Independent Health
Quality Management Program Description – 2014

Independent Health Mission:
We provide health related products and services that enable affordable access to quality health care.

Independent Health Vision:
We will be the recognized leader in customer engagement and delivering solutions that improve the health of the communities we serve.

Independent Health Value:
Passionate – Create an exceptional, memorable experience for others.
Caring – Support the well-being of others.
Respectful – Respect everyone and build trust
Collaborative – Work together to create solutions
Accountable – Deliver what we promise.

I. PROGRAM INTRODUCTION/PRINCIPLES

Our Quality Management approach is guided by the knowledge and commitment to our principles, such that we:

- put into action our course of direction set by our Mission and Vision,
- live by our values
- engage all levels of the organization to participate in the transformation of the organization as identified in our corporate strategies
- have an understanding that our primary customer is our member, who is at the core of our business of improving access, service and health care of the people we serve.
- A philosophy where every associate is available to listen, seek to understand, and evaluate the needs of the customer or stakeholder in ways that will provide a solution or value beyond what is expected.
- Thinking from the outside in; we seek to understand, and then design our internal processes with the customer in mind while being mindful of their cultural and linguistic needs.

These specific principles are:

- Trust and Integrity – Independent Health has nothing of greater value than its associates. We succeed because of the quality, motivation and shared values of our team. We strive to be an organization characterized by trust and integrity, listening carefully and treating everyone with respect.
- Quality First – To continuously improve the quality of health care in our community is Independent Health’s highest priority; best in class becomes the minimum level to which we aspire.
- Member Focus – Promoting the health of our members always comes first. Their needs and expectations will drive the design of our benefits and services. We evaluate our success through the eyes of our membership.
• **Physician Partnership** – We work with our physicians to develop and implement programs based on jointly endorsed clinical guidelines. Together we seek to provide the best value for our customer and to enhance the physician-patient relationship.

• **Community Relationships** – Independent Health works closely with employers, physicians and providers and other leaders of our community, ensuring their input into the design and improvement of our services. We volunteer our expertise to meet community needs and support cultural, educational and charitable organizations that improve the health of our community.

• **Health and Wellness** – Healthy lifestyles are important to our customers and our associates. We are committed to educating, encouraging and supporting programs that improve health at work and in the community.

• **Operational Excellence** – We recognize and accept our responsibility to provide effective services. Through process improvement and the use of technology, we embrace best practices in all the services we provide. We aim to perform at these levels the first time and consistently thereafter.

## II. PURPOSE AND DESIGN

The purpose of the Quality Management (QM) Plan is to ensure that members are provided superior quality care by improving clinical care and service for our members within the context of the value equation. The organization has the responsibility of designing, measuring, assessing, and continually improving its performance.

Independent Health's Quality Management Plan is a coordinated and collaborative effort that involves management, multiple departments and disciplines, physicians, and other professionals working together as a team and collaborating to improve our organizational performance. The performance improvement activities are systematic. The main goal of quality management and improving organizational performance is a member centric approach to continuously improve member physical and behavioral health outcomes and service that is culturally and linguistically sensitive.

The program's primary focus originates from an analysis of the demographics and disease incidence of the population, as well as an analysis of quality management monitoring activities. The program is also designed to meet or exceed state and federal regulatory and accreditation requirements (i.e., New York State Department of Health/Department of Financial Services (NYS/DOH/DOFS), Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA) and employer requests/mandates. The annual QM Work Plan provides an overview of key initiatives, a timeline and stakeholders for the organized activities scheduled for the coming year. The QM Program results provide the basis for the annual program evaluation. Program effectiveness is demonstrated by improvements in both the processes and system through which care and service are delivered and from which improvements in clinical/service outcomes are generated.

The program is aimed at operationalizing our mission to improve health in the community through leadership in managing and developing innovative quality health systems and our vision that Independent Health will be the recognized leader in delivering customer engagement and delivering solutions that drive health care value.
It is our intention to proactively engage our organization in the evaluation of our business, at every level of the organization, and appropriately integrate existing processes and activities into the quality management program, with the focus on overall value and the interrelationship of performance, satisfaction, population health status and finance. To that end, quality management activities align with Independent Health's overall strategic plan and initiatives.

III. GOALS/OBJECTIVES

- To improve the health of Independent Health’s membership through programs focusing on preventive health, behavioral health, disease management, complex case management and coordination of care while remaining sensitive to the members’ cultural and linguistic needs.

- To maintain strong relationships with physicians and their office teams by providing them with education, training, tools and resources, engaging them in collaborative process improvements and supporting their efforts to improve clinical quality and patient outcomes i.e. The Primary Connection and Clinical Advisory Groups.

- To promote member, physician and provider office staff satisfaction with Independent Health

- To align physician and provider reimbursement models to support enhanced clinical quality

- To collaborate, as appropriate, with other health plans, hospitals and community-based organizations to improve clinical quality

- To define quality metrics and build the organization’s capability to facilitate high-quality patient care and service, evaluate the effectiveness of our quality activities through measurement on an annual basis, or more frequently as deemed necessary

- To promote Independent Health’s leadership in quality improvement in the community, as evidenced by improved Health Plan Effectiveness Data Information Set (HEDIS) outcomes

- To demonstrate an organizational commitment to improving safe clinical practices by fostering a supportive environment to help physicians and providers improve the safety of their practice and to help members improve their knowledge about safety issues

IV. SCOPE OF CARE AND FOCUS OF MEASUREMENT

Independent Health is an Individual Practice Association (IPA) model health plan operating in the eight counties of Western New York (Allegheny, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming). The QM Program encompasses all health care services (high volume, high risk) provided to Independent Health members of all ages including behavioral
health, prenatal, pediatric, adult and senior services. The QM Program includes all members: Commercial, Medicaid, Child Health Plus, Medicare, New York State Exchange and self-insured members. Independent Health provides a comprehensive health care delivery system for its members which include ambulatory care, inpatient and outpatient hospital and facility services, ancillary services, mental health and substance abuse, home care and administrative support services. Independent Health also oversees an ancillary and facility provider network that supports the counties and services noted above.

The scope of the QM Program includes an overall assessment of the efficacy of performance improvement activities, including the review of specific processes and outcomes at the physician and provider level as well as those performed by Independent Health.

Collaborative and specific indicators of both key processes and outcomes of care are designed, measured, and assessed by all appropriate departments/services and disciplines of the organization in an effort to improve organization performance. These indicators are objective, measurable, based on current reference databases, knowledge, and experience and are structured to produce statistically valid performance measures of care provided.

V. ACCOUNTABILITY

The Independent Health Board of Directors (governing body), as the licensed entity, is ultimately accountable for the QM Program. The physicians of the Individual Practice Association of Western New York (IPA/WNY) partner with Independent Health in achieving the goals of the QM Program and are responsible for participation in and adherence to the Independent Health QM Program. The Health Care Quality (HCQ) Committee has been designated by the Independent Health Board of Directors as the committee that provides oversight and evaluation of the QM Program. The Medical Director for Quality & Disease Management is responsible for the implementation and day-to-day operation of the QM Program and presents the QM reports to the HCQ Committee regarding QM activities, at least quarterly. (Refer to pages 6 and 7 for illustration of the committee and team structure and communication flow).

A. Roles/Responsibilities – Individuals

1. Chief Executive Officer (CEO)
   The CEO holds responsibility for the operational performance of Independent Health and assigns responsibility of quality management processes/activities to the Chief Medical Officer. The Chief Medical Officer communicates information regarding quality management processes/activities to the CEO at the Executive Team meetings.

2. Chief Medical Officer
   The Chief Medical Officer is ultimately responsible for the development, implementation and ongoing operation of the QM Program. The Chief Medical Officer designates the Medical Director for Quality and Disease Management as the Chairperson of the HCQ Committee. The Chief Medical Officer is also ultimately responsible for directing Clinical Quality Committee (CQC) functions,
directing peer review functions, ensuring physician and provider participation in the program, monitoring physician and provider performance and instituting and monitoring corrective actions when necessary. The Chief Medical Officer delegates the aforementioned responsibilities to the Medical Director for Quality and Disease Management. The Chief Medical Officer is a member of the senior management team provides this interdisciplinary team with reports on CQC progress and issues. In addition, the Chief Medical Officer is an ex-officio member of the Independent Health Board of Directors.

3. **Executive Vice President, Chief Engagement Services Officer**
The Executive Vice President, Chief Engagement Services Officer is responsible for collaborating with the Chief Medical Officer in the development and implementation of the QM Program as well as organizing and managing the staff.

4. **Medical Director for Quality & Disease Management**
The Medical Director for Quality and Disease Management provides oversight and guidance to the Quality Management Program in fulfilling its role in monitoring quality and improving performance; is responsible for directing Clinical Quality Committee (CQC) functions, directing peer review functions, ensuring physician and provider participation in the program, monitoring physician and provider performance and instituting and monitoring corrective actions when necessary.

5. **Medical Director, Behavioral Health Services**
Independent Health internally manages behavioral health services and further integrates behavioral health with medical care management initiatives. Internal management and integration provides greater opportunity for coordination of care between medical and behavioral care, partnership with behavioral health physicians and providers and the ability to develop strong disease management interventions with our physician and behavioral health partners. The Medical Director for Behavioral Health is a board certified psychiatrist who understands local practice patterns and the continuum of care available in Western New York, and is the designated physician involved in the behavioral health aspects of the QM Program. The Medical Director for Behavioral Health is responsible for leadership, oversight and implementation of the behavioral health program, and is also the physician leader for Independent Health’s Behavioral Health Clinical Advisory Group. Independent Health also convenes a separate Substance Abuse Advisory Group ad hoc to provide feedback regarding best practice and current practice patterns for our geographic area. Both groups assist the behavioral health staff in developing initiatives and processes regarding continuity and coordination of care and the UM process. Behavioral health specialists function as part of multidisciplinary care management teams focused on assessing and addressing the needs of the whole person with both behavioral health and medical components.
6. **Director, Quality & Health Management**
The coordination of the QM Program is assigned to the Director, Quality & Health Management. She works collaboratively with members of the CQC, Peer Review Committee and HCQ Credentialing Subcommittee. The Director, Quality & Health Management provides reports on CQC progress and issues to HCQC, as well as providing written and verbal reports as requested to interdisciplinary teams. The Director, Quality & Health Management coordinates adherence to regulatory and accreditation standards related to Quality Management, including but not limited to, NCQA, CMS and NYSDOH.

7. **Director, Clinical Services**
The coordination of the Utilization Management, Case Management and Disease Management program is assigned to the Director, Clinical Services.

8. **Program Manager, Behavior Health**
The Program Manager, Behavioral Health is responsible for coordination, oversight, and development of case management, utilization management, and quality assurance services including: assessment, care planning, service facilitation, care coordination, evaluation and advocacy to identified high risk and targeted members with mental health and/or substance use needs. The Program Manager, Behavioral Health oversees activities to ensure that regulatory, compliance, production, quality, and operational requirements are met and coordinates the planning, implementation, development, and ongoing evaluation of projects and programs that support interdisciplinary team and community provider collaboration, local and state government initiatives, and best practices and effective standards of care as they impact behavioral health outcomes and other co-occurring disorders and conditions.
Independent Health – Western New York Committee/Communication Structure

Independent Health Board of Directors

Pharmacy & Therapeutics Committee

HCQ Committee

Credentialing Subcommittee

Contractual 
& Clinical Member 
Appeal Committees

Clinical Quality Committee

Provider Appeals 
Committee

CMO

Peer Review 
Committee

Clinical Quality 
Committee

Technology Assessment and Approval Committee TAAC
**B. Department Responsibilities**

All departments are responsible for participating in quality management activities, as well as the provision of trended reports, as requested.

1. **Quality Management/Credentialing**

The Quality Management Department is responsible for working with the Chief Medical Officer and the Medical Director for Quality & Disease Management and the members of the CQC Team to ensure:

   a. Implementation of the QM Program
   b. Annual review and update of the QM Program Description
   c. Preparation of annual QM Program evaluation/annual report
   d. Development of annual QM Work Plan
   e. Timely implementation of QM Work Plan, evaluation and monitor of results, and revision of Work Plan, as indicated, throughout the year
   f. Review, implementation, and compliance with regulatory and accreditation standards (NYSDOH, CMS, NCQA)
   g. Clinical practice guideline coordination, distribution, annual review and monitoring of compliance to guideline, based upon population analysis
   h. Monitoring, evaluation and promotion of preventive health services, including annual distribution of preventive health guidelines to members
   i. Ensure there is analysis and reporting of key QM Programs:
      - Continuity and coordination of care
      - Access/Availability
      - Satisfaction
      - Complaints/appeals
      - Over and Under utilization
      - Member Safety
      - (Behavioral Health Preventive Health)
   j. Credentialing/recredentialing of physicians and providers (to include primary care physician, specialists, mid-level practitioner, ancillary practitioners, behavioral health specialists, and facilities) to include review of specific quality, and complaint data to be included in process
   k. Limitation of physician and provider privileges, terminations, and required reporting to the New York State Office of Professional Medical Conduct and the National Practitioner Data Bank by the direction of the chief medical officer
   l. Facilitation of and implementation of recommendations of the HCQ Credentialing Subcommittee
   m. Coordination of the privileging process
   n. Medical record keeping practices and facility management reviews for credentialing of primary care physicians, OB/GYN’s, and behavioral health specialists
   o. QM/Credentialing policy and procedure development and annual review
   p. Meeting preparation and implementation of recommendations for Peer Review and CQC meetings.
q. Preparation of teams and documentation for external reviewers, i.e., National Committee Quality Assurance (NCQA), New York State Department of Health (NYSDOH), Island Peer Review Organization (IPRO), Centers for Medicare and Medicaid Services (CMS), Office of Inspector General (OIG).

r. Preparation and evaluation of reports for Healthcare Effectiveness Data and Information Set (HEDIS), Quality Assurance Reporting Requirements (QARR) and Quality Improvement Projects (QIP)/Performance Improvement Projects (PIP) reported to NCQA, NYSDOH, CMS.

s. Physician Evaluation Team (PET) – Process that applies consistent criteria and thresholds to assess physician’s performances and establish action plans to improve efficiency and effectiveness of network.

Staff dedicated to QM/Credentialing Activities

a. 1 full time – Chief Medical Officer (MD)
b. 3 full time – Medical Directors (MD)
c. 1 full time – Associate Medical Directors (MD)
d. 4 part time – Associate Medical Directors (MD)
e. 1 full time – Director, Quality & Health Management (RN, MHSA)
f. 1 full time – Senior Program Manager, Quality & Health Management (PhD)
g. 1 full time – Manager, Quality & Health Management (RN, BSN, CCM)
h. 2 full time – Quality & Health Management Review Nurses (RN)
i. 1- .4 part time Quality & Health Management Investigator (RN)
j. 1 full time – Quality & Health Management Specialist
k. 1 full time – Quality & Health Management HEDIS Program Manager (BS)
l. 2 full time – Quality & Health Management Assistant System Administrators
m. 1 full time – Manager, Credentialing (CPCS)
n. 1 full time – Administrative Coordinator/Team Leader, Credentialing
o. 1 full time – Credentialing Analyst
p. 3 full time – Credentialing Specialists
q. 2 full time – Credentialing Support Staff

Privileging Process

When a physician is credentialed, they are provided with a list of CPT codes for reimbursement, which are appropriate to their specialty. After the credentialing phase has been completed, a physician may request additional procedures beyond their current fee schedule assignment. Each of these requests is handled on an individual, case-by-case basis. The objective is to ensure that all physicians have the appropriate training and experience to support the addition of services to members beyond that assigned to all of the physicians in the particular specialty. Privileging policies are established to address high-risk procedures and new technology. In addition, to further promote consistent quality and safety standards, all providers of high-end radiology services are required to attain and maintain accreditation.

Network Evaluation Process
The Network Evaluation Process is designed to support the review and analysis of all information gathered throughout the Independent Health organization as it relates to a physician or provider’s capacity to deliver quality, value-added services to our members. This information includes, but is not limited to: medical and behavioral health care outcomes, credentials, compliance, member complaints, quality of care concerns and patient satisfaction across all sites of service.

The Network Evaluation Process occurs on an ongoing basis throughout the year, as well as in conjunction with the recredentialing process at which time all of the profile information is gathered and analyzed to ensure that all areas identified as relevant to monitoring a practitioner’s capacity to deliver quality healthcare to our members are reviewed.

2. Clinical Services/Medical Resource Management (MRM)

The Clinical Services/MRM department includes management of medical conditions and behavioral health conditions. The department is responsible for working with the Chief Medical Officer, the Executive Vice President, Chief Servicing Officer, the Medical Directors, the Associate Medical Directors and the Program Manager, Behavioral Health to implement an integrated medical management program that incorporates the components of utilization management (UM) and comprehensive care management activities (care coordination, complex case management and chronic disease management). The goal of the medical resource management program is to ensure the appropriateness of health care services across the care continuum that improve member engagement, clinical outcomes and manage medical expense. Medical resource management program objectives include:

   a. Utilization management (UM) Program:
      i. Utilization review (UR) of healthcare services to include pre-service, concurrent and post-service reviews that systematically evaluate medical necessity, appropriateness, quality and efficiency of health care services;
      ii. Identification, assessment, planning, implementation, coordination, monitoring and evaluation of at-risk members to ensure that the most clinically appropriate and cost effective setting is utilized for medical and behavioral health services.
      iii. Standard application of nationally recognized, evidenced-based criteria, clinical guidelines and decision support tools (such as InterQual, IHA medical policies) to evaluate services that are high risk, high cost, over/under utilized in accordance with the UM/UR process defined above.

   b. Comprehensive Care Management throughout the healthcare continuum:
      i. Care coordination and discharge planning that support safe transitions from acute/post-acute inpatient care to home and reduces fragmentation across all care settings/levels of care.
      ii. Provide comprehensive and holistic case management/disease management (CM/DM) programs along the healthcare continuum designed to achieve member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation.
iii. The development, execution and monitoring of specialty programs that utilize evidence based best practices to favorably impact quality of care, utilization trends and medical expense.

iv. Facilitate collaboration with member, family/care-giver, primary care physician and the interdisciplinary team to develop and implement a plan of care that meets the member’s healthcare needs; collaboration includes active coordination between the Clinical Services and Behavioral Health clinician staff to support members’ medical care and behavioral healthcare needs.

v. Physician and provider intervention and education programs delivered through telephone, mail-based, on-site and web-based interventions to improve clinical care.

vi. Member intervention and education programs delivered through telephone outreach to members, mail-based, classroom and web-based interventions with particular attention to the members’ cultural and linguistic needs.

c. Monitor and evaluate medical management program performance to identify opportunities to improve outcomes across healthcare settings and transitions of care.
   i. Analyzes data to identify trends in populations, provider practice, service delivery, member/provider satisfaction and quality/utilization performance indicators; utilizes analyses for care planning, network management, credentialing, evaluation of program effectiveness and continuous quality/performance improvement.
   ii. The oversight and management of contracted vendors that provide medical management services and/or programs designed to improve healthcare outcomes such as member engagement, healthcare utilization, and quality performance measures (HEDIS/STAR/QARR).
   iii. Facilitation and implementation of recommendations from the Technology Assessment and Approval Committee (TAAC), Clinical Quality Committee (CQC), Health Care Advisory Committee (HCAC) and the clinical advisory groups.

Implementation of a comprehensive staff development program that supports ongoing evaluation of clinical practice, development of individualized training programs and provides an educational platform to ensure staff are instructed/trained on new/updates to clinical practice, quality/process outcomes and performance improvement.

**Staff dedicated to Clinical Services/Medical Management activities:**

a. 1 full time – Chief Medical Office (MD)
b. 3 full time – Medical Directors (MD)
c. 1 full time – Associate Medical Directors (MD)
d. 4 part time – Assoc. Medical Directors and 3 specialty consultants (MD, DDS, DC)
e. 1 full time – Director, Utilization Management (RN, MSM, CPHQ)
f. 2 full time – Manager, Utilization Management
g. 1 full time – Supervisor, Utilization Management Assistants (UMA)
h. 14 full time – Utilization Management Assistants
i. 13 full time – Utilization Review RNs
j. 1 full time – Clinical Operations Specialist
k. 1 full time – Program Manager, Medical Policy
l. 1 full time – Clinical Services Program Manager
m. 1 full time – Cost Containment Supervisor (RN)

n. 1 full time – Cost Containment Coordinator

o. 3 part time – Cost Containment Coordinators

p. 2 full time – Retro Review (RN)

**Staff dedicated to Case/Disease Management department:**

a. 1 full time – Director, Case Management/Disease Management (RN, MSM, CPHQ)

b. 1 full time – Clinical Manager, Medicaid LOB (RN, CCM)

c. 1 full time – Clinical Manager, Medicare LOB (RN, CCM)

d. 1 full time – Clinical Manager, Commercial LOB (RN)

e. 3 full time – Senior Care Managers (RN, CCM, BS, EPT)

f. 19 full time – Care Managers (RNs, exercise physiologists, LPNs, LCSWs, Certified Diabetes Educator/dietician, respiratory therapist)
   *3 full time FTEs realigning to Health Management

g. 6 part time – Care Managers (RNs, respiratory therapists, physical therapist, LPNs)

h. 1 full time – Community Resource Program Coordinator

i. 4 full time – Care Management Assistants

j. 2 full time – Administrative Assistants

k. 1 part time – Project Coordinator

l. *1 full time – Disease Management Program Coordinator

m. *4 full time – Community Outreach Workers

n. *1 full time – Case Management Assistants

o. 4 full time – Case Management Assistants

p. 5 full time – Community Outreach Workers
   *Transitioning to Health Management

**Behavioral Health**

a. 1 full time – Program Manager, Behavioral Health (LMHC)

b. 7 full time – Behavioral Health Case Managers (RNs, LCSWs, LMHCs)

c. 1 part time – Behavioral Health Case Manager (RN, CASAC)

d. 1 full time – Behavioral Health Senior Case Management (LCSW)

**Support Staff:**

a. 3 full time - Secretarial Staff

3. Wellness

**Mission**

In keeping with Independent Health’s vision to improve the health of the communities we serve, the plan offers an array of interventions to members engaging them in education, physical activity and health screening to maintain or achieve healthy lifestyles. In addition, Corporate Wellness Specialists work with employer groups to bring worksite wellness programs to the associates.
Description
Independent Health’s approach to wellness includes comprehensive awareness and education on healthy behaviors and health promotion information. Independenthealth.com provides a robust set of online health tools and information available to all Independent Health members. In addition, Independent Health provides worksite-based health promotion programs which are developed in collaboration with the employer and provide measurable outcomes. IH also promotes and provides extensive web based education and health management tools, classes and seminars educating and engaging members in healthy lifestyle behaviors. These initiatives heighten awareness, enrich understanding through education on topics such as nutrition, exercise/physical activity, stress management and tobacco cessation, to promote healthy choices with sensitivity to the members’ cultural and linguistic needs to improve or maintain health status.

Goals
- Improve member knowledge about healthy lifestyle behaviors
- Engage members in healthy lifestyle practices
- Engage employers in supporting the health and well-being of their employees
- Strengthen relationships with employers through collaborative development and implementation of customized, on-site associate health promotion and wellness programs
- Lead the communities we serve in healthy lifestyle behavior promotion
- Retain and attract membership through value-added programs

Objectives
Weight Management
- Education
- Exercise
- Nutrition
Cardiovascular Health Promotion
- Education
- Exercise
- Nutrition/Weight Management
- Smoking Cessation
- Stress Management
- Blood pressure and lipid levels through health screening and education
Stress Management
- Education
- Exercise

a. Work Site Wellness Program
Design and implement customized health risk management programs in collaboration with employer groups based upon the Wellness Council of America (WELCOA) Seven Benchmarks of Success
- Create awareness and determine needs through health risk assessment surveys and biometric screening
• Promote member engagement in Health Promotion Initiatives including the use of Web based health information and self-management tools
• Promote education and active engagement in employer endorsed programs based on the group’s specific needs and interests
• Advise employer groups in developing an incentive program to increase engagement and participation in healthy lifestyle behaviors
• Evaluate effectiveness of initiatives through measuring outcomes

b. Associate Wellness Presentations & Seminars:

Introduction to Wellness
“Taking Action for a Healthier You”
“Self-Care Essentials”

Stress Management
“Achieving Balance”

Nutrition
“Eating on the Run”
“Healthy Holidays”
“Supermarket Savvy”

Weight Management
“The Five Secrets to Weight Loss”
“Stimulate Your Metabolism”

Smoking
“Smoking Risk Awareness”

General
“Ergonomics & Back Health”
“Exercise for a Healthier Life”
“Prenatal/Post-Partum Exercise”
“Prenatal/Post-Partum Nutrition”
“Heart Health”
“Women and Heart Disease”

c. IH Member Discounts
IH partners with area organizations to offer programs and services for free, at a discount or partial reimbursement which encourage and support members in adopting healthy lifestyle behaviors.

Staff
a. 4 full time – Corporate Wellness Specialists
b. 1 full time – Wellness Manager
c. 1 part time – Wellness Coordinator
d. 1 full time – Vice President, Servicing & Wellness
4. Benefit Administration Department

Benefit Administration is responsible for:
   a. Reconsideration determinations on all written and verbal appeals/grievances from members and physicians and providers
   b. Tracking and trending appeals and grievances
   c. Monitoring turnaround times to meet regulatory requirements
   d. Conducting real time and monthly reviews for accuracy and compliance

Staff dedicated to the Appeal Process:
   a. 1 full time – Vice President, Servicing
   b. 1 full time – Assistant Director, Benefit Administration
   c. 1 full time – Manager, Quality and Compliance
   d. 2 full time - Clinical Reviewers (RNs)
   e. 4 full time - Sr. Reviewer Specialists
   f. 1 full time - Administrative Staff

5. Pharmacy Services Department

The Pharmacy Services Department is responsible for working with the Chief Medical Officer, the Medical Directors and the Associate Medical Directors to ensure:
   a. Pharmacy & Therapeutics Committee is provided with current new drug and current clinical review information for their recommendations.
   b. Pre-service concurrent and post service reviews are based upon Pharmacy and Therapeutic approved clinical recommendations
   c. Notification of urgent and emergent drug review decisions
   d. Notification of standard request for drugs review decisions
   e. Drug Formulary management
   f. Medication Therapy Management (MTM) program participation (our program of drug therapy management that is furnished by a pharmacist in conjunction with the member’s provider and is designed to assure that medications are appropriately used to optimize therapeutic outcomes and to reduce adverse drug events with special emphasis on our members with complex health needs.)
   g. Drug/Disease pharmacy system drug safety edits
   h. Member/Physician and provider drug communications and education.

6. Member Services

The Member Services Department is responsible for:
   a. Functioning as a member advocate and assisting MRM department with quality initiatives with our membership. Directing members to case management, health coaches and other MRM departments as needed
   b. Educating members regarding accessing services and educating members on product benefits and member liability
c. Addressing and resolving member inquiries and complaints
d. Advising members of their rights and responsibilities as plan members
e. Assisting the member in selecting or changing his/her primary care physician
   while taking into consideration their cultural, linguistic and accessibility needs.
f. Monitoring, evaluating and providing reports regarding primary care physician
   change rates to credentialing, provider networks and Clinical Quality Committee
g. Providing responses that are accurate and concise
h. Assist member’s through the Language Line, Interpreter services as needed

7. **Network Contract Management**

Network Management is responsible for:

a. Hospital and provider networks
b. Leased Networks
c. Maintenance, entry and audit of the provider data system and fee schedules
d. Maintenance of the provider directory including provider-spoken languages and
   handicap accessibility of the office.
e. Quarterly submission of HPN reports to the DOH
   Monitoring, evaluating and ensuring availability of services and physician and
   providers.

8. **Provider Services**

The Provider Services Department is responsible for:

a. Functioning as a provider advocate
b. Providing education on programs offered including utilization, case and disease
   management and wellness.
c. Providing education on electronic tools offered (i.e. WNYHealtheNet, Reveal,
   Scope, and the provider website).
d. Providing education on mailings that are sent out regarding policy, incentives
   and fee schedule changes.
e. Advising physicians and providers of their rights and responsibilities
f. Verifying member eligibility
g. Researching and responding to claims status checks
h. Providing informative and concise responses to physician and provider inquiries

9. **Marketing**

The Marketing Department is responsible for:

a. Product sales and service to groups and individuals without prejudice for
   cultural, linguistic or physical ability needs.
b. Maintaining a professional image of Independent Health
c. Product development
d. Benefit design
- Conducting satisfaction surveys: member, physicians and provider, office staff, employer, and voluntary member disenrollment
- Monitoring, evaluating and improving satisfaction of Independent Health customers
- Communicating employer needs to CQC for evaluation/inclusion in QM Workplan and Program Description

10. Information Technology (IT)/Informatics

The Information Technology/Informatics Departments are responsible for providing prompt, clear, concise data resources devoted to HEDIS, meeting state and federal reporting requirements, and providing data for population analysis, to include potential existence of significant health care disparities in clinical areas.

11. Internal Operations

The Internal Operations Department is responsible for the prompt and accurate adjudication of claims in accordance with all Independent Health policies.

12. Finance

The Finance Department is responsible for:
- Identification of catastrophic cases for reinsurance purposes
- Premium rating
- Enrollment
- Distribution of member identification cards
- Cost analysis

13. Teams dedicated to Physician Engagement

- Coordinate the Advanced Primary & Specialty Care initiatives, for example The Primary Connection initiative utilizes the Patient Centered Medical Home model as the framework for high quality, patient-centered care. The initiative is focused on the improvement of care coordination across the entire health care delivery system. Quality and safety are hallmarks of the practice.

C. Committee/Team Definition

Committee/team meetings shall be conducted according to a formal agenda. Signed and dated minutes shall be kept reflecting committee deliberations and actions, specifically, documenting topics discussed, recommendations and actions to be taken.
1. Health Care Quality (HCQ) Committee

The HCQ Committee is the quality improvement committee for Independent Health. The HCQ Committee is comprised of representatives from Independent Health’s physician and provider network, as well as consumer and industry/management representatives of the Independent Health Board of Directors.

a. Key Functions:
   - Recommend policy decisions
   - Review and evaluate results of quality improvement activities
   - Identify and recommend needed action
   - Ensure follow-up

b. Specific Functions:
   - Evaluates QM Program implementation and provides feedback regarding the effectiveness of the QM Program (at least annually).
   - Reviews and approves the QM Program Description and Work Plan (at least annually).
   - Reviews and approves the Care Coordination Program Description and evaluates the Care Coordination Program (at least annually).
   - Reviews trends and aggregate data to identify opportunities for improvement, assigning accountability where appropriate, (i.e., member satisfaction surveys, member complaints and other key quality indicators of care and service).
   - Monitors, at least quarterly, the QM Program implementation and provides a report on a quarterly basis to the Independent Health Board of Directors.
   - Monitors adherence to the QM Work Plan and provides feedback.
   - Reviews population analysis which includes potential significant health care disparities and provides feedback at least annually.
   - Monitors both under and over utilization.
   - Approves clinical practice guidelines.
   - Recommends new health care policies and procedures.
   - Reviews and provides feedback regarding existing medical and behavioral healthcare policies and procedures.

   Responsible for individual and organizational physician and providers’ credentialing and recredentialing as follows:
   - Appoints a credentialing subcommittee composed of peers. The subcommittee shall have the responsibility for determining whether a physician, behavioral health specialist, or other health care provider meets the professional criteria set forth by Independent Health, and whether their practices are in accordance with Independent Health criteria, guidelines and policies.
   - The subcommittee reviews, at least annually, the credentialing/ recredentialing criteria, policies and procedures and provides recommendations to the HCQ Committee, which retains final authority for approval.
   - The subcommittee acts as a peer review body and is responsible for making recommendations regarding the credentialing/ recredentialing of
physicians and providers to the HCQ Committee, which retains final authority for approval.

c. Frequency of meeting:
The HCQ Committee meets at least quarterly.

d. Reports to:
The HCQ Committee reports to the Independent Health Board of Directors at least quarterly; the Chief Medical Officer provides feedback from the board to the Medical Director for Quality & Disease Management. The chair of the HCQ Committee is the Medical Director for Quality and Disease Management of Independent Health.

e. The committee’s current members are:

Title
Medical Director for Quality & Disease Management, Chairperson (Internal Medicine)
IHA Board (Industry/Management Rep.)
IHA Board (Industry/Management Rep.)
IHA Board (Provider Rep.-Internal Medicine)
IHA Board (IPA Rep.-Family Medicine)
IHA Board (Consumer Rep.)
IHA Board (Industry/Management Rep)
IHA Board (Consumer Rep.)
IHA Board (Consumer Rep.)
IHA Board Chairperson (Provider Rep.-OB/GYN)

f. The following are staff attendees of the Committee on behalf of Independent Health or IPA/WNY:

Title
Representative from – IPA/WNY General Counsel’s Office
Medical Director, Quality & Disease Management
Associate Medical Director, (Pediatrics), Credentialing
Medical Director (Psychiatry)
Director, Quality & Health Management
Senior Deputy Counsel
Director, Case Management
VP, Medical Management

2. HCQ Credentialing Subcommittee

The HCQ Credentialing Subcommittee is a subcommittee of the HCQ Committee and is comprised of provider network representatives.

a. Key Functions
   Develops criteria for credentialing/recredentialing.
   Reviews the criteria at least annually.
   Reviews the credentialing/recredentialing policies and procedures at least annually.
   Assesses all physician and providers’ qualifications against the criteria for credentialing/recredentialing.
Provides recommendations regarding credentialing and recredentialing of
physicians and providers to the HCQ Committee.
Provides input and makes recommendations to the HCQ Committee for
those physicians and providers who do not meet all criteria for
credentialing/recredentialing.
Frequency of Meetings:
The HCQ Credentialing Subcommittee meets eight times a year on the last
Thursday of the month.

b. Reports to:
The HCQ Credentialing Subcommittee reports to the HCQ.
c. Membership:
The HCQ Credentialing Subcommittee consists of the following members:

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<tbody>
<tr>
<td>Associate Medical Director, Chairperson (Pediatrics)</td>
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<tr>
<td>Community Physician - ENT</td>
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<tr>
<td>Community Physician - Cardiology</td>
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<td>Community Physician - Internal Medicine</td>
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<tr>
<td>Community Physician - Orthopedic Surgeon</td>
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<tr>
<td>Community Physician - Neurology</td>
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<tr>
<td>Community Physician - Ophthalmology</td>
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<tr>
<td>Community Physician - General Surgery</td>
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<tr>
<td>Community Physician - Pediatrics</td>
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<tr>
<td>Community Physician – Psychiatry</td>
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<tr>
<td>Community Physician – Obstetrics/Gynecology</td>
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</table>

The following are staff members of Independent Health
Medical Director, Health Care Services - ad Hoc
Senior Deputy Counsel
Manager, Credentialing
Coordinator/Team Lead, Credentialing
Representative from IPA/WNY General Counsel’s Office

3. Clinical Quality Committee

The Clinical Quality Committee (CQC) is comprised of Independent Health
leadership staff representing various departments. The purpose of the CQC is to set
strategic direction for the QM process and to ensure development, implementation,
and evaluation of a corporate-wide quality improvement program through a
systematic process to monitor, measure, trend, evaluate and improve the quality of
care and service provided to Independent Health members.

a. Leadership responsibilities:
    Set priorities for quality improvement efforts based on population analysis
    and identified opportunities for improvement in clinical care and service;
    Develop and oversee implementation and evaluation of Quality Management
    Work Plan;
Focus efforts on strengthening key relationships while improving quality; Provide long-term direction for QM Program.

b. Key functions:
Oversight and monitoring of key quality improvement initiatives in areas of clinical care and service;
Ensure members have access and availability to qualified medical and behavioral health care physicians and providers;
Ensure decisions regarding medical and behavioral health care are fair, consistent, and adhere to best practice with consideration of their cultural, linguistic and accessibility needs.
Protect members’ rights, especially relating to disclosure, confidentiality and complaints and appeals;
Ensure members receive needed preventive and chronic health services.
Review and provide feedback regarding existing healthcare policies and procedures.
Establish a systematic process for identification of occurrences of poor care and service and ensure action is appropriately taken.
Establish effective processes for monitoring potential under and over utilization and assure that interventions are initiated as appropriate.
Provide oversight and approval of the Care Coordination Program Description.
Perform annual review regarding Independent Health policies and procedures directly or indirectly relating to quality of care and service to members is delegated to the Health Care Policy Review Committee, whose membership includes physicians and other clinical members of the Clinical Quality Committee.
Adoption and annual approval of clinical criteria utilized to render medical decisions.
Review of inter-rater reliability audits and actions taken to improve consistency across reviewers.
Reviews population analysis which includes potential significant health care disparities and provides feedback at least annually.
Delegation oversight of contracted UM vendors.

c. Decision making:
Review QI initiatives and prioritize based on QM Plan;
Delegation and oversight of QM Program implementation;
Ensure resources support strategic initiatives and QM Plan.
Assess effectiveness of programs and make recommendations for continuation or change of programs.

d. Communication:
Ensure all key stakeholders are aware of QM programs and accomplishments;
Facilitate communication of directives and discussion from the HCQ committee.

e. Measurement:
Monitor key QM performance indicators/Value Compass;
Monitor key strategic initiatives.
f. Culture:
   Promote interdepartmental cooperation in focused QI efforts for the purpose of improving care and service to members;
   Identify, implement and evaluate best practice in operational processes and clinical care.

g. Frequency of Meetings:
The CQC meets at least quarterly.

h. Reports to:
The CQC reports to the HCQ Committee.

i. Membership:
The Clinical Quality Committee is composed of the following members:

<table>
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<th>Title</th>
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<tbody>
<tr>
<td>Medical Director, Quality &amp; Disease Management (Internal Medicine), Chairperson</td>
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<tr>
<td>Medical Director, Health Care Services</td>
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<tr>
<td>Associate Medical Director – Community Liaison</td>
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<tr>
<td>(Allergy/Immunology)</td>
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<tr>
<td>Associate Medical Director – Community Liaison</td>
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<tr>
<td>(Cardiology)</td>
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<tr>
<td>Director, Quality &amp; Health Management</td>
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<tr>
<td>Senior Program Manager, Quality &amp; Health Management</td>
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<tr>
<td>Director, Case/Disease Management</td>
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<tr>
<td>Director, Utilization Management</td>
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<tr>
<td>Manager, Behavioral Health</td>
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<tr>
<td>Manager, Informatics Analytics</td>
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<tr>
<td>Director, Physician Clinical Services</td>
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<tr>
<td>Assistant Director, Benefit Administration</td>
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The following are ad hoc members
Manager, Quality & Health Management
Director, Pharmacy Services
Vice President, Servicing
Director, Provider Network Administration
Medical Director – Behavioral Health
Associate Medical Director – Credentialing

Other functional areas are invited as reports are needed, i.e., internal operations, credentialing, provider services.

4. Technology Assessment and Approval Committee (TAAC)

The TAAC is composed of primary care physicians and specialty care physicians with expertise and/or professional interest in the development of new or evolving medical technology/procedures.
a. Key functions:
   Evaluate new technologies and new uses for existing technologies including
   assessment of safety and efficacy.
   Provide policy recommendations.
   Review of input from government agencies overseeing Medicare and
   Medicaid programs.

b. Frequency of meetings:
The TAAC meets monthly.

c. Reports to:
   TAAC is a subcommittee of the CQC.
   The Medical Director provides reports to the CQC on a semi-annual basis.
   The committee is chaired by the Chief Medical Officer or his designee.

d. Membership:
The TAAC is composed of the following members:

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<tr>
<td>Medical Director, Health Care Services (Chairperson)</td>
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<tr>
<td>Medical Director, Quality &amp; Disease Management</td>
</tr>
<tr>
<td>Medical Director, Behavioral Health Services</td>
</tr>
<tr>
<td>Associate Medical Director  Colo-Rectal Surgery</td>
</tr>
<tr>
<td>Director, Physician Clinical Services</td>
</tr>
<tr>
<td>Manager, Utilization Management</td>
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<tr>
<td>Manager, Cost Containment</td>
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<tr>
<td>Program Manager, Medical Policy</td>
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<tr>
<td>Program Manager, Operations</td>
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<tr>
<td>Manager, Quality &amp; Health Management</td>
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<tr>
<td>Sr. Clinical Coding Coordinator, Reimbursement</td>
</tr>
<tr>
<td>Senior Program Manager, Quality &amp; Health Management</td>
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<tr>
<td>P&amp;T/Drug Evaluations Pharmacist</td>
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<tr>
<td>Manager, UM Self-Funded Plans</td>
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<td>Clinical Trainer, Self-Funded Plans</td>
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<tr>
<td>Manager, Credentialing</td>
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<tr>
<td>Community Physician-General Surgery</td>
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<tr>
<td>Community Physician-Family Practice and Epidemiology</td>
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<tr>
<td>Community Physician-Internal Medicine (2)</td>
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<td>Community Physician-Pediatrics (2)</td>
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<tr>
<td>Community Physician-Radiation Oncology</td>
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5. Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee (P&T) is responsible for the
development and maintenance of Independent Health's drug formulary. The
formulary represents the list of drugs which physicians in the IPA can use to guide
their prescribing decisions. For a drug to be added to the formulary it must:
- Be approved by the FDA and have labeling to support the intended use on the formulary
- Have demonstrated ("evidence-based") efficacy and safety that is comparable or better than agents currently on the formulary
- Have equal or better pharmaco-economic profile compared to existing formulary alternatives.
  a. Key Functions:
     Determine which agents should be on the drug formulary based on safety, efficacy and pharmaco-economic criteria.
     Review and provide feedback regarding drug-specific policies that determine when exceptions to the formulary will be accepted as well as criteria for prior-authorization drugs.
  b. Frequency of Meetings:
     The P&T Committee will formally meet quarterly. Between meetings the committee may be presented with urgent decisions via phone or fax and any actions will be reviewed at the next meeting.
  c. Reports to:
     The Pharmacy and Therapeutics Committee reports to the HCQ Committee.
  d. Membership:
     The membership of the P&T Committee is determined by the Chief Medical Officer, Pharmacy Director, and the P&T Chairperson. Membership requirements are:
     - Must be an IPA member in good standing;
     - A signed confidentiality statement must be executed and the candidate must have a demonstrated ability to hold information in confidence;
     - A signed Disclosure Statement declaring any relationships that might encumber a member in decision-making (e.g., relationships with pharmaceutical companies); during discussion any voting members must disclose any potential conflicts and abstain from the discussion and vote;
     - Attendance on a regular basis is essential to maintain continuity.

Appointments are for an undefined period of generally 12 to 24 months with the option to be renewed. The composition of the committee is structured to involve general/family practitioners plus the key specialties covering the majority of the decisions to be made. Guest physicians are invited to provide perspective in areas not directly covered by P&T membership. Independent Health staff support the committee and attend meetings but are non-voting members.

The Pharmacy and Therapeutics Committee is composed of the following members:

**Practice Type**
- Community Physician - Dermatology
- Community Physician - Infectious Disease
- Community Physician - Allergy
- Community Physician - Internal Medicine (3)
Community Physician - Pediatrics
Community Physician - Neurology
Community Physician - Family Practice
Community Physician - Gastroenterology
Community Physician - Internal Medicine (Chairperson)
Community Physician - Internal Medicine/Pediatrics
Community Physician – Psychiatry
Community Physician - Cardiology
Community Physician- OB-GYN
Community Pharmacists (4)

Title
Assistant Director, Pharmacy
Clinical/Disease Management Pharmacist
Director, Pharmacy Systems
Director, Pharmacy Services
Associate Medical Director (Cardiology)
P & T/Drug Evaluations
Assistant Clinical Review Pharmacist
Assistant Clinical Review Pharmacist
Assistant Clinical Review Pharmacist
Utilization Management Pharmacist
Pharmacy Manager, Medication Therapy Mgt.
Associate Medical Director (Internal Medicine)
Assistant Director, Pharmacy Operations
Rebates, Reporting & Analysis
Medical Director, Quality & Disease Management
Utilization Management Pharmacist
Medication Therapy Management Pharmacist
Medication Therapy Management Pharmacist
Vice President and General Counsel
Manager, Pharmacy Help Desk

e. Communication
The content of the formulary is contained in a publication that is updated and re-printed quarterly. The updates to the formulary as well as Drug Specific Policy updates are sent to physicians via the SCOPE publication and to pharmacists via the SCRIPT publication on a quarterly basis. Members can obtain a copy of the formulary from member services on request. The formulary is also available on the Independent Health web page. Drug specific policies are also available to physicians on the web page.

6. Contractual Member Appeals Committee

The Contractual Member Appeals Committee is responsible for review of second level member appeals on contractual matters. The committee meets every two...
weeks and is composed of individuals who were not involved in any previous decision regarding the issue. The member has the right to appear by conference call, or by other appropriate technology.

The committee members are as follows:
- IH Board, Consumer Representative, Committee Chairperson
- IH Board, Consumer Representative
- IH Board, Consumer Representative
- [IH Board Industry/Management Representative](SC1)
- IH Board Consumer Representative
- IH Board, Consumer Representative
- Medicare Advantage Member

Staff members of Independent Health:
- 2 – Member Review Specialists – Benefit Administration

7. **Clinical Member Appeals Committee:**

The Clinical Member Appeals Committee is responsible for review of standard clinical member appeals. The committee meets every three weeks and is composed of community physicians and Independent Health Medical Directors and Associate Medical Directors who were not involved in any previous decision regarding the adverse determination or expedited appeal. The member has the option to appear by conference call, or by other appropriate technology.

The committee members are as follows:
- Community Physician - Pediatrics
- Community Physician – Gastroenterology
- Community Physician – Internal Medicine
- Medical Director - ENT
- Medical Director - Internal Medicine
- Medical Director - Psychiatry

Staff members of Independent Health:
- Clinical Review Pharmacist
- Clinical Review Specialist, Benefit Administration
- Clinical Review Specialist, Benefit Administration
- Manager, Case Management, Acute & Rehab

8. **Peer Review Committee**

The Peer Review Committee is a multi-disciplinary physician committee comprised of both primary care physicians as well as specialty care physicians.

a. Key functions:
   - Peer review of provider issues which may be individual cases or trended issues.
Provide recommendations to the Chief Medical Officer to address presented issues, (e.g., physician or provider education, placement of limitation, termination, etc.).

b. Frequency of meetings:
The Peer Review Committee is scheduled monthly, and meets on an as-needed basis.

c. Reports to:
The Chief Medical Officer. A physician committee member (Medical Director for Quality and Disease Management) chairs the committee. A summary of actions taken by the committee will be given to the Chief Medical Officer.

NOTE: A copy of all determination decisions will be placed in the recredentialing file of the physician or provider as part of the Network Evaluation review that is incorporated into the recredentialing process. A summary of actions will be made available to the Credentialing Subcommittee at the time of consideration of the physician or provider for continued participation with Independent Health.

d. Membership:
The Peer Review Committee is composed of the following members:

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<tr>
<td>Community Physician - OB/GYN</td>
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<td>Community Physician - Ophthalmologist</td>
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<td>Community Physician - General Surgery</td>
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<td>Community Physician - Gastroenterologist</td>
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<tr>
<td>Community Physician - IM/Pulmonology</td>
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<td>Community Physician – Pediatrics</td>
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<tr>
<td>Community Physician – Orthopedics</td>
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<tr>
<td>Community Physician – Family Practice</td>
</tr>
<tr>
<td>Community Physician - Psychiatry</td>
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</table>

Staff members of Independent Health:
Medical Director, Quality and Disease Management (Internal Medicine) - Chairperson
Chief Medical Officer, (Pediatrics) Ex-Officio
Associate Medical Director, Credentialing Manager, Quality & Health Management

VI. PROGRAM PROCESS

A. Quality Management Work Plan

The Quality Management Work Plan is prepared annually by the Clinical Quality Committee (CQC) in conjunction with the review of the program description and the annual quality management report. The Quality Management Work Plan delineates
individuals responsible for each activity and target dates for completion. The approval of updates and revisions to the Quality Management Work Plan are made by the Health Care Quality Committee (HCQC). The Work Plan will be updated throughout the year as necessary.

B. Data Sources

Independent Health has analyzed and assessed its membership through a demographic profile, prevalence and utilization data and multiple other data sources. Available data sources include, but are not limited to the following:
1. Medical records
2. Member complaints and appeals
3. Provider complaints and appeals
4. Member/provider complaints regarding quality issues
5. Member surveys
6. Provider surveys
7. Office manager surveys
8. Employer surveys
9. Utilization management reports
10. Financial data
11. Prescription and pharmacy reports
12. Provider profiles
13. Office site reviews
14. Claims data
15. Member health assessments

C. Quality Management Process

1. Identification of meaningful issues relevant to population for assessment and evaluation.

Independent Health assesses the demographics and health risks of its enrolled population and chooses meaningful issues that reflect the medical and behavioral health needs and potential clinical disparities of significant groups within the population. Focus will be placed on high-volume, high-risk, complex and problem-prone areas. These issues may be chosen from, but are not limited to the following:
   a. Primary care services
   b. High-volume specialty services
   c. Mental health/substance abuse services
   d. Inpatient hospital services
   e. Home health services
   f. Skilled nursing facility services
   g. Free-standing surgery center services
   h. Acute Rehab and Sub-acute facilities
   i. After-hours urgent care centers
   j. Infusion centers
   k. Ancillary services
1. Continuity and coordination of care  
   m. Preventive health care  
   n. Access to health care and services  
   o. Access to Independent Health services  
   p. Member safety  

2. Measurements/Monitors  
   a. Select the important aspects of care and service to be measured/monitored  
   b. Establish measures to assess performance that are objective, quantifiable and  
      based on current scientific knowledge, evidence-based practice and clinical  
      experience  
   c. Establish goals and/or benchmarks for each measure adopted from national or  
      local industry standards  
   d. Utilize appropriate data collection methodology and identify frequency of data  
      gathering  
   e. Use multi-disciplinary teams to analyze, address issues and barriers, and  
      implement improvement activities  

3. Adopt and disseminate clinical practice guidelines or specific criteria for provision of  
   services  
   a. Base guidelines on reasonable medical and behavioral health evidence and  
      national standards  
   b. Obtain physician and provider involvement in development and adoption of  
      guidelines  
   c. Review guidelines annually or as needed  
   d. Make guidelines available to physicians and providers  
   e. Measure performance, against a minimum of two guidelines, which are  
      significant to the population  
   f. Provide feedback to appropriate individuals, departments, committees and  
      physicians and providers  
   g. Make preventive health and clinical practice guidelines available to members  
      in an easy to use format  
   h. Ensure decisions are consistent with guidelines regarding benefit  
      determination, medical appropriateness, and member education  

4. Intervention/Follow-up  
   a. Independent Health identifies opportunities for improvement and decides  
      which opportunities to pursue based upon meaningful issues and their  
      measurements.  
   b. If indicated, intervention will be developed and implemented in order to  
      improve performance.  
   c. Re-measure to determine the effectiveness of the intervention.  
   d. Identify, investigate and act upon, when appropriate, population-wide or  
      individual occurrences of poor quality and implement interventions and/or  
      corrective actions.  
   e. Provide feedback to appropriate individuals, departments, committees and  
      physicians and providers.
D. Mechanism for Remedial Action

1. Analysis

Medical Director for Quality and Disease Management has the discretion, authority and responsibility to analyze the quality and the utilization of medical and behavioral healthcare services and other practices of participating physician and providers.

The Medical Director for Quality and Disease Management, is expected to analyze the quality, scope, and manner of management of medical and behavioral health care services by a physician and provider which includes: appropriateness of referrals, compliance with IPA/WNY and IHA bylaws, rules, regulations and policies, accurate and descriptive medical record documentation for patient/client information and billing purposes, adherence to standards that improve quality of medical and behavioral health care and efficiency of the medical/behavioral health specialty practice.

2. Remedial Action

The Chief Medical Officer may take the following actions with individual physicians and providers:
   a. Direct consultation and education with the physician or provider under review
   b. 100 percent review of physician or provider claims
   c. Mandatory second opinions for surgical care
   d. Limit physician or provider privileges
   e. Impose “Status X” = (no new patients)
   f. Hold all payment of claims
   g. Conduct focused review of ambulatory or hospital care
   h. Increase withhold
   i. Suspend or terminate the physician or provider agreement

The Chief Medical Officer shall notify the physician or provider in writing of the reason for the limitation or termination, the right of appeal, the duration of the limitation and the conditions necessary to rescind the limitation. The physician and provider may appeal this decision according to the Provider Appeal Policy.

If remedial action is taken, the Chief Medical Officer and clinicians/staff will work with the physician or provider to educate and to assist the physician or provider in achieving compliance with Independent Health standards.

Based on the decision of the Chief Medical Officer, Independent Health will re-evaluate the physician or provider's performance at predetermined times regarding the identified concerns.

VII. QUALITY MANAGEMENT PROGRAM COMPONENTS
A. Medical Records and Facility Management Reviews
Goal: To systematically monitor, evaluate and improve physician and behavioral health specialist compliance with Independent Health medical record and facility management guidelines.

Objectives:
- To review medical records to ensure that they are maintained in a manner that is current, detailed and organized and permits timely, effective and confidential patient care and quality review. This is performed as deemed necessary as a result of member complaints and quality of care concerns, as well as through specific coordination of care projects conducted throughout the year. In addition, offices are reviewed against facility management guidelines to ensure that care is provided in a safe, clean and accessible setting. This is accomplished during on-site reviews at the time of credentialing. The following physicians and providers are included in this review:
  1. All primary care physicians (family practitioners, internists, pediatricians, general practitioners and other designated primary care physicians
  2. All OB/GYNs
  3. Behavioral Health Specialists (facility review only)
  4. Independent Practice Nurse practitioner

- To distribute medical record and facility management guidelines and policies to all physicians. These guidelines will continue to be provided to all new participating physicians at the time of their orientation. As updates are made to the guidelines or policies, or new policies are developed, they are communicated to the physician and providers through SCOPE, the physician/specialist newsletter and made available online via the Internet on the Independent Health web site. They are also distributed and discussed at the time of all facility management reviews. In addition, Independent Health makes the following office record forms, created to assist the physician and specialist in maintaining current, detailed and organized records, available online via Independent Health's web site.
  1. Adolescent Initial Visit
  2. Adult Health Maintenance Flowsheet
  3. Antepartum Record
  4. Asthma Care Flowsheet
  5. At Risk for CAD Flowsheet
  6. CAGE Alcohol Self-Test
  7. Check List (Multipurpose, i.e., documentation of medication rotation, refrigerator temperatures, etc.)
  8. DAST-10 Drug Self-Test
  9. Diabetes Eye Exam Report
  10. History and Physical - Initial
  11. Medication List
  12. Pediatric Health Maintenance Flowsheet
  13. Pediatric Medication/Problem List
  14. PHQ9 Scale for Depression
  15. Problem List - Adult
  16. Progress Note
17. Telephone Inquiry Form  
18. Vaccine Administration Record  
19. Well Baby Care  
20. Well Childhood Visits  
21. Women’s Health Care Visit - Initial GYN Evaluation  
22. Women’s Health Care Visit - Yearly GYN Evaluation

- To distribute and maintain policy and procedure for confidentiality of all medical records of Independent Health members.

The medical record and facility management reviews will be developed and monitored according to the quality management process as described in Section VII C.

B. Medical and Behavioral Care Outcome Studies and Management

Goal: To reduce morbidity of diseases affecting the Independent Health of Western New York member population; improve functional status of members; improve member and physician and provider satisfaction; ensure that care provided by participating physicians and providers is appropriate, timely, effective and consistent with current national/community standards; and, to assist members in achieving optimal control of their disease through adherence to treatment plans including self-monitoring and appropriate medical testing and acquire more meaningful outcome data.

Objectives:  
The following programs and performance measurements are outlined below:

1. Asthma Management Program
   a. Emergency room visit rate/1000 members  
   b. Inpatient admission rate/1000 members  
   c. Influenza Vaccination/1000 members  
   d. 2 or more physician visits/1000 members  
   e. Preferred pharmacy management rate  
   f. Medication management for people with Asthma (HEDIS)  
   g. Over-use of short-acting beta2 agonist rate

2. Cardiovascular Management Programs (Congestive Heart Failure/CAD) MI, Atrial Fib, HTN
   a. Inpatient admission rate/1000 members (CHF and CVD by complications)  
   b. ACE inhibitor/ARB pharmaco-therapy rate (CHF)  
   c. LDL screening rate and LDL Control (HEDIS)  
   d. Beta blocker pharmaco-therapy rate (MI & CHF)  
   e. Adequate control (< 140/90) (HEDIS)  
   f. BP control (< 140/80) (HEDIS)

3. Depression Management Program
   a. Inpatient admission rate/1000 members  
   b. Rate of ambulatory follow-up after inpatient admission for mental health  
   c. HEDIS behavioral health pharmacology measures
4. Diabetes Management Program
   a. Emergency room visit rate/1000 members
   b. Inpatient admission rate/1000 members
   c. Diabetic retinal exam rate (HEDIS)
   d. Comprehensive diabetes care (HEDIS)

5. Chronic Obstructive Pulmonary Disease Management Program
   a. Emergency room visit rate/1000 members
   b. Inpatient admission rate/1000 members (by complications)
   c. Pharmacotherapy for management of COPD exacerbation (HEDIS)
   d. Spirometry rate for assessment and diagnosis of COPD (HEDIS)

6. High-Risk Maternity Management Program
   a. Prenatal case management engagement rate
   b. Prenatal care in the first trimester of pregnancy (HEDIS)
   c. Check-up after delivery (HEDIS)
   d. Low and very-low birth weight deliveries
   e. Neonatal ICU days per 1000 live births
   f. Percentage of C-Section deliveries of all live births
   g. Rate of elective deliveries prior to 39 weeks; count by provider and maternal/newborn complications

7. Measures identified for Chronic Kidney Disease and End Stage Renal Disease:
   Chronic Kidney Disease:
   a. Percentage of members with Diabetes and/or HTN with creatinine/GFR
   b. Percentage of Nephrology referrals when GFR is below 60
   c. Percentage of members on Nephrotoxic Drugs
   d. Percentage of members with iron/ferritin test prior to Epogen initiation
   e. Percentage of members on ACE/ARBS

8. End Stage Renal Disease:
   a. Percentage of Hemodialysis vs. Peritoneal Dialysis
   b. Percentage of members with 1st Dialysis Treatment as Outpatient
   c. Percentage of members with AV Fistula vs. Catheter Percentage of members on Nephrotoxic Drugs

C. Preventive Health Care

Goal: To systematically monitor, evaluate and increase access to preventive health care. Provision of primary preventive health care to promote wellness and optimal quality of life can result in reduction of the incidence of illness, disease and accidents and can provide secondary prevention to promote the early detection of potentially serious illnesses which may reduce the impact of the illness on members.

Objectives:
   Develop, distribute and maintain preventive health guidelines that:
   1. are age, gender, and risk-status specific
   2. describe the prevention or early detection interventions and the recommended frequency and conditions under which the interventions are required
3. document the source or authority upon which it is based
4. include the involvement of participating physicians
5. review or update annually.

Independent Health has guidelines for the following:
1. Adult Immunization
2. Pediatric/Adolescent Immunization
3. Primary and Preventive Care for Infancy/Early Childhood/Adolescents
4. Adult Primary and Preventive Care
5. Routine Prenatal Care
6. Smoking Cessation

Independent Health communicates the preventive health and disease specific guidelines to participating physicians at the time of initial participation and at the time of any guideline updates, via the web site at www.independenthealth.com. Physicians and providers are informed annually in the physician and provider newsletter (SCOPE) of the opportunity to obtain a hard copy of the guidelines upon request.

Independent Health communicates the preventive health guidelines, at a minimum, annually to its members in the HealthStyles newsletter. At this time members are also advised that they can view the preventive health guideline and any subsequent updates on line @ www.independenthealth.com. The communication also encourages members to obtain these services. As identified by Independent Health, specific segments of the population will be targeted.

Performance measurements:
At a minimum, Independent Health will annually assess via, the HEDIS, PIP, QIP and QARR reports and additional plan defined measures, whether preventive health care is provided appropriately to the membership. The assessment will use a population-based methodology (i.e., HEDIS, PIP, QIP, QARR). Based upon this assessment, Independent Health will take action to improve preventive health care as indicated. The following are the major measures:

- Adult Immunizations – HEDIS (CAHPS survey)
- Child/Adolescent Immunizations – HEDIS
- Colorectal Cancer Screening rate - HEDIS
- Breast Cancer Screening rate – HEDIS
- Cervical Cancer Screening rate – HEDIS
- Member smoking cessation data - HEDIS (CAHPS survey)
- Member Access to Health Care Provider for adults and children – HEDIS

The following initiatives will adhere to the QM process described in Section VII C:
1. Maternity/Prenatal Management Programs
2. Child/Adolescent Immunizations Programs
3. Child/Adolescent Screening/Testing: Lead, Pharyngitis and Chlamydia
4. Cancer Screening Programs: Breast and Cervical and Colorectal
5. Adult Immunizations Program
6. Member Access to a Health Plan Practitioner Program
7. Smoking Cessation Program
8. Worksite Health Promotion Program
9. Member Safety

D. Member Safety

Independent Health has an organization-wide approach to promote member safety. Member safety is improved by creating and maintaining processes and structures that foster a supportive environment to help physicians and providers improve the safety of their practice and to help members understand their responsibility related to safety. The scope of activities includes:

1. Independent Health, in collaboration with the hospitals, designed incentive programs around improving quality. Network hospitals have reportable performance measures that support member safety as defined in Independent Health contracts.
2. Pharmacy specific initiatives to promote appropriate pharmaceutical use and to decrease medication errors and adverse events using concurrent and retrospective drug utilization review procedures and processes.
3. Health information and education for members and physicians and providers related to safety including communicating performance data to members and physicians and providers.
4. Surveillance for patient safety issues identified through credentialing/recredentialing and concern/complaint processes/TAAC.
5. Surveillance for safety in Skilled Nursing Facilities and Sub-Acute Units through monitoring of DOH surveys and notification of Denial of Payment for New Admissions (DOPNA) from CMS.
6. Radiation Awareness Program
7. Fall Prevention

E. Clinical Practice Guidelines

Goal: To improve the quality of care to all Independent Health members by:

- Improving the clinical performance of physicians and providers by decreasing the variation of care among physicians and providers.
- Increasing awareness of member responsibilities by providing member clinical practice guidelines.

Objective:

Independent Health uses preventive clinical practice guidelines and disease specific guidelines to help physicians and providers and members make decisions about appropriate health care for specific clinical circumstances.

Process:

Independent Health has made the following clinical practice guidelines available to physicians and providers:
**Preventive Health Guidelines:**
1. Adult Immunization
2. Recommended Immunization Schedule for Children aged 0-6 years
3. Recommended Immunization Schedule for Children ages 7-18 years
4. Catch up Immunization Schedule for Children aged 4 months-18 years
5. Recommendations for Preventive Pediatric Health Care
6. Routine Prenatal Care
7. Adult Preventive Health Guidelines
8. Primary Prevention of Cardiovascular Disease (CVD)
9. Smoking Cessation Guideline

**Disease Specific Guidelines:**
1. Asthma Guideline
2. Heart Failure Guideline
3. Management of Depression in Primary Care
4. Guidelines for Adult Diabetes Care
5. American Academy of Pediatrics Attention Deficit Hyperactivity Disorder
6. Secondary Prevention for Patients with Coronary and Other Vascular Disease
7. Global Strategy for the Diagnosis, Management and Prevention of COPD
8. HIV/AIDS Guideline (external website)
9. Chronic Kidney Disease Reference Guidelines

Independent Health has made the following clinical practice guidelines available to members:

**Member Wellness Guidelines**
1. Managing Your Asthma
2. Understanding Depression, Depression and Chronic Disease, Depression in Older Adults
3. Managing Your Diabetes, Controlling your Diabetes, Diabetes and Kidney Disease, Diabetes Food Pyramid
4. Heart Failure Guidelines
5. Living with Cardiovascular Disease
6. Prevention of Cardiovascular Disease
7. Kicking the Smoking Habit
8. Prenatal Care Guidelines
9. Preventive Care Guidelines

Clinical Practice review procedure:
1. The clinical practice guidelines will be reviewed biennially, or more frequently, and updated as needed.
2. New guidelines will be developed, as indicated, by the Office of the Medical Director at Independent Health and based on the population analysis. Clinical practice guidelines are developed from best practice standards and evidence-based medicine from recognized sources.

3. Guidelines will be made available to the appropriate physicians and providers who are new to Independent Health and to all appropriate physicians and providers when a guideline is new/revised or updated.

4. Guidelines for members are made available with routine informational and health education mailings and are available on the Independent Health website.

5. Development will be according to the quality management process as described in Section VII C.

Performance Measurement:
Annually, four clinical practice guidelines (including two for behavioral health) are reviewed against HEDIS data or other internal measures to determine physician compliance with practice guidelines.

F. Availability

Goal: To systematically monitor, evaluate, improve and ensure availability of primary care physicians, specialty care physicians, and behavioral health specialists to members in all geographic areas of the plan to ensure there are sufficient numbers and types of physicians and providers to meet the cultural, linguistic and physical needs of the members.

Objectives:
Independent Health defines which physicians can function as primary care physicians and providers (family practice, general practice, internal medicine, pediatricians and other designated primary care physicians). Independent Health establishes and monitors standards for the number and geographic distribution of primary care and specialty care physicians and providers.

Performance Measurement for Availability:
1. Number and geographic distribution of primary care and specialty care physicians and providers
2. Patients per primary care physician, specialty care physician, and behavioral health specialist
3. Primary care physician member capacity
4. Patient/member satisfaction surveys
5. Member complaints

Availability standards will be developed and monitored annually according to the quality management process as described in Section VII C.
G. Access

Goal: To systematically monitor, evaluate, improve and ensure accessibility of primary care and behavioral health care services, urgent services, and member services.

Objectives: Independent Health establishes and monitors standards for:
1. Emergency Care: member should have care rendered immediately by physician or provider, or be given a referral to the emergency room, if appropriate. A member with non-life-threatening behavioral health emergency needs should be seen within 6 hours.
2. Urgent medical or behavioral problems: an appointment should be scheduled within 24 hours of a member’s call based on symptoms and physician judgment.
3. Non-urgent sick visits (if clinically indicated): an appointment should be scheduled within 48 to 72 hours of a member call, based on symptoms and physician judgment.
4. Routine, non-urgent or preventive care visits: an appointment should be scheduled within four (4) weeks of a member call.
5. Adult baseline and routine physicals: an appointment should be scheduled within twelve (12) weeks of a member call.
6. Initial prenatal visits: the initial appointment should be scheduled within three (3) weeks of diagnosis or notification of the pregnancy, if the member is in the first trimester of pregnancy. If the member is in the second trimester of pregnancy, an initial appointment should be made within two (2) weeks of diagnosis or notification of the pregnancy. If the member is in the third trimester of pregnancy, an initial appointment should be made within one (1) week of diagnosis or notification of the pregnancy.
7. Initial visit for newborns to their primary care physicians: an appointment should be scheduled within two (2) weeks of hospital discharge or medical record should reflect rationale for later visit.
8. Well child care: an appointment should be scheduled within four (4) weeks of a member call.
9. Initial family planning visits: an appointment should be scheduled within two (2) weeks of a member call.
10. In-plan, non-urgent mental health or substance abuse: an appointment should be scheduled within two (2) weeks of a member call.
11. In-plan, mental health or substance abuse follow-up visits (pursuant to an emergency or hospital discharge): an appointment should be scheduled within five (5) days of discharge, or as clinically indicated.
12. Specialist referrals (non-urgent): an appointment should be scheduled within four (4) to six (6) weeks of the member or primary care physician request.
13. Physician accessibility: physicians should employ 24-hour per day coverage for telephone calls with office staff, an answering service or a taped message with appropriate instructions or triage. Once physician or provider has been notified of member’s call, a return call should be made within 20 minutes or sooner depending on member’s need.

Performance tools and measures used to determine interventions:
1. On-site physician reviews
2. Patient/member satisfaction surveys
3. Member complaints/primary care physician transfer reasons
4. Member services telephone response rates

Access standards will be developed and monitored annually according to the quality management process as described in Section VII C.

H. Continuity and Coordination of Care

Goal: To ensure that all members receive seamless, continuous, and appropriate care and services along the healthcare continuum to includes behavioral health care in conjunction with medical care provided by primary care physician and safe transitions across healthcare settings to include discharges from hospital acute/post-acute levels of care.

Objectives:
- To establish and monitor standards related to continuity and coordination of care for members with general medical conditions and those with behavioral health and general medical conditions across practice sites
- To ensure there is continuity and coordination of general medical care with behavioral health care
- To monitor continuity and coordination of care, analyze the data, identify opportunities for improvement, and take action toward improvement, if indicated
- Facilitate discharge planning that assesses the member’s healthcare needs after an inpatient stay and ensures that the necessary services and resources are in place to support an appropriate transition to the next level of care

Performance measures to assess continuity and coordination of care include:
1. Medical Care
   - Specialist rate of compliance with communication to the primary care physician.
   - Documentation of follow-up from specialist in primary care physician’s office medical records
   - Discharge summary documentation from hospital in primary care physician’s office medical records
   - Communication issues regarding continuity and coordination of care reflected in complaints and concerns
   - Care coordination issues identified on medical record review during credentialing and recredentialing
2. Behavioral Health Care
   - Behavioral Health Specialist rate of compliance with communication to the primary care physician
• Prevalence of members identified with depression and PCP referrals to outpatient mental health treatment
• Antidepressant Medication Management: Effective Acute and Effective Continuation Phases of Treatment (HEDIS)
• Health risk assessments and risk profiles showing co-existing medical and behavioral health conditions and care opportunities
• Follow-up Care for Children with ADHD, Initiation and Continuation Phases of Treatment (HEDIS)

3. Discharge Planning/Transitions of Care
• Hospital readmissions rates by facility, LOB, Care Transitions program participation
• Care Transition Program performance measures
  o Engagement rate
  o Rates for timely PCP follow up visit within 7 days of discharge
  o Rate of completed medication reconciliation within 48-72 hrs. of discharge
  o Rates for timely completion of home visit to include completion of the risk assessment and member self-management tool

I. Complaints and Appeals

Goal: To systematically monitor, evaluate and track member and provider complaints/appeals; ensure written policies and procedures for their timely resolution; and, identify areas that may be indicative of a system-wide problem that needs to be addressed.

Objectives:
Independent Health has established written policies and procedures for registering and responding to both oral and written complaints and appeals. These include, but are not limited to:
1. Documentation of the substance of the complaint/appeal and the action taken
2. Investigation of the complaint/appeal including any clinical care issues
3. Resolution of the appeal including:
4. At a minimum, one level of review by someone not involved in the original decision process
5. The right to participate by telephone before the panel
6. Standards for timeliness of response

Independent Health will maintain a system to track complaints/appeals to resolution. Performance measurement includes aggregating complaints and appeals for and reporting to CQC:
1. Provider specific categories
2. Member specific categories
3. Complaint type (e.g., utilization management, claims, quality of care, service)

Independent Health provides members with written information about how to voice a complaint and how to appeal a decision that adversely affects the member's coverage, benefits or relationship with Independent Health. [There are policies and procedures for each complaint and appeal process:
1. Member complaints and appeals
2. Provider complaints and appeals
3. Member/provider complaints regarding quality of care
4. Urgent complaint and appeal case reviews
5. Member complaints/inquiries immediately resolved by member services.
6. Member and Provider Appeals Committees (SC3)

Service Projects:
Independent Health’s Senior Leadership Team will identify and oversee the service projects for 2014. Any quality issues identified by the Operations Council will be brought to the Clinical Quality Committee for discussion and/or action.

J. Member/Provider Satisfaction

Goal: To "be the plan in demand"

Objectives:
To identify trends of member/provider satisfaction and institute appropriate improvement strategies. Independent Health assesses member/provider satisfaction through:
1. Member/provider/office staff satisfaction surveys
2. The evaluation of patient complaints and appeals
3. The evaluation of requests for primary care physician and/or site changes (primary care physician changes)
4. Member satisfaction surveys (patient, CAHPS surveys)
5. As a result of the above data collection and assessment, a quality improvement team will be formulated to address areas of dissatisfaction. This may be clinical/non-clinical in nature.

K. Credentialing/Recredentialing

Goal: Independent Health maintains and implements a credentialing and a triennial recredentialing process to select and evaluate physicians and providers who are within the scope of the process.

L. Care Coordination
Goal: The overall goal of the Care Coordination program is to ensure the provision of appropriate, effective and optimal medical and behavioral health care to Independent Health members in all practice settings. The program's intent is to promote efficient use of resources by monitoring and ensuring appropriate use of services. The underlying principle of the Care Coordination monitoring process is to ensure that members receive appropriate clinical services consistent with their individual needs and conditions, at the right time and in the right setting.

M. Risk Management

Goal: Systematically monitor and evaluate sources of potential risk to prevent future occurrences.

Objectives:
Ensure delivery network is comprised of qualified physicians and providers through a systematic credentialing process taking place every three (3) years, which includes the evaluation of credentials, member complaints and satisfaction, quality on-site and medical record review results, past/current liability cases and a minimum malpractice coverage, identify and evaluate any potential quality of care issues. Incidents are investigated and reviewed by the Peer Review Committee as appropriate. Outcomes of the investigation may result in action and, at times, termination from the plan.

Investigate and make recommendations for the appropriate utilization of new clinical technologies through the Technology Assessment and Approval Committee (TAAC). This committee, comprised of various specialists, reviews the latest, high-priority technologies to identify best practices. Policies are then developed to outline appropriate use.

Improve the health of the membership through systematic population-based analysis of disease prevalence, development of best practice guidelines, provision of educational interventions to members and physicians and providers and monitoring of clinical outcomes.

Ensure that all in-patient facility admissions are medically necessary and appropriate through concurrent and retrospective review/audit using approved clinical criteria.

Ensure care delivery in the physician/specialist's office setting is in compliance with policy and that billing is appropriate through systematic auditing of physician/specialist office records.

N. Special Investigations Unit
The Quality Management Program supports the organization’s fraud prevention policy by reporting any potentially illegal or fraudulent practices that may be identified in quality management review activities.

The Quality Management Program will facilitate best practices and standards of quality care among internal and external customers through the monitoring of quality issues, utilization, billing practices, medical necessity of services, and credentialing/recredentialing processes.

VIII. Delegated Functions

**National Imaging Associates** - full delegation. National Imaging Associates provides utilization review and management services for outpatient advanced radiology imaging (CT, PET, MRI/MRA) provided by hospitals, radiologists and other imaging physicians and providers. Services provided by National Imaging Associates include pre-service medical necessity determination (authorization or denial), post-service medical necessity determination (authorization or denial), and written notice to physicians or providers and covered individuals regarding authorization or adverse determination.

**Family Choice** – Family Choice of New York, a partner with Independent Health, provides a specialized program for Independent Health Medicare Advantage members who reside in skilled nursing facilities in Erie Niagara, Wyoming and Orleans Counties. The program provides medical management to these members through frequent assessment, preventive care and early interventions, when medical issues arise, to minimize unnecessary ER visits, hospitals stays and maintain the highest quality of life for these members. The program is designed to achieve positive clinical and utilization outcomes in a cost effective manner. Family Choice of New York is delegated for all Utilization Management functions, which include pre-service medical necessity determination (authorization or denial), post-service medical necessity determination (authorization or denial), and written notice to physician or providers and covered individuals regarding authorization or adverse determination.

**Optum Health Care** - **Optum** is the vendor utilized for the 24-hour medical help line. They provide the service and supply Independent Health with monthly and annual usage reports as well as performance reports.

**Healthplex** –is the delegated entity we have contracted with to provide utilization management, appeals management and credentialing for the MediSource Child Health Plus and Family Health Plus Dental benefit.

**EyeMed Vision Care** – is the delegated entity we have contracted with to administer the routine vision benefit. EyeMed provides credentialing for all Independent Health plans that offer routine vision and they supply utilization and performance reports on an annual and/or quarterly basis.

**Beacon Health Strategies** – Beacon Health Strategies is the delegated entity co-located with the Independent Health Medical Management team and contracted to provide, Behavioral/Mental Health Management for Medicaid Managed Care (MediSource, Child
Health Plus and Family Health Plus) members. Services provided by Beacon Health Strategies include utilization management of inpatient, outpatient, and diversionary services, quality management including HEDIS/QARR and other regulatory reporting, and integrated case/care management. Beacon Health Strategies is also responsible for developing alternative community programs and identifying special populations.

XI. EVALUATION OF EFFECTIVENESS OF PROGRAM

The Independent Health QM Program may be amended, as needed, to ensure that it continues to meet the quality improvement needs of Independent Health. At a minimum, the program description will be reviewed, evaluated and revised annually. The annual report of QM initiatives will include:

a. A description of completed and ongoing QM initiatives;
b. Trending of key measures to assess performance in quality of clinical care and quality of service;
c. An analysis of whether there have been demonstrated improvements in the quality of clinical care and quality of service to members; and
d. An evaluation of the overall effectiveness of the QM Program. This evaluation should assess whether the QM Program and the associated initiatives have contributed to meaningful improvement in the quality of clinical care and quality of service provided to members.

All key departments will be called upon to assist in the identification of strengths and limitations of the program. The results of the evaluation are utilized for the development of the following year’s program. Quality indicators and other performance data will be evaluated to identify strengths and limitations/barriers and to assess effective changes in the QM Program.

X. CONFIDENTIALITY

All reports, committee minutes, audits, studies and documentation of QM activities are privileged and confidential, and as such, will receive every affordable consideration of non-disclosure.

Review of minutes by third parties is restricted to reviews conducted by state and federal auditors, or other parties authorized by law, and accreditation survey teams.

All committees/teams acknowledge its responsibility to protect the confidentiality of the information and data it develops and receives from other sources.

XI. DATES OF ALL REVISIONS TO QUALITY MANAGEMENT PROGRAM
The Quality Management Program Description builds upon the quality assurance plan originally approved by the Independent Health Board of Directors in January, 1989.

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XII. GOVERNING BODY REVIEW AND APPROVAL

The Quality Management Program is to be reviewed and approved annually by the Clinical Quality Committee, the Health Care Quality Committee, and the Independent Health Board of Directors.