and Resources
The Quality Improvement Department has multidisciplinary staff to address all aspects of the department functions. A full organizational chart is attached to this program description with all appropriate job descriptions. Care1st has staff and resources to conduct statistical and data analysis sufficient to establish quality controls and improvement projects. Data analysts are capable of developing Access databases relevant to specific functions and pulling appropriate information relevant to specific studies. The staffs include, but are not limited to:
  ➢ QI Manager of Accreditation and Special Projects
  ➢ Q.I. Manager, Facility Site Review
  ➢ Credentialing Manager
  ➢ QI Manager, PQI
  ➢ Clinical Nurse Supervisor, RN
  ➢ Clinical Quality Review RNs
  ➢ QI Specialists
  ➢ Clinical QI Specialist for Accreditation and Special Projects
  ➢ Data Analysts
  ➢ QI Coordinators
  ➢ Credentialing Supervisor and Credentialing Coordinators
  ➢ HEDIS Clinical Nurse Supervisor
  ➢ HEDIS/Quality Outreach Leads & Coordinators
  ➢ Facility Site Review RNs and FSR Coordinator
  ➢ Other supporting administrative staff
  ➢ Interdepartmental HEDIS support (UM and Pharmacy Coordinators)
VII. MEDICAL SERVICES COMMITTEE

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

1. Scope (includes but is not limited to):
   - Directing all Quality Improvement activities.
   - Recommending policy decisions.
   - Reviewing, analyzing and evaluating Quality Improvement activity.
   - Ensuring practitioner participation in the QI program through planning, design, implementation and review.
   - Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Credentials/Peer Review, Pharmacy & Therapeutics or Delegated Oversight Committees).
   - Monitoring, evaluating and directing the overall compliance with the Quality Improvement Program.
   - Annually reviewing and approving the Quality Improvement Program, Work Plan, and Annual Evaluation.
   - Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, CMS, DHCS, DMHC, and NCQA.
   - Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols.
   - Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria.
   - Developing relevant subcommittees for designated activities and overseeing the standing subcommittee’s roles, structures, functions and frequency of meetings, as described in this Program. Ad-hoc subcommittees may be developed for short-term projects.
   - Conducting peer review, assigning severity levels and making recommendations for corrective actions, as needed.
   - Reviewing and evaluating reports regarding any/all potentially litigious incidents and sentinel events.
   - Reviewing and evaluating reports submitted by the Plan’s counsel.
   - Developing and coordinating Risk Management education for all Health Plan Practitioners and staff.
   - Evaluating and giving recommendations concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access audits, HEDIS audits and IQIP studies.
   - Evaluating and giving recommendations from monitoring and tracking reports.
   - Ensuring follow-up, as appropriate.
2. **Reporting**
The Medical Services Committee shall submit a summary report of quality activities and actions for review and approval to the Care1st Board of Directors at least 3x a year. This is completed by the approval of the QI’s quarterly reports.

3. **Composition**

a) **Chairperson**
The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:
- Directing the Medical Services Committee meetings
- Reporting Medical Services Committee activities to the Board
- Acting on behalf of the committee for issues that arise between meetings
- Ensuring all appropriate QI activity and reports are presented to the committee
- Ensuring there is a separation between medical and financial decision making

b) **Membership**
Membership is assigned and will include representatives from the following disciplines:
- Primary Care Practitioners
- Specialty Care Practitioners
- IPA/PMG Medical Directors
- Vice President, Utilization Management
- Director, Medical Services
- Medical Director, Quality Improvement
- AVP, Quality Improvement
- Quality Improvement Manager
- Accreditation Manager & QI Special Projects
- Member Services and Provider Relations (as needed)
- Health Education
- Behavioral Health Practitioner
- Other members appointed at the discretion of the Chairperson

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

4. **Quorum and Voting**
Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. All approval of actions is by a majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. Non-Physician members of the Medical Services Committee may not vote, but shall attend the meetings and provide support to the deliberations. In the event that the Medical Services Committee is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) will be selected as needed, at the discretion of the Chairperson. Representatives and other guests may attend the meetings upon invitation and prior approval.
5. **Meetings**
The Medical Services Committee meets at least three times per year but can meet more frequently if needed to accomplish the committee’s objectives. The Chief Medical Officer may act on the Committee’s behalf on issues that arise between meetings.

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

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

The dissemination of Medical Services Committee information and findings to physicians may take various forms. These methods may include but not limited to:
   - Informal one-on-one meetings
   - Formal medical educational meetings
   - Care1st Newsletters
   - Provider Relations and Physician Reports
   - Quarterly Reports to the Board of Directors
VIII. OTHER MEDICAL SERVICES COMMITTEES

A. Credentials Committee

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

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

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

4. Composition
   Chairperson
   The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:
   - Overseeing the credentialing program
   - Directing the Credentials Committee meetings
   - Reporting Credentials Committee activities to the Board of Directors
   - Reviewing credentialing and re-credentialing applications
   - Reviewing requested changes to credentialing status or specialty
   - Acting on behalf of the committee for issues that arise between meetings
   - Ensuring all appropriate credentials activity is presented to the committee
   - Ensuring there is a separation between medical and financial decision making.

5. Membership
   Membership is assigned and will include representatives from the following disciplines:
   - Primary Care Practitioners
   - Specialty Care Practitioners
   - Medical Director, Quality Improvement
   - Director, Quality Improvement
   - Credentialing Manager
Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of the committee functions. Representatives of CMS, DHCS and DMHC may attend upon request.

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

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

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

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

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

The dissemination of Credentials Committee information and findings to physicians may take various forms. These methods may include but not limited to:
- Informal one-on-one meetings
- Formal medical educational meetings
- Monthly reports to the Board of Directors

B. Peer Review Committee
1. Description
The Peer Review Committee was established by the Board of Directors. The Peer Review Committee is delegated the responsibility of monitoring peer review of practitioners.

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

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

4. Composition
Chairperson
The Chief Medical Officer shall chair the Committee and is primarily responsible for but not limited to:
- Directing the Credentialing/Peer Review Committee meetings
- Reporting Credentialing/Peer Review Committee activities to the Medical Services Committee
- Acting on behalf of the committee for issues that arise between meetings
- Ensuring a separation between medical and financial decision making
- Ensuring all appropriate Quality Improvement activity and reports are presented to the committee
5. **Membership**  
Membership is assigned and will include representatives from the following disciplines:  
- IPA Medical Directors  
- Primary Care Practitioners  
- Specialty Care Practitioners  
- Medical Director, Quality Improvement  
- Director, Quality Improvement  
- Manager, Quality Improvement  

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

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

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

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

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

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

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

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

C. **Model of Care (MOC) & Quality Improvement Committee**

1. **Internal Quality Performance Process**

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

2. **Roles and Responsibilities of MOC & QI Committee:**

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

   - Approves the scope of improvement activities as documented in the MOC program description annually.
   - Reviews the progress as documented in the work plan and makes recommendations as needed every quarter.
   - Ensures adequate practitioner participation in planning, implementing, and evaluating the MOC program.
Communicates the results of the MOC program quarterly to Medical Services Committee, CEO, and the Board of Directors.

- Annually reviews and approves the annual evaluation, program description and work plan for the subsequent year.
- Responsibility for evaluating and giving recommendations, concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access audits, HEDIS audits, and QIP studies.
- Review and approves other ad-hoc reports and studies as needed

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

4. **Composition**
The MOC and QI Committee is a multi-disciplinary committee that includes the following members:

<table>
<thead>
<tr>
<th>Chair: Chief Medical Officer (CMO)</th>
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<tr>
<td>• Corporate Medical Director</td>
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<td>• QI Medical Director</td>
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<tr>
<td>• Director of Quality</td>
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<td>• Director of Social Services</td>
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<td>• Quality Improvement Specialist/</td>
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<td>Analyst</td>
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<td>• Community Providers/Practitioners</td>
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<td>• Director of Provider Relations</td>
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<td>• Director of Member Services</td>
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<td>• Director for Behavioral Health Services</td>
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<td>• Director of Pharmacy Services</td>
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5. **Confidentiality**
All committee members and participants, including network practitioners, consultants and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement. All members and invited guests to MOC & QI Committee meetings annually sign a Confidentiality Statement that is kept on file in the Quality Improvement Department. Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the MOC & QI Committee are for the sole and confidential use of Care1st Health Plan and are protected by State and Federal laws (1157 of the California Code of Evidence, Federal Information Act SB 889 and the Healthcare Portability and Accountability Act (HIPAA)).

6. **Recording of Meeting and Dissemination of Action**
- All MOC & QI Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made
- Meeting minutes and all documentation used by the MOC & QI Committee are the sole property of Care1st Health Plan and are strictly confidential. A written agenda will be used for each meeting.
Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities. The minutes are recorded in a nationally recommended format.

All unresolved issue/action items are tracked in the minutes until resolved.

The minutes and all case related correspondence are be maintained in the Quality Improvement Department.

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

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

- Informal one-on-one meetings
- Formal medical educational meetings
- Reports to the Board of Directors
- Provider and Member Executive Summaries

7. **Communication with Key Stakeholders**

Care1st shares the results of the quality improvement performance plans and updates on ongoing activities with the key stakeholders on an ongoing basis. These reports can be shared with the key stakeholders in the following ways:

- Electronically via email
- Teleconferences
- Face to face meetings held with internal and external business owners. Examples include:
  - Internal business owners – MOC & QI Committee Meetings
  - IPA and Medical Group administrators – Joint operations meetings
  - Contracted providers – Face to Face meetings or conference calls

**IX. DELEGATION**

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

Care1st delegates responsibility for specific functional activities for the delivery of care and service to its members to IPA/PMGs. Care1st does not delegate Quality Improvement activities to contracted IPA’s and Medical Groups. Care1st maintains accountability and ultimate responsibility for the associated activities by overseeing performances in the following areas: Utilization Management, Credentialing, Quality Improvement, Culture and Linguistics and Health Education. Delegated functions include, but are not limited to: preventive health services, health education activities, clinical practice guidelines, and access standards. Non-delegated functions include clinical studies, clinical grievances, appeals, HEDIS/QIP studies, facility site/medical record reviews, access studies, Health Education materials’ development and review, member and practitioner satisfaction surveys. Delegated IPAs are expected to have a functioning quality improvement program in place. Care1st retains the right to revoke any delegated function if compliance with standards is not met.
Care1st has a process in place to assess and ensure the IPA/PMG’s ability to perform the delegated functions. NCQA, DMHC, DHCS and LA Care regulations and requirements are used to evaluate and determine the IPA/PMG’s potential for delegation. An initial assessment is conducted pre-contractually to determine the IPA/PMG’s ability to provide delegated services and at least annually thereafter. Care1st’s UM Delegation and Credentialing Departments are responsible for oversight of the IPA/MGs and reporting which is presented to Compliance Delegation Oversight Committee (CDOC). CDOC activity is reported to the Board of Directors for final review and approval.

B. Availability of Practitioners

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

- Ensuring that standards are in-place to define practitioners who serve as primary care practitioners (Pediatrics, Family Practice, General Practice, Internal Medicine, etc.).
- Each member shall be assigned to a Practitioner with-in five (5) miles of their home unless specially requested by the member or family.
- Each member shall be referred to a specialist with-in ten (10) miles of their home unless specially requested by the member or family.
- Members live within fifteen (15) miles or 30 minutes from contracted hospital and ancillary service.
  - Care1st provides members with transportation as needed.
- Ensuring a database is in-place which analyzes practitioner availability and ability to meet the special cultural need of our members.

Care1st has processes in-place for member requests of special cultural and language needs. Care1st will annually review and measure the effectiveness of these standards through specialized studies. (Please refer to our Quality Improvement Policies and Procedures for Availability of Practitioners)

X. QUALITY IMPROVEMENT PROCESS

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

A. Standards of Practice

1. The standards of practice used as criteria, measures, indicators, protocols, practice guidelines, review standards or benchmarks in the Quality Improvement process are based on professionally recognized standards. Sources for standards include but are not limited to:
a. National and local medical professional associations  
b. Local professionally recognized practices  
c. Review of applicable medical literature  
d. Available medical knowledge  
e. State and federal requirements

2. Standards are used to evaluate quality of care of Practitioners.

3. Standards are incorporated into policies and procedures.

4. Thresholds and targets derived from these standards/norms and accepted are:
   • Measurable  
   • Achievable  
   • Consistent with national/community standards  
   • Consistent with requirements of regulatory agencies and legal guidelines  
   • Valuable to the assessment of quality or the potential improvement of quality for our member population.

5. Standards are communicated to practitioners through the Plan in a systematic manner in ways that may include but not limited to:
   • Care1st Provider Manual.  
   • Newsletters  
   • Bulletins

B. Access to Service

Care1st has established standards and mechanisms to assure the accessibility of primary care, specialty care, and behavioral health and member services. Standards include but are not limited to:
   • Preventive care appointments  
   • Regular and Routine care appointments  
   • Urgent care appointments  
   • Emergency care  
   • After-hours care  
   • Wait times  
   • Telephone service

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

Behavioral Health Access to Care and Availability

Care1st contracts with an NCQA Accredited MBHO and delegates the following functions to ensure BH access to care and geographical availability to ensure access and availability of BH Practitioners:
   a. BH Access to Care  
   b. BH Telephone access to care  
   c. BH Geographical Availability  
   d. Annual BH CAHPS (Member Experience)  
   e. Annual BH CAHPS opportunities for improvement
C. Member Satisfaction

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

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

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

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

4. Public Policy Meetings
Our Care1st Member Services Department holds a quarterly Public Policy meeting where members have the opportunity to voice any opinions or concerns about the services provided to them. This meeting is an open forum and has educational purposes for the members who attend. This meeting was developed to educate members about the health plans processes and elicit input on these processes from enrollees. (Refer to the Member Services Program for a more detailed description).
D. Disease State Management / Complex Case Management
Care1st Health Plan has developed its own proactive Disease Management Program and Complex Case Management system, which are overseen by the Utilization Management Department. All clinically-related policies and procedures and measurements can be found in Medical Services.

1. Chronic Care Improvement Program (CCIP):
Pursuant to 42 CFR Section 422.152(c)-(g), SNPs must conduct both a Chronic Care Improvement Program (CCIP) and a Quality Improvement Project (QIP) targeting the SNP population it serves.

The Chronic Care Improvement Program (CCIP) focuses on chronic conditions designed to improve the health of the SNP Medicare population we serve. The Medical Services Division has a written process for identifying enrollees with multiple or sufficiently severe chronic conditions that meet the criteria for participation in the program. All Special Needs Plan members have an annual risk assessment completed where an individualized care plan for that member is generated and completed. The criteria are developed through the MOC Subcommittee and reviewed and approved through our Medical Services Committee. The program details what chronic conditions are monitored, types of services offered and the types of measures that are used to assess performance.

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

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

a) Reporting to CMS
Care1st follows the required components of CCIP Plan:

- **Basis for Selection** – an overall description of the CCIP and rationale for selection that includes impact on the member, anticipated outcomes, and rationale for selection.
- **Program Design** – description of the process used to identify the target population, risk stratification, and enrollment method.
- **Evidence-Based Medicine** – includes the clinical practice guidelines and standards of care to be employed.
- **Care Coordination Approach** - describes the expected collaboration and communication among a multidisciplinary team that may include providers, staff and targeted member.
• **Education** – describes the method of education and the topics that will be addressed, including the education directed to applicable providers and/or targeted members.

• **Outcome Measures and Interventions** – setting objectives in measurable terms; identifying the appropriate data source(s) to measure; and the methodology used to analyze the data to determine whether the initiative impacted the health status of the targeted population.

• **Communication Sources** – methods used to inform patients, physicians, and other providers on what is occurring in the CCIP and any changes over time.  
  (Source: MMCM, Ch 5)

b) **Annual Update**

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

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

• **Interventions** – describes the specific actions/approaches implemented to achieve the goal.

• **Barriers** – describes the barriers encountered, and if applicable, the specific actions to mitigate those barriers.

• **Findings and Analysis of Results** – discussion of results in relation to established goal, benchmark, timeframe, and identification of steps based on the evaluation and ongoing assessment of the CCIP, revisions to the interventions, methodology, goals or other aspects of the initiative.

• **Best Practices** – any identified approaches proven to be reliable and appear to contribute to the success of the CCIP.

• **Lessons Learned** – description of pertinent knowledge gained through CCIP experience. (Source: MMCM, Ch 5)

Currently, Care1st has been approved by CMS to implement the following CCIP/QIPs in all previously-stated SNP-approved Counties:

- Hypertension
- Hyperlipidemia
- Diabetes

c) **Monitoring Beneficiaries that Participate in CCIP**

The monitoring and the interventions provided to the beneficiaries are geared towards achieving the following objectives:

• To deliver effective care;

• To engage beneficiaries and families and/or caregivers in beneficiary’s care;

• To promote communication and coordination of care;

• To encourage self-care management; and

• To promote a healthy lifestyle
Care1st’s CCIP plan includes systematic and regular communications with beneficiaries, families, caregivers, as well as collaboration with PCPs and clinic staffs. These processes give Care1st staff an assurance that the stakeholders are well-informed of the treatment plan, so as to encourage beneficiary’s participation in care and promote continuous and coordinated care by the primary care provider.

d) **Measuring Health Outcomes of CCIP Participants**
Health outcomes are evaluated through:
- Medical record review – medical records of non-HEDIS participants and HEDIS records of specific CCIP subjects are reviewed and analyzed.
- Analysis and comparison of lab reports from previous
- Overall HEDIS rates on the specific CCIP project measures

e) **Follow-Up of CCIP Participants:**
Outreach and follow-up calls are conducted on those participants whose monitoring levels remain elevated and/or continue to be non-compliant, and appropriate interventions are instituted until a desirable outcome is achieved.

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

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

2. **Health Risk Assessment**
Care1st Health Plan created a standardized Health Risk Assessment questionnaire that evaluates the physical, psychosocial, cognitive, and functional needs of both MAPD and SNP new members. The questionnaire is designed to help identify key care needs. It does not replace the need for a comprehensive physical exam conducted by the primary care practitioner.

Care1st Health Plan has a comprehensive health risk assessment process in place, which assesses member health status and applies an acuity that helps direct nursing staff to appropriate services the member might need or require. The assessment includes but is not limited to:
- Health history
- Special care needs (DME, home health, social worker, etc.)
- Specialty care needs
- Living situation
- Activities of daily living (ADLs)
- Safety issues
- Mental status
- Functional assessment
- Pain assessment
- Medication history
- Health educational needs
The information gathered is entered into Care Enhance Clinical Management Software CCMS, and direct the nurse on specific actions (referrals), but is not limited to:

- Case Management
- Complex Case Management
- Disease Management Programs
- Utilization Management review
- Pharmacist review
- Health Education
- Cultural or linguistic support
- Member Services or Benefit explanations

The main goal of the risk assessment process is to assess the member and identify specific needs based on the individual responses.

Care1st Health Plan has contracted with a vendor who will contact newly enrolled and current Care1st dual-eligible beneficiaries to perform the survey telephonically. The vendor will initiate the survey calls based on a list of new enrollees provided by Care1st Health Plan shortly after the beneficiaries enrollment transaction is confirmed by CMS. If the vendor is unable to contact the beneficiary by phone, the survey will be mailed to the beneficiary. All calls, successful and unsuccessful will be documented and reported to Care1st on a monthly basis. Beneficiary responses to the survey calls and responses to mailed surveys will be forwarded to Care1st Health Plan and entered into the Care Enhance Clinical Management Software (CCMS). Care1st will monitor adherence to conducting all initial assessments within 90 days of enrollment. An annual reassessment will be conducted within one year of the last assessment for all dual-eligible SNP beneficiaries.

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

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

4. Peer Review
   - Peer review is conducted in any situation where peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific practitioner or to review aspects of care, behavior or practice, as may be deemed inappropriate.
   - The Chief Medical Officer is responsible for authorizing the referral of cases for peer review.
   - All peer review consultants (including members of the Credentials/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in active practice.
• At least one consultant will be a practitioner with the same or similar specialty training as the practitioner whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty.
• The Chief Medical Officer can send cases out for a specialty review and consultation to be used for the peer review process.
• The Chief Medical Officer will confirm that the peer review consultants have the necessary experience and qualifications for the review at hand.
• The Quality Improvement Director and Manager prepare all materials for review by the Peer Review Committee to conduct all follow-ups, as required by the Committee. (Refer to Peer Review Policy and Procedure.)

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

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

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

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

The Quality Improvement Department has initiated new facility site review criteria aimed at improving patient safety in the offices and provide our members with added information that can help them make a decision on what office is best for them. This Physical Accessibility Review Survey (PARS) looks at the general areas of Parking, Exterior Building, Interior Building, Restroom, Exam Room(s), and Exam Table/Scale. The facility site review sub-department performs these safety audits when conducting on-site review of the Practitioners. This information is now being used to provide offices with an accessibility level for physically challenged members. The levels are posted in our practitioner directory both hard copy and on the web, giving members the opportunity to know if the office site meets their individual needs.
The Facility Site Review Department also looks at percentage of yes answers in Facility criteria with the initial and periodic reviews for the following criteria which directly impact patient safety: Disabled Parking, Accessible Restroom, Diagramed Evacuation Routes, and Personnel Trained in Medical Emergency procedures, Emergency Equipment, Emergency Medications and documented preventive equipment maintenance.

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

XI. **Clinical Measurement Activities and Quality Performance Reporting**

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

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

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

Care1st Health Plan actively takes part in annual Health Plan Effectiveness Data and Information Set (HEDIS) and Structure and Process measures. HEDIS Studies and Structure and Process measures are conducted for all SNP lines of business (30 or more members) and are in accordance with CMS and NCQA standards. Care1st QI Department collects HEDIS measure data through multiple sources:

- Claims and encounter data
- Proactive medical record review
- Disease Management and Complex Case Management Programs
- Proactive Measure Review
  - Specialized NCQA Certified software program that runs each measure proactively every month during the measurement year.
  - Member listings of services that have not been captured are provided to primary care practitioners every six months
  - Quality Outreach Nurses and Coordinators visit primary care practitioners offices every six months to discuss the importance of these services
  - Primary care practitioners are provided a quality profile report every six month detailing their specific rates compared to their peers, Care1st overall and National benchmarks (Report in April-May details previous year, report in September details status of current year).
Medical record reminder sheets are provided in April of each year to PCPs to be placed in the member's record reminding the practitioner on the next visit the specific services that are required.

- HEDIS Hybrid Medical Record Review Process

Care1st utilizes an NCQA Certified software program to generate proactive reports and HEDIS sample frames for the hybrid pursuit process and reporting requirements. Care1st contracts with an NCQA Certified HEDIS auditor to annually review data systems, such as encounter and claims systems, supplemental data systems, eligibility, pharmacy, lab repository, and all HEDIS processes related to medical record review and data collection efforts to assure they conform to specific NCQA standards. Care1st must pass this audit process to be able to report HEDIS measures publicly. The certified software program generates final measure reports for reporting to NCQA, which are audited by the NCQA certified auditor and signed off prior to submission. These reports are uploaded through a web based portal to NCQA and the plan applies a lock. When the plan locks the reports the auditor can then access these reports through the NCQA portal to audit and approve these reports. The auditor will apply the auditor lock and the reports then are marked as final. Specific Non-HEDIS specialty measures can be developed within the software program but are not considered certified by NCQA.

Every measure is compared to National benchmarks (or if a benchmark is not available, a goal is established) and final rates are reported through Medical Services Committee. All measure that do not meet minimum performance levels (25th percentile of the National rate, or not meeting goal) or have a significant drop in rate will have a formal corrective action plan developed. All other measures will have an improvement plan written that details specific actions or processes aimed at improving rates.

Care1st cooperates and assists the QIO in the review of quality outcomes and timeliness of services provided. All results are presented to the Medical Services Committee for recommendations on interventions and re-measurement timeframes. (Refer to QI Policy and Procedure for HEDIS.)

B. Health Outcomes Survey (HOS)

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

The Health Outcomes Survey Baseline Report and the Health Outcomes Performance Measurement Report received from the contracted vendor are presented at the MSC Committee for review, analysis and interventions. In any measure that fails to meet the minimum performance level (MPL) or has a statistically significant drop in rate, a formal corrective action plan will be required.
C. Quality Improvement Projects (QIPs)
QIPs are focused on one or more clinical and/or non-clinical areas with the objective of improving health outcomes and beneficiary satisfaction.

Care1st conducts at least one Quality Improvement Projects (QIP) each year and participates in statewide collaborative. All QIPs are focused on the SNP population, with clearly defined objectives, measureable quality analysis, population-specific interventions, and health outcomes studies. All SNP members are considered for the QIP if they meet the clinical criteria. All SNP members have an annual risk assessment and individualized care plan developed and completed each year to assure the most accurate data is available. Care1st uses NCQA HEDIS specifications for QIP measures.

All QIPs are written on the recognized NCQA QIP written format, which assure we evaluate the intervention completely. Furthermore, all QIPs meet the guidelines for preventive care standards. These guidelines include Advisory Committee on Immunizations Practices, U. S. Preventive Services Task Force and all other nationally recognized practice guidelines as appropriate.

Currently, Care1st participates in DHCS-driven State Collaborative for All-Cause Readmission and diabetes.

1. Monitoring the Beneficiaries that Participate in QIP
The QIP starts with the identification of beneficiaries that meet the criteria for the selected project. All beneficiaries, including HEDIS sampling will be used to identify and determine qualification for participation.

QIP activities include interventions that promote:
- delivery of effective care;
- engagement of beneficiaries and families/caregivers in members’ health;
- promotion of communication and coordination of care;
- promotion of healthy lifestyle and e) beneficiary satisfaction.

2. Measuring Health Outcomes of QIP Participants
Measurement of the effectiveness of interventions and health outcomes are done through:
- Medical record review – medical records of non-HEDIS participants and HEDIS records of specific QIP subjects are reviewed and analyzed.
- Analysis and comparison of lab reports with the previous.
- Overall HEDIS rate on the QIP-specific measure
- CAHPS Survey
- Internal Member Surveys

3. Follow-Up of QIP Participants
Outreach follow-up calls are conducted on those participants whose monitoring levels remain elevated and/or members continue to be non-compliant.

CCIP/QIP staffs will continue to monitor the beneficiary’s lab results, pursue medical record reviews and institute appropriate actions, as necessary.
4. **Reporting to CMS**

Care1st will implement the PDSA cycle to make improvements. The QIPs and CCIPs will be reported to CMS in a timely manner and in accordance with the requirements set forth by CMS.

Care1st follows the following components of QIP:

- **Basis for Selection** – description of the QIP and rationale that includes impact on the member, anticipated outcomes, and rationale for selection. QIP for SNP may include the elements for the Model of Care.
- **Program Design** – describes the process to identify target population, risk stratification and enrollment method.
- **Prior Focus** – description of previous attempts to address the problem that the QIP will be addressing.
- **Barriers** – examination of barriers and potential impact on the success of the QIP.
- **Outcome Measures and Interventions** – setting objectives in measurable terms identifying appropriate sources to measure and the methodology used to analyze the data. (Source: MMCM, Ch 5)

5. **QIP Annual Update:**

The QIP Plan will be submitted to CMS for approval using the PDSA model. The QIP Annual Update is due during the CMS-determined submission window in the fall of the first year of implementation following approval of the QIP Plan, and annually, thereafter, until project completion. Components of the QIP Annual Update are:

- **Interventions** – describes the specific actions/approaches implemented to achieve the goal.
- **Barriers** – describes the barriers encountered, and if applicable, the specific actions to mitigate those barriers.
- **Findings and Analysis of Results** – discussion of results in relation to established goal, benchmark, timeframe, and identification of steps based on the evaluation and ongoing assessment of the CCIP, revisions to the interventions, methodology, goals or other aspects of the initiative.
- **Best Practices** – any identified approaches proven to be reliable and appear to contribute to the success of the CCIP.
- **Lessons Learned** – description of pertinent knowledge gained through CCIP experience. (source: MMCM, Ch 5)

D. **Quality Improvement Organization (QIO)**

CMS contracts with a QIO in each State to fulfill provisions in Title XI of the Social Security Act, as amended by the Peer review Improvement Act of 1982. These provisions relate to improving the quality of care for SNP Medicare beneficiaries, protecting the integrity of the SNP Medicare Trust Fund by ensuring that payments for services are reasonable and medically necessary and protecting beneficiaries by addressing care related complaints and other beneficiary issues. Care1st will adhere to the reporting requirement set forth by CMS through the QIO.
E. **Practitioner/Provider Performance Data**
To ensure compliance with regulatory agencies (e.g., National Committee of Quality Assurance, (NCQA), Practitioners and Providers must comply with Care1st policies and procedures and allow the health plan to use their performance data (i.e., HEDIS, clinical performance data).

F. **Other Quality Improvement Activities**
Care1st conducts quality improvement studies and programs to assess quality of service to our members, including the following:

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

2. **Facility Site Review (FSR)**
   - A facility site review is conducted for all PCPs in the Care1st network prior to entering the network and at least every three years thereafter.
   - FSRs include all requirements, as outlined in the DHCS MMCD Policy Letters 02-02, 11-013, 12-006 and 13-001 revised. Facility Site reviews will also be conducted related to appropriate member complaints and grievances.
   - The standards for FSRs are communicated to Practitioners in Practitioner bulletins, newsletters and the Care1st Provider Manual.
   - In addition, with a recent FSR Database implementation, the purpose is to streamline/automate the FSR process. This cross-functional database/tracking system, will improve Quality Improvement’s ability to track and trend quality issues and identify areas for quality improvement. Furthermore, it will ensure compliance with DHCS, improve data collection efforts and lead to positive hits for HCC, HEDIS and QIFs. (Refer to the Quality Improvement Facility Site Review/Medical Record Review Policies and Procedures)

3. **Medical Record Audit**
   A component of the Quality Improvement Program is the review of medical record keeping practices. Medical record audits are conducted in conjunction with the FSR process. In addition, Care1st conducts follow-up audits with Practitioners who (1) fail (score less than 80%) the medical record portion of the FSR audit or (2) have a failing score (less than 80%) on any preventive care section of the Medical Record Review. (Refer to the Quality Improvement Facility Site Review/Medical Record Review Policies and Procedures.)
4. **Credentialing**

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

G. **Quality Improvement Interventions**

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

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

1. **Severity Levels**

The Quality Improvement Department has adopted a system of severity levels to be applied by the Chief Medical Officer to any and all grievances, potential quality of care and service issues and actual quality of care and service issues. Any severity level that reveals a borderline quality of care issue, or above, is required to have a corrective action plan developed. (Refer to the Quality Improvement Policy and Procedure for Severity Levels).
2. **Corrective Action Plans**

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

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

3. **Dissemination of Information**

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

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

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

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

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

XII. **Behavioral Health Program**

Care1st Health Plan is contracted with Managed Behavioral Healthcare Organizations (MBHOs) that have a comprehensive Behavioral Health Program (BHP). The MBHOs are fully delegated coordinate and administer Care1st behavioral health benefits.
A. Behavioral Health Program for the Medicare Population
The Medicare Behavioral Health Benefits are defined in accordance with the Centers for Medicare and Medicaid Services (CMS) and include services and programs to help diagnose and treat mental health conditions. These services and programs may be provided in outpatient and inpatient settings. Medicare helps cover outpatient and inpatient mental health care, as well as prescription drugs needed to treat a mental health condition.

B. Care1st's Behavioral Health Director's responsibilities:
Care1st’s BH Director is a doctoral-level behavioral healthcare practitioner involved in all the behavioral health aspects of the QI and UM Programs and is responsible for, but not limited to, the following functions:
1. Ensuring that the process by which the MBHO reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of behavioral health services to enrollees, complies with the requirements in State Federal regulatory and accrediting entities, as they apply to LOB.
2. Providing substantial involvement in MBHO’s QI and UM Program operations through significant time devoted to UM activities, clinical oversight, and guidance to QI staff.
3. Providing substantial involvement in Care1st’s Medical Services Committee and other sub-committees through collaboration with MBHO’s Behavioral Health Director.
4. Establishing QI and UM policies and procedures relating to behavioral healthcare
5. Participating in activities related to continuity and coordination of care between medical and BH practitioners

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

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

As part of the Quality Outreach Program, staff will routinely visit the office site offering intensive education on the following:
1. Provider Portal Orientation
2. Healthcare Effectiveness Data and Information Set (HEDIS).
3. Ways to improve documentation practices
4. Tools that focus on the practitioners’ office on specific members requiring services and the use of HEDIS specific encounter forms.
5. Suggestions and assistance in the development of office processes that limit the possibility of these services being missed.
6. Identification of opportunities to limit barriers between the physician and the health plan.
7. Clinical care resources, such as Disease Management Programs and referral processes.
8. Collaboration on the collection of important diagnosis and service information to limit the intrusion on the physician office.
9. Information that the physician is the resource to get questions answered and issues resolved quickly.
10. Working toward improvement in access to care for our members.
11. Offering practice management suggestion that would limit barriers to care.
12. Looking for opportunities to free up physician time so additional time can be spent with the patient.
13. Providing in-service reminders that will be placed on the member’s medical record (i.e., on the next visit this member needs a Mammogram and Colorectal Cancer Screening completed).

A. Physician and Office Staff Incentives
As a part of the QI Outreach process, participating practitioners will be offered incentives to complete specific HEDIS related services. The providers’ office staff will earn small incentives, such as movie tickets, food and gift cards for using the web portal, filing medical record HEDIS reminders and contacting member to schedule them for specific services.

Quality Outreach Tool-Kit consists of:

<table>
<thead>
<tr>
<th>Physician Profile Report:</th>
<th>The report details their specific rates compared to their peers (i.e., pediatricians are compared to pediatricians), national benchmarks and health plan’s overall rates.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Listing:</td>
<td>Physicians are supplied a listing of their assigned members that based on administrative data, have not obtained the required services.</td>
</tr>
<tr>
<td>Medical Record Reminder:</td>
<td>A member-specific medical record reminder sheet which is filed in the member’s record.</td>
</tr>
<tr>
<td>Health Risk Assessment</td>
<td>This Progress Note Form contains a complete comprehensive Risk, functional, pain and health history assessment, including meeting several other HEDIS related components. Providers are offered incentives for completing these assessments on our Medicare members.</td>
</tr>
</tbody>
</table>

B. Provider Web Portal
Our web-based Provider Portal contains the essential Quality Outreach Program tools which are immediately available to practitioners. By integrating the tools electronically for practitioners, the Physician Profile Report, Assigned Members Listing, Member Medical Record Reminder(s) and the Encounter Form are easily accessible.
With the Provider Portal implementation, we have eliminated hard copy encounter forms which has increased the turnaround time, further streamlined the internal clinical review, HEDIS record/data collection process and practitioner payment process. Please refer to the Provider Portal/QI Data Information Exchange Policy.

The Quality Outreach Program sustainability is attributed to the following two factors:

- Ensuring that Providers understand the requirements. The better the office understand the measures, the higher the probability to reach an improvement over time.
- Outreach Staff become a permanent resource to practitioner's offices.

C. Care1st Pay For Performance Program
Care1st is launching a new pay for performance program to reward primary care providers who are performing better than their peers. This program is based on a number of outcome and process-based HEDIS measures. The providers are rewarded a high incentive amount if they meet goals that are focused on outcome measures.

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

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

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

The predictive modeling software quantifies the relative risk between members, based on a variety of factors and takes into account demographic information, such as age and gender, healthcare episode treatment groups from Medi-Cal and pharmacy claims, and lab results. These episode treatment groups describe a member's observed mix of diseases and conditions and underlying co-morbidities and complications. The software then compiles a set of risk markers for each member. It considers complications and co-morbidities, as they increase risk; it assigns risk factors and provides a numeric score of relative risk.
Identification of most vulnerable population is also based on multiple hospital admissions, high pharmacy utilization, high cost, or combination of medical, psychosocial, cognitive, and functional challenges.

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

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

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

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

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

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

- SNP leadership (Committees and Board of Directors)
- SNP personnel and staff
- SNP provider network
- Beneficiaries and caregivers
- Regulatory agencies
- Public

C. SNP-Specific Care Management Measurement: Measuring the Effectiveness of the Model of Care
Care1st uses the following internal quality processes and methodologies for collecting data and reporting quality measures:

a. Healthcare Effectiveness Data Information Set (HEDIS)

b. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

c. Grievance and Appeals Data
d. Health Risk Assessment and Individual Care Plan Data  
e. Member Eligibility and Enrollment Data  
f. Access to Care Survey Results  
g. Geo Access Study Reports  
h. Provider Network Adequacy Reports  
i. Delegation Oversight Audit Results  
j. Staff and Provider Training Completion Data

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

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

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

XV. EFFECTIVENESS OF THE QUALITY IMPROVEMENT PROGRAM

A. Quality Improvement Work Plans  
Quality Improvement Work Plan is developed annually outlining Quality Improvement activities for the year. The Work Plans will include all activities not completed during the previous year, unless identified in the Annual Evaluations as issues that are no longer relevant or feasible to pursue. The Work Plans are reviewed by the Chief Medical Officer and submitted to the Medical Services Committee and Board of Directors for review and comment.

The Quality Improvement Work Plan is a dynamic document and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement.

B. Measuring Effectiveness of Care Management Programs  
Care Management Programs, such as Model of Care, QIPs, CCIP, Disease Management Programs, Complex Case Management, HEDIS, CAHPS, HOS, grievances and PQIs, are measured on a consistent basis to demonstrate effectiveness of the interventions established. These measurements are established through the MOC Sub-Committee and submitted to Medical Services Committee. Specific timeframes for re-measurement and methodology vary. All measurements and studies are presented to the Medical Services Committee and summarized on the annual evaluations, which are available for regulatory agencies' review.
C. **Quarterly Reports**
Quarterly reports are an evaluation of the progress of the Quality Improvement activities, as outlined in the Work Plan, and are submitted to the Medical Services Committee and Board of Directors for review and recommendations at least 3x a year.

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

XVI. **RESOURCES, QI PERSONNEL AND INTERDEPARTMENTAL INTERFACE**

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

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

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

D. **Credentialing Department**
The Credentialing Department is part of the Quality Improvement Department. Quality Improvement information is provided to the Credentialing Department for inclusion in the credentialing / recredentialing process. The Quality Improvement Department provides the Credentialing Department with Facility Site Review and Medical Record audit scores and any sanction activity related to those reviews and with identified QCIs, as appropriate. The Quality Improvement Manager works with the Credentialing Department to take peer review cases, as directed by the Chief Medical Officer, to the Peer Review Committee for review and action.
E. **Provider Relations/Contracting Department**
   The Provider Relations/Contracting Department assists the Quality Improvement Department in obtaining Quality Improvement information from and disseminating information to practitioners. In addition, the Provider Relations/Contracting Department:
   - Serves as a liaison between the Quality Improvement Department and Practitioners to facilitate education and compliance with approved Care1st standards.
   - Schedules Joint Operating Committee meetings.
   - Serves as a liaison with delegated IPA/PMGs.
   - Assists the Quality Improvement Department with Practitioners who do not comply with requests from the Quality Improvement Department.
   - Ensures contracted ancillary providers and facilities meet regulatory and accreditation requirements.

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

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

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

H. **Cultural and Linguistic Department (C&L)**
   The Quality Improvement Department utilizes the Cultural and Linguistic Department to translate materials and ensure they are culturally sensitive prior to submitting them to members. All materials must be approved by CMS prior to utilization. The C&L Department uses QI to analyze studies and identify any areas for improvement by using cultural and linguistic breakdowns. In addition, the C & L Department has objectives for serving a culturally and linguistically diverse population.
I. Health Information System

1. Identifying Eligible D-SNP Beneficiaries

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

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

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

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

- In counties where Care1st has a CMC plan, the DSNP policy restricts enrollment in the DSNP to CMC-excluded beneficiaries only. This applies to Care1st’s Los Angeles and San Diego DSNPs.

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

Excluded Beneficiaries include the following:

- Individuals under the age of 21;
- Individuals with other private or public health insurance;
- Individuals receiving services through the State’s regional centers or developmental centers or intermediate care facilities for the developmentally disabled;
- Individuals with a share of cost that do not meet the requirements outlined above;
- Individuals residing in one of the Veterans’ Homes of California; and
- Individuals residing in an excluded zip code per the Memorandum of Understanding between the State and the Centers for Medicare and Medicaid Services (CMS)
In counties not participating in the CMC program, there are no additional restrictions impacting DSNP enrollment. This applies to Care1st’s Alameda and San Francisco DSNPs.

D-SNP beneficiary applicants must live in one of the approved zip codes in their respective counties and must be verified as a full-dual eligible in the State of California Department of Health Care Services online eligibility verification system on the effective date of their requested D-SNP enrollment. Beneficiary applicants with spend down share of cost requirements must have completed their spend down amounts before enrolling with the Care1st D-SNP plan. Applicants that are not eligible for Medi-Cal or have unmet spend down requirements are denied enrollment by Care1st per CMS guidelines.

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

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

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

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

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

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

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

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

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

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

Based on the multiple resources available to internal staff and providers, the ability to check eligibility is widely available and contributes to the provision of coordinated care without interruption.
Screen Shot from EAM Enrollment System
Member applications are data entered into a system that is used to validate eligibility, capture and code all CMS-required codes and for sending eligibility request transaction to CMS. This system also accepts and process the CMS return file and generates CMS-required letters to the enrollees.

Screen Shot from MHC Managed Care System
Members that are approved by the CMS return file are enrolled in the main eligibility and claims system. From this main system, eligibility files are extracted and sent to other data systems such as the Pharmacy Benefit Manager, Medical Management (CCMS), etc.
Screen Shot from MHC Managed Care System Showing Enrollment History
Part 2 showing the members can and do have multiple enrollment segments, particularly when the Low Income Subsidy levels change.

Screen Shot from CCMS Medical Management System
All members are loaded to the CCMS Medical Management system which is used by utilization management, case management, risk assessments, and quality outreach.
Screen Shot from MCG (Clinical Guidelines) System
All members and certain inpatient events are loaded to this system which for using clinical guidelines based on the member's condition.
2. **Health Data System Overall Schematic**

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

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

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**Care1st SNP Health Data System**

- **Data Sources**
  - Providers Claims Data
  - Providers Encounter Data
  - Medical Records Data
  - Call Center Data
  - Pharmacy Data
  - Eligibility Data
  - Provider Data
  - Audits & Other Data

- **Data Storage**
  - Medical Management System
  - Oracle Data Warehouses
  - SQL Server Data Warehouses
  - Clinical Guidelines System
  - Predictive Modeling System
  - HEDIS Certified Vendor

- **Data Analysis**
  - User Applications Interfaces
  - Reporting Databases
  - Reporting Repositories

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XVII. **PART C and D REPORTING ELEMENTS**

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

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

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

XVIII. (PART D) MEDICATION THERAPY MANAGEMENT PROGRAM (MTMP)

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

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

Quality Improvement

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

HEDIS

70.1.2.1 HEDIS Studies and QISMC Studies Reporting
90.1.2.1 HEDIS Studies and QISMC Studies Reporting
70.1.2.2 HEDIS Medical Record Abstraction Process
70.1.2.3 HEDIS Oversight Audit Process
90.1.2.3 HEDIS Oversight Audit Process
70.1.2.4 HEDIS Reporting and Dissemination of Results
70.1.2.5 HEDIS Corrective Actions and Interventions
90.1.2.5 HEDIS Corrective Actions and Interventions
70.1.2.6 Internal HEDIS Tracking Database and Collection Process
70.1.2.7 Healthy Start Program
70.1.2.8 HEDIS Provider Incentive
Care1st Health Plan
2015 SNP Quality Improvement Program

**Credentialing**

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

**Facility Site Review**

70.1.4.1 Facility Site Review/Medical Record Review Process
80.1.4.2 Facility Site Review/Medical Record Review Auditor Training
70.1.4.3 Facility Site Review/Medical Record Review PCP Access Requirements
70.1.4.4 Facility Site Review/Medical Record Review Corrective Action Plans
70.1.4.5 Facility Site Review/Medical Record Review Inter-Rater Reliability
10.1.4.6 Facility Site Review/Medical Record Review Score Notification to L.A. Care
70.1.4.7 Facility Site Review/Medical Record Review Practitioner Feedback Process
80.1.4.8 Collaborative FSR Process
80.1.4.9 FSR Scoring Collaborative
80.1.4.10 Medical Record Collaborative
80.1.4.11 FSR Interim Review of Facility and Medical Records
80.1.4.12 Member Complaint-Related Office Visit
50.1.4.13 Medicare Facility Site Review Process
50.1.4.14 Facility Site Review Delegation
70.1.4.15 Facility Site Review -Staying Health Assessment tool