



**2018  
Quality Management  
Program Description**

## Table of Contents

Independent Health Overview .....	3
Quality Management Goal Statement .....	3
Quality Management Guiding Principles.....	4
Quality Management Objectives.....	5
Quality Management Program Framework.....	6
Regulatory and Accreditation Framework.....	6
Quality Assurance and Performance Improvement Framework.....	6
Annual Plan-Do-Study-Act Cycle .....	7
Framework Documentation.....	8
Quality Management Scope .....	9
I. Patient Safety.....	9
II. Member Satisfaction.....	9
III. Provider Participation and Satisfaction.....	11
IV. Population Health .....	11
V. Quality Measurement.....	15
Quality Management Program Resources.....	24
Quality Management Program Metrics.....	<b>Error! Bookmark not defined.</b>
Review and Revision of the Quality Management Program.....	<b>Error! Bookmark not defined.</b>

### Independent Health Overview

Independent Health is a community based health plan committed to our mission of providing health-related products and services that enable affordable access to quality healthcare. Our vision is to be the recognized leader in customer engagement and deliver solutions that improve the health of the population we serve. Independent Health serves the eight counties of Western New York (Allegheny, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming) as an Individual Practice Association (IPA) model health plan, providing coverage of benefits via traditional commercial and marketplace exchange products, as well as Medicare Advantage, Managed Medicaid, Child Health Plus and Essential Plan.



#### **Core Values**

***Passionate*** – We love what we do

***Caring*** – We support the well-being of others

***Respectful*** – We are considerate and value individual differences

***Trustworthy*** – We instill confidence through our character and competence

***Collaborative*** – We work together to create solutions

***Accountable*** – We deliver what we promise

Independent Health has a vested interest in the health and well-being of our community, as our members and our employees live, play, and raise families here. Independent Health pursues the Quadruple Aim of better patient care, better health, improved affordability and improved provider satisfaction by continuously improving the safety, effectiveness and experience of care our members receive for preventive services and treatment of acute and chronic conditions in a manner that supports the vitality of our primary care physician partners.

### Quality Management Goal Statement

Independent Health's Quality Management (QM) Program exists to proactively provide the required structure and process necessary to define, measure, analyze, and improve the quality and safety of clinical care and services that our members receive in the care delivery system, in pursuit of the Quadruple Aim. Independent Health's QM program realizes success through the active oversight and multidirectional input from its Board of Directors, Executive Team, Quality Committees, associates, and physician advisory panels. The QM program is committed to continuous quality improvement and is evaluated annually for its overall effectiveness in meeting its objectives. Based on the evaluation findings, the QM program is modified to ensure problems are addressed and opportunities are acted upon to improve the safety and quality of care our members receive.

### Quality Management Guiding Principles

Independent Health's Quality Management program is guided by a common set of principles to frame our approach towards achieving our objectives and mission:

- Trust and Integrity – Independent Health has nothing of greater value than the trust of its members. We strive to be an organization characterized by trust and integrity, by listening carefully, treating everyone with respect, and remaining steadfast in preserving ethical conduct in our business practices and among our associates.
- Quality First – To continuously improve the quality of health care in our community and for our members is Independent Health's highest priority, while maintaining itself as a perennial high performing health plan.
- Member Focus – Promoting the health of our members is paramount. The needs of our population will drive the design of our benefits and services, and therefore improve the quality of our offerings. Our success in meeting our members' needs can be measured through their positive experiences.
- Physician Partnership – We develop and implement programs to closely partner with our community physicians to benefit the care our members receive. 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 and community organizations to ensure 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 critical to our customers' wellbeing and the whole community. We help members make smart decisions regarding their health behaviors. We are committed to educating, encouraging and supporting programs that improve health at work and throughout Western New York.
- Operational Excellence – It is Independent Health's responsibility to provide efficient and effective services to members. Through process improvement and the use of technology, we embrace best practices in the benefits, services and most importantly care provided.

Decision making in accordance with these guiding principles ensures that the program is aligned with its objective and Independent Health's mission.

### Quality Management Objectives

To achieve the overarching goal of the Quadruple Aim, while abiding by our guiding principles, the main objectives of Independent Health's Quality Management Program are to improve the health and health outcomes of our member population by facilitating the delivery of high quality, safe care along the care continuum, while remaining cognizant of the diverse medical, behavioral, and social needs of special populations. We can measure our success against these objectives in our ability to maintain our high performing status within national quality ratings, our ability to maintain excellence in the administration and oversight of health plan activities and consumer protections for our members, and our ability to maximize satisfaction among our provider partners so that they may continue to deliver high quality and safe care. The specific objectives are as follows:

- To minimally retain an NCQA Health Plan Rating  $\geq 4$ ,
- To minimally retain an NCQA Health Plan Accreditation Rating of Excellent, and
- To minimally achieve a provider satisfaction rating of  $\geq 85.0\%$ , as measured by our provider Voice of the Customer Survey.

The achievement of these objectives will reflect how well Independent Health is able to optimize our members' health outcomes, health-related quality of life and experience with the healthcare delivery system. Achievement of an NCQA Health Plan Rating  $\geq 4$  is indicative of a high performing health plan based on normative national benchmarks, while achievement of an NCQA Health Plan Accreditation Rating of Excellent is indicative that health plan programs for service and clinical quality meet or exceed rigorous requirements of consumer protection and quality improvement. Achievement of a provider satisfaction rating of  $\geq 85\%$  is indicative that providers are receiving the services, tools, information, and payment structures that they need to provide safe, high quality care to our members.

Independent Health's pursuit of these three objectives is guided by the Institute of Medicine's (IOM) *Six Aims for Improvement* within the healthcare system. These specific aims are to ensure care that is:

- **Safe:** avoiding injuries to patients from the care that is intended to help them;
- **Timely:** reducing waits and sometimes harmful delays for both those who receive and those who give care;
- **Effective:** providing services based on scientific knowledge and evidence based interventions to all who could benefit, and refraining from providing services to those not likely to benefit;
- **Efficient:** avoiding waste, including waste of equipment, supplies, ideas, energy and time;
- **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status; and
- **Patient-centered:** providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

### Quality Management Program Framework

#### Regulatory and Accreditation Framework

Independent Health's Quality Management Program is designed to exceed state and federal regulatory requirements, as well as any applicable accreditation requirements:

- New York State Department of Health/Department of Financial Services (NYS/DOH/DOFS); measured primarily through Quality Assurance Reporting Requirement (QARR) results and Medicaid Managed Care Quality Incentive awards;
- Centers for Medicare and Medicaid Services (CMS), measured primarily through Star ratings;
- National Committee for Quality Assurance (NCQA), primarily measured through Health Plan Accreditation (HPA), Healthcare Effectiveness Data and Information Set (HEDIS) benchmarks and Health Plan Ratings (including Health Plan Consumer Assessment of Healthcare Providers and Systems [CAHPS 5.0H]).

The framework is additionally guided by the following reference sources:

- National Quality Strategy
- Institute of Healthcare Improvement Triple Aim
- CMS Quality Plan
- NYS Quality Plan, inclusive of the Delivery System Reform Incentive Payment (DSRIP) Program
- NYS Prevention Plan

#### Quality Assurance and Performance Improvement Framework

Independent Health applies a Quality Assurance (QA) and Performance Improvement (PI) framework to ensure a systematic and data-driven approach towards maintaining and improving the safety and quality of care our members receive. These two mutually-reinforcing components of our quality management system are commonly referred to as QAPI:

- QA is the identification and specification of standards for quality of service and outcomes, with a process to assure that care and service is maintained at acceptable levels in relation to those standards. QA is an on-going effort to identify how and why the organization is performing as it is, and includes root cause analysis and the identification of special and common cause variance. The quality assurance pathway strives to ensure that all gains are maintained against established benchmarks and best practices, and monitors that the operational processes and handoffs applicable to member functions are in adherence with regulatory requirements. Regular monitoring and oversight occurs against the established controls of Article 43/44/49 and Medicaid managed care contract. This strong operational platform maintains ongoing compliance with established and newly announced regulatory laws, mandates, and best practice recommendations. Policies are maintained and reviewed annually, processes are built with input from all applicable stakeholders, and comprehensive procedures are implemented, against which internal monitoring efforts and mock audits occur.

- PI is the continuous study and improvement of processes with the intent to improve services or outcomes by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent or systemic problems or barriers. Performance improvement activities are developed and launched in response to identified population needs, community collaborative efforts, or as pilots of innovation in response changing trends. All initiatives are developed in response to opportunities identified through comprehensive data analysis, are constructed based on evidence-based research, and vetted by the appropriate committees to assure that efforts are integrated, well-designed, measureable, and closely monitored through project management timelines and milestones.

The comprehensive implementation of the QAPI framework across the organization allows for an ongoing, organized method of monitoring and achieving desired results in improving quality and safety. Efforts may target clinical, pharmacy, experience or operational improvement in support of care delivery. Data analytics is a critical component of the QAPI focus.

### **Annual Plan-Do-Study-Act Cycle**

The framework progresses through the following annual PDSA cycle:

- Quarter One: The first quarter of each calendar year includes concurrent work streams; preparation for annual HEDIS/QARR hybrid record collection commences. Final measurements from quarter four of prior year are collected; analyses and evaluation of outcomes set in past year work plan is completed. The final report and evaluation is provided to the appropriate committees; any recommendations and/or edits to the current work plan are incorporated and approved. The final approved work plan for current year is implemented by close of the quarter.
- Quarter Two: Review of first quarter measurements occurs, with iterative improvement efforts based off of current performance. Quarter two is predominantly focused on and dedicated to HEDIS/QARR hybrid record collection activities and continued work plan initiatives.
- Quarter Three: The third quarter of each calendar year commences to include mid-year review and discussion of work plan initiatives during annual planning sessions. This allows for iterative focus on processes to evaluate performance toward strategic goals. Adjustments are made as necessary based on the prior year work plan evaluation and trending of current year outcomes to determine recommendations for the upcoming year work plan. Once these recommendations are in hand, the oncoming year work plan is drafted and circulated in preparation for the annual quality planning process. Annual quality planning is an event in which senior leaders of the plan review the work plan to review and identify appropriate responsibility and accountability for key goals. Measures are discussed, defined, and documented in preparation for implementation.
- Quarter Four: Fourth quarter is similar to the first in that there are two concurrent work streams. Preparation for HEDIS/QARR review occurs to ensure adherence to technical specifications; analyses and evaluation of current year work plan outcomes continues while process and reporting are refined for upcoming year work plan activities. The final draft of the annual work plan is provided to the appropriate committees for review and approval at the end of the quarter. Once

approved, implementation of the work plan commences quarter one of the new calendar year. CAHPS results are received; NCQA Health Plan Quality Ratings are publicly released.

### Framework Documentation

Independent Health's Quality Management Program framework is documented by the following three components:

- **Quality Program Description:** A summary of the Quality Management Program's structure, components, goals and objectives.
  
- **Quality Work Plan:** an outline of key specific initiatives, tasks, lead associates, expected time frames, and status. The work plan identifies tasks as either QA or PI. QA work plan indicators capture all embedded, permanent functional elements of the Quality Program that have consistently met the defined benchmark or threshold for a minimum of four quarters. Activity that is iterative with no identified end date is captured on this work plan and will remain there unless a statistically significant change in score is realized, at which time targeted improvement actions are assigned to the Performance Improvement work plan. These indicators are edited and brought forth through appropriate committee structure only upon significant revision. PI work plan tasks are inclusive of targeted strategic initiatives that are in specific response to trends, community collaborative efforts, or newly released mandates or provisions. PI work plan indicators will be monitored and reported on a quarterly basis through the appropriate committee structure. In addition, unique project documents may be included for review and approval based on RACI assignments. RACI stands for 'Responsible, Accountable, Consulted, and Informed' and is the matrix approved for quality program activities to assure seamless activity. Annual evaluation of the Quality Program work plan is performed with recommendations made to keep activity as PI or move to QA status.
  
- **Quality Program Evaluation:** an assessment, summary and analysis of the previous year's activities. This enables the organization to evaluate the overall effectiveness of the Quality Program and our progress toward stated goals. 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.



### Quality Management Scope

The scope of the Quality Management Program includes aligning plan activities with the intent and focus of Quadruple Aim priorities. The following sections describe the scope of focus for Quality Management Program activities.

#### **I. Patient Safety**

While Independent Health does not directly provide care to its members, it does have a responsibility to identify, report and document potential quality concerns that impact the clinical safety of the patient. Independent Health reviews complaints regarding clinical quality to ensure that the care delivered is in accordance with professionally recognized standards of medical practice. Independent Health takes action on quality of care concerns to reduce risk to its members through its clinical quality review process. A corrective action and/or intervention is implemented as necessary given the outcome of the investigation, as recommended by the Peer Review and Credentialing/Recredentialing committees. Quality of care member complaints are tracked and trended and presented to the Quality Performance Committee at least annually.

#### **II. Member Satisfaction**

##### ***A. Member Experience***

Satisfaction and experience are distinct and separate concepts. Satisfaction is indicative of a moment in time, whereas experience is representative of the whole of those moments, and is impacted by both direct and indirect input. Independent Health is consistently one of the highest ranked plans in the country for consumer experience for its Commercial and Medicare lines of business.

The following areas of member experience are included in the scope of the Quality Management program:

- Member access and availability to network primary care, specialty care, and urgent emergent care for both medical and behavioral health needs;
- Member access to pharmacy services;
- Appropriate member access to and understanding of plan materials and services, both in print and via website; and
- Member complaints, grievance and appeal activity, including complaints and appeals for quality of service, access, attitude and service, billing and financial issues, and the quality of the practitioner office site.

Independent Health monitors member experience and satisfaction by conducting and/or monitoring the results from the following member surveys:

- CAHPS – Consumer Assessment of Healthcare Providers and Systems (CAHPS) is conducted annually in the spring of each year for Independent Health’s Commercial line of business and separately for our Marketplace Qualified Health Plan. Medicare, QHP and EP CAHPS are

conducted through Independent Health's vendor (DSS), and data is submitted to CMS. NYS conducts a CAHPS survey on behalf of our Medicaid population.

- ECHO – Experience of Care and Health Outcomes survey will be conducted in the second half of 2018 for members who have received a mental health service in the past 12-months.
- HOS – Health Outcomes Survey is administered to Medicare members through CMS. The HOS survey is longitudinal, and thus compares a member's state of health at two different time points, two years apart. Medicare HOS is conducted through Independent Health's vendor (DSS), and data is submitted to CMS.
- Case Management – The Case Management Survey is designed to measure the member's satisfaction and experience with the Case Management program, and also determines member loyalty through the insertion of select Voice of the Customer questions
- Voice of the Customer – Independent Health's proprietary survey is administered monthly to a sample of members who have had an interaction with Independent Health, either by calling the Service Center, visiting Independent Health's website, or meeting face-to-face with an Independent Health servicing representative.
- Member Stakeholder – annual survey of all consumers in WNY, including IH members and competitive plan members. Survey is used as a satisfaction benchmarking tool against the local competition as well as a market assessment of WNY consumers wants/needs/opinions related to healthcare.
- PCMH CAHPS – Patient Centered Medical Home CAHPS survey is conducted annually in the summer. Survey measures the patient's experience of care among select physician groups.

### ***B. Member Servicing***

The Member Servicing team functions with an advocacy approach, and provides education and clarification regarding rights and responsibilities, benefits and cost-sharing and contractual questions.

Servicing also facilitates the following member centric functions:

- Assistance with language line/interpreter services as appropriate;
- Linkage to primary care upon request, including assistance due to convenience or culturally and linguistically appropriate (CALA) indicators;
- Direct referral for clinical intervention internally through Health Promotion and Wellness, Case Management, Disease Management, or Behavioral Health; and
- Process initial information regarding member complaints and quality of care concerns, and forwards these appropriately to Benefit Administration or Health Care Services.

### ***C. Benefit Administration***

The Benefit Administration (BA) team processes member complaints, contractual appeals (grievances), and utilization review appeals based on medical necessity adverse determinations. A full, independent investigation is performed by qualified personnel who were not involved in the initial adverse determination. BA works closely with Member Servicing and Utilization Management to address member issues expediently and thoroughly, and to collate information to assist in identification of provider specific improvement activities. The volume of complaints and appeals per 1,000, overall and by category, are monitored and brought before the Quality Performance Committee quarterly to determine if the volume is within performance standards. The categories of complaints and appeals monitored include Quality of Care, Access, Attitude/Service, Billing/Financial, and Quality of Practitioner Office Site. If the quarterly review indicates that performance standards are not being met or that a

certain category is trending upward, the Quality Performance Committee is responsible to commission a working group to understand the root causes and recommend an action plan to improve performance. Opportunities identified by the working group are brought back to the Quality Committee for further review, discussion and approval.

### **III. Provider Participation and Satisfaction**

#### ***A. Network Contract Management (NCM)***

Independent Health's NCM team is an active partner in the planning of quality incentives for participating hospitals and skilled nursing/subacute facilities. Topics of focus include value based design modules, patient safety initiatives, and palliative care referrals and consults. Feedback from other quality levers is incorporated into contract review and negotiation. The main functional work streams of NCM include:

- Hospital and provider networks
- Maintenance, entry and audit of the provider data system and fee schedules
- Maintenance of the provider directory including provider-spoken languages and handicap accessibility of the office.
- Quarterly submission of HPN reports to the DOH
- Monitoring, evaluating and ensuring access and availability of services, physicians and providers.

#### ***B. Provider Relations and Engagement (PRE)***

The PRE team acts as a liaison to provide effective answers, education and solutions for the primary care office, to assist them in understanding Independent Health's policies, guidelines and initiatives. The PRE team provides an 'outside in' lens for the plan, providing feedback from the 'voice' of primary care physicians. In addition, the PRE team serves as an effective barometer to gauge reaction and satisfaction with plan policy and new programs/initiatives that may impact or necessitate contracting changes. Overall provider satisfaction is measured via the Voice of the Customer Survey, Independent Health's proprietary survey that is administered monthly to a sample of members who have interacted with Independent Health, such as through the Service Center.

### **IV. Population Health**

Population Health begins with health promotion and wellness and spans through to the end of life. Independent Health strives to address its members' needs across the care continuum through initiatives that maintain and improve their physical, mental and social well-being through the identification of their health needs, beliefs and variances in health outcomes. To accomplish this, Independent Health performs an annual population analysis that assesses the characteristics and needs, including the social determinants of health, of our entire member population. This includes assessing the needs of relevant sub-populations, such as children and adolescents, members with physical or developmental disabilities, and members with serious and persistent mental illness.

Based on the annual assessment of our population needs, Independent Health develops and/or updates its population health management strategy, including programs and initiatives. While Independent

Health stratifies its entire population, focused programs and initiatives are developed around four pillars of focus:

1. Keeping members healthy;
2. Managing members with emerging risk;
3. Managing health outcomes, including care transitions and member safety, across setting; and
4. Managing multiple chronic conditions.

Population Health clinical programs developed around these four pillars contribute significantly in the overall Quality Management Program, as these activities in large part drive member experience and outcomes. Population Health clinical programs include the following initiatives and interventions:

### ***A. Health Promotion & Wellness (HPW)***

HPW seeks to provide education and resources for members regarding basic preventive care and services and a holistic approach to well-being. HPW provides preventative health tools and programs for members across the entire care continuum, seeking to maximize healthy living and disease prevention. Empowering members to achieve and maintain a state of physical and mental health balance is a plan wide focus and seeks to:

- Educate members on benefits, assistance, and resources available;
- Communicate available programs to members, such as self-help tools to assess health risk and resources to reduce modifiable risk factors to improve health;
- Develop and implement processes to educate and empower members to make informed decisions based on safety, quality, and cost of care in a collaborative manner with providers;
- Improve member identification and subsequent triage to programs by implementing appropriate intervention based on members' current position along the care continuum; and
- Improve integration of existing programs and provide tools and incentives to support active member participation.

### ***B. Utilization Management (UM)***

UM functions are inclusive of inpatient and outpatient medical management with prospective, concurrent, and retrospective review types applied per applicable product regulations. UM determines that the right care is delivered in the right setting at the right time for the member. Select procedures are placed on prior authorization review based on patient safety and applicable trends. UM works closely with Care Management functions to assure full continuity and coordination of care across all settings and levels of care. In addition, in an effort to reduce hospital readmissions, the Independent Health medical record system contains user-triggered and auto-triggered tasking features, which allows associates manually generate tasks to the case management team queue (home page) for referral at any point in the UM process. In addition, there are automated tasking rules that have been developed to initiate a referral to case management when specific criteria are met. The UM Program Description contains full information regarding the scope and breadth of this effort.

### ***C. Case Management (CM)***

Care Management services include oversight by the Medical Director, Population Health and the Director, Case and Disease Management. These services offer identification, assessment and intervention for critically complex and episodic needs and diagnoses. CM also addresses chronic condition management for members identified with high severity of disease burden. CM is also inclusive of care transition activities. Members transitioning to alternate level of care or site of service are identified and interdisciplinary, inter-departmental coordination occurs. Review and shared planning occur between the plan and applicable external providers.

A key function of case management is to help reduce hospital readmissions, and as such, proactive monitoring of high volume facility inpatient reports are used to identify care management opportunities for outreach when patients are preparing to be discharged. UM clinicians are trained to generate tasks to case management when a complex inpatient to outpatient transition occurs. Case management reviews daily discharge reports to data mine and generate referrals for post-acute telephonic case management services. When triggered for case management outreach post-inpatient admission, case manager contact members promptly. Discharge instructions are reviewed, home and community based service needs are identified and telephonic medication reconciliation occurs. Case managers ensure that face to face follow up visits are planned and in some cases, assist the member in scheduling a visit. Should a medication issue be identified, an immediate outreach will occur to the provider. A patient centered plan of care is created in collaboration with the member and in some cases, the caregiver. Discharge planning is facilitated by reports that are received daily from local facilities to provide timely notification of hospital discharges. At the time of contracting with hospitals, written information about the Independent Health Case management program is provided. The hospital is responsible for ensuring all discharge planning staff are aware of the Independent Health case management services and how to initiate a referral.

The CM Program Description contains full information regarding the scope and breadth of this effort.

### ***D. Chronic Condition Management (CCM)***

Chronic condition management encompasses high prevalence conditions, such as diabetes and cardiovascular disease, inclusive of heart failure. Members are stratified into three levels of severity, with Level 1 being the lowest. Level 3 is addressed at the CM level due to complexity and acuity level. Chronic Condition L3 information is found within CM Program information.

### ***E. Behavioral Health (BH)***

BH works to provide a full wrap of support for mental health and substance abuse needs, providing care coordination assistance to help Independent Health members access mental health and substance abuse care within the desired timeframe to optimize care and outcomes, with an appropriate practitioner, and within an appropriate treatment setting. Through health risk screening, data analytics, emergency room and inpatient hospital utilization, as well as other methods of referral, Independent Health identifies members at high risk for behavioral health issues, and seeks to engage them in the BH case management program. The BH program seeks to integrate medical and behavioral health needs, and works closely with CM and CCM to address barriers and challenges for members.

Independent Health recognizes the need to improve patient care coordination and communication across the continuum of healthcare delivery and has placed a high priority on improving continuity of care and improving rates of outpatient follow-up post-inpatient admission for behavioral health. Independent Health annually reviews the level of care continuity between outpatient behavioral health specialists and PCPS, with the goal of 90% of PCPs having documentation of communication from the outpatient behavioral health specialist in the member's medical record, among members who were seen by the outpatient behavioral health specialist with three or more office visits in the past year. Attainment of this goal is monitored annually, with remedial action and/or performance improvement activities initiated if the goal is not attained, including general and targeted provider education.

Independent Health seeks to improve the outpatient follow-up its members receive following an acute inpatient or emergency room visit for behavioral health through BH case manager telephonic facilitation of visit scheduling, if not already scheduled, and assessing and removing any barriers to completing it. Independent Health's goal is to score at or above the NCQA 90<sup>th</sup> percentile for seven-day follow-up after inpatient hospitalization for mental illness for its Commercial population. If monthly reporting indicates that achievement of this goal is at risk, remedial action and/or performance improvement activities are initiated to ensure that members are receiving the follow-up care needed.

To assist primary care physicians in the holistic management of their patients, initiatives have been implemented that offer primary care physicians psychiatric guidance regarding common behavioral health conditions, as well as psychotropic medication and dosing management assistance, through a PCP Consultation Line. The Consultation Line is staffed by board-certified psychiatrist advisors, who are available to discuss many facets of mental health and substance abuse screening, diagnosis and treatment. Additionally, a Home Based Therapy Program ensures access to mental health services for post-hospitalized members who are risk for non-adherence to their aftercare plan.

The BH Program Description contains full information regarding the scope and breadth of Independent Health's efforts to monitor and improve the care its members with behavioral health needs receive.

### ***F. Pharmacy***

Pharmacy Services processes requests for pharmaceuticals within the appropriate timeframe, and works closely with the CMO and Office of the Medical Director, Population Health, and Quality Management to assure the following:

- Research and recommendations regarding new drug and current clinical review information;
- Formulary management, changes and enhancements;
- Medication Therapy Management (MTM) program participation;
- Drug/Disease pharmacy system - drug safety edits; and
- Member/Physician Rx communications and education.

The MTM program is a drug therapy management that is furnished by a pharmacist in conjunction with the treating physician, 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. Members with complex health needs***

Through the annual population analysis, Independent Health identifies the prevalence and needs of members that may have complex health issues, including physical or developmental disabilities, multiple chronic conditions, or severe mental illness, and adjusts its program offerings accordingly. Members with these complex conditions may be triggered through the monthly stratification process as potentially appropriate for CM, CCM, or BH based on their demographic, social, clinical and utilization history and engaged for program participation as appropriate.

### ***H. Health Equity and Serving a Diverse Membership***

Independent Health understands the importance of addressing the cultural and linguistic needs of our memberships to ensure that they can adequately understand and access services and care. Independent Health identifies any changes that have occurred in the cultural background, spoken language, or educational attainment, which may serve as a rough approximation for health literacy, through the annual population analysis. Since member information on race, ethnicity, language, and educational level are not always readily available via administrative enrollment information, Independent Health supplements this information with US census tract information based on our members' location of residence. Based on the results of the population analysis, Independent Health initiates activities to build the linguistic and cultural competencies of our internal resources, as well as among health care professionals in our network. These activities may include internal and external trainings, community-based outreach, as well as expanding our print and web-based member-facing materials. Independent Health's objective is to ensure that culturally and linguistically appropriate materials for both print and web for any population segment that represents  $\geq 5\%$  of our overall member population.

## **V. Quality Measurement**

### ***A. Healthcare Effectiveness Data and Information Set (HEDIS) and Quality Assurance Reporting Requirements (QARR)***

The Healthcare Effectiveness Data and Information Set (HEDIS) and New York State's Quality Assurance Reporting Requirements (QARR) measure performance across six domains of quality care: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Relative Resource Use, Health Plan Descriptive Information, and Measures Collected Using Electronic Clinical Data Sources.

The results of Independent Health's HEDIS and QARR scores are used to target specific opportunities for improvement across preventive care, chronic treatment, and experience. Data is collected via administrative claims, medical records, or approved supplemental data and processed through a certified HEDIS vendor. An NCQA certified auditor verifies the accuracy of the data that is abstracted and reported. HEDIS and QARR results, as well as opportunities identified via the HEDIS reporting process, are brought forth for annual review. Performance improvement opportunities are reviewed and prioritized for the subsequent year.

### ***B. National Committee for Quality Assurance***

The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that assesses, reports, and seeks to improve the quality of care provided by organized delivery systems. NCQA's health plan accreditation process evaluates a plan's consumer protections and ability to deliver high quality care, and includes, but is not limited to, standards for quality management, population health management, verifying proper provider credentials, appropriate denial and appeal practices, and helping enrollees understand and use their coverage and manage their health. Health plans undergo a triennial survey and annual re-accreditation for all accredited products based on the plan's triennial health plan standards score, as well as the plan's annual HEDIS and CAHPS scores. Independent Health's multi-disciplinary ACTION team, led by the Program Manager, Accreditation and Quality Assurance, ensures that the organization is continually survey-ready. The ACTION team also ensures compliance with new and updated standards and required elements.

### **Quality Management Governance**

Independent Health's Quality Management Program is a coordinated and collaborative effort that involves senior management, multiple departments and disciplines, physicians, and other professionals working together as a team and collaborating to improve our organizational performance. The responsibility for the direction, monitoring, and outcomes applicable to the Quality Management Program is held by the Independent Health Board of Directors (BOD). The BOD annually reviews and approves all applicable content of the program and ensures that the appropriate required resources are allocated to the Program. The BOD has delegated day to day responsibility and oversight of all health plan governance and operations to Independent Health's Executive Team. The CEO leads the Executive Team at Independent Health, which includes the following members:

- Chief Medical Officer
- Chief Clinical Improvement Officer
- Chief Legal Counsel
- Chief Human Resource Officer
- Chief Financial Officer
- Chief Operating Officer
- Chief Engagement and Servicing Officer
- Chief Network and Performance Management Officer

The CEO has delegated full accountability of the program to the Chief Medical Officer. The Chief Medical Officer works in tandem with the Chief Clinical Improvement Officer, who oversees the Office of the Medical Director and provides direction and decision-making authority regarding Independent Health's population health management strategy and initiatives. The Chief Clinical Improvement Officer is responsible for the oversight of the integration of enterprise wide quality efforts, working in close collaboration with other Medical Directors and clinical and member engagement leadership. The Medical Director – Quality, Case and Disease Management, chairs the Quality Review Oversight



Committee (QROC) along with a representative of the BOD and the Director of Quality Measurement and Improvement. The Chief Medical Officer has further delegated quality departmental oversight to Vice President of Health Care Services, with day-to-day operations and annual planning overseen by the Director of Quality Measurement and Improvement. Together, the Medical Directors for Medical Policy & Utilization Management, Quality, Disease & Case Management, and Clinical Performance Management work with the Chief Clinical Improvement Officer and the Director of Quality Measurement and Improvement to realize the program framework and meet strategic goals set and approved by the Executive Team.

### **Quality Management Committee Structure**

#### **Quality Management Program Structure**

The Quality Management Program's governance cultivates transparency and an ability to effectively inform and communicate initiatives, improvements and potential barriers throughout the organization, particularly to those associates with decision making authority. Although the governance structure is robust, the more day to day substantive functions reside within the various committees that comprise the Quality Management Program. The committee structure encompasses many operational components within Independent Health. Collectively these committees are representative of functional areas that are capable of implementing and monitoring quality management improvements, enhancements and refinements.

#### **Designated Physician Involvement**

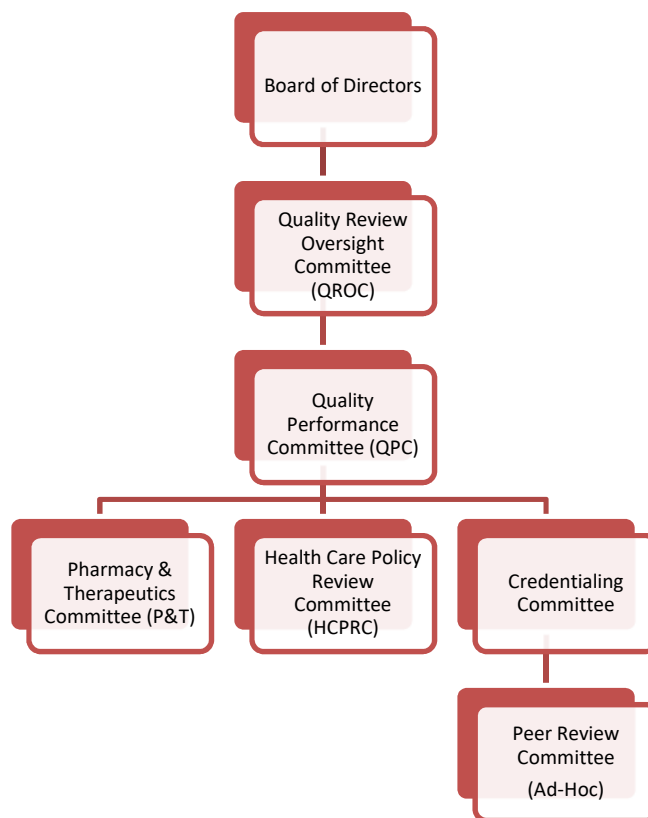
The Chief Medical Officer is ultimately responsible for the development, implementation and ongoing operation of the Quality Management Program. The Chief Medical Officer designates the Medical Director – Quality, Case and Disease Management, as the chairperson of the QROC Committee. The Chief Medical Officer is also ultimately responsible for directing Quality Performance Committee (QPC) 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-Clinical Performance Management and the Medical Director-Quality, Case and Disease Management. The Chief Medical Officer is a member of the executive team and provides this interdisciplinary team with reports on QPC progress and issues. In addition, the Chief Medical Officer is an ex-officio member of the Independent Health Board of Directors.

#### **Behavioral Healthcare Practitioner Involvement**

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, Behavioral Health is board certified in psychiatry and is the designated physician involved in the behavioral health aspects of the Quality Management Program. The Medical Director, Behavioral Health is responsible for leadership, oversight and implementation of the behavioral health program, and is also the designated behavioral health practitioner for Independent Health's QROC and QPC. 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. The behavioral health specialists are overseen by the Director of Behavioral Health, who is a core member of QPC.

**Figure 1. Quality Management Program Committee Structure**



### **Quality Review Oversight Committee (QROC)**

QROC is a Committee of the Company, which the Board of Directors has established as the oversight body of the Quality Management Program. QROC meets on a quarterly basis. QROC 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.

Key functions of QROC include:

- Review and evaluate results of quality improvement activities,
- Identify and recommend needed action, and
- Ensure follow-up.

In addition to the Key Functions, QROC has been designed to perform the following functions for Independent Health's Quality Program:

- Evaluates Quality Management Program implementation and provides feedback regarding the effectiveness of the Program;
- Reviews and approves the Quality Management Program Description and Work Plan;
- Monitors adherence to the Quality Management Work Plan and provides feedback;
- Provides external practitioner involvement in the Quality Management program through planning, design, implementation or review;
- Provides reporting on a quarterly basis to the Independent Health Board of Directors;
- Reviews population analysis, population health management strategy, and the evaluation of the effectiveness of the strategy and initiatives on impacting the desired goals, at least annually; and
- Reviews and approve meeting minutes and action items of the main quality committees, the Quality Performance Committee.

### **Committee Structure - Downstream from QROC**

The Quality Review Oversight Committee has one main committee which reports directly to it, the Quality Performance Committee. Furthermore, there are three sub-committees that report to the Quality Performance Committee. These are the Pharmacy and Therapeutics Committee, the Health Care Policy Review Committee, and the Credentialing Committee. Other committees of the organization bring forth information and reporting to the Quality Performance Committee as requested.

### **Quality Performance Committee**

The Quality Performance Committee (QPC) is a sub-committee of QROC. QPC meets monthly, though often ad-hoc meetings are held. The role of the QPC is to review quality projects and initiatives to monitor key process measures impacting outcomes. QPC reviews various quality initiatives across all lines of business to assure continued improvement across all measures. QPC works to identify root cause of identified gaps and/or barriers in process and provides timely visibility to QROC regarding risk of progress toward goal, allowing for assessment and remedial action to occur to effectively mitigate.

QPC is comprised of Independent Health leadership staff representing various departments. The purpose of the QPC 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.

➤ Leadership responsibilities:

- Set priorities for quality improvement efforts based on population analysis, historical measurement trends 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;
- Ensure resources support strategic initiatives and QM Plan; and
- Assess the effectiveness of programs and make recommendations for continuation or change of programs.

➤ Key functions:

- Oversight and monitoring of key quality improvement initiatives in areas of clinical care and service;
- Review QI initiatives and prioritize based on QM Plan;
- Ensure all key stakeholders are aware of QM programs and accomplishments;
- Facilitate communication of directives and discussion from the QPC committee;
- Review population analysis, population health management strategy, and population health strategy effectiveness analysis, and provide feedback at least annually;
- Establish effective processes for monitoring potential under and over utilization and assure that interventions are initiated as appropriate;
- Performance of the annual review regarding Independent Health policies and procedures relating to quality of care and service to members is delegated to the Health Care Policy Review Committee; the Committee's membership includes physicians and other clinical members of the Clinical Quality Committee;
- Review of inter-rater reliability audits and actions taken to improve consistency across reviewers;
- 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; and
- Oversight of UM and Credentialing delegation.

- Membership of QPC includes the Medical Director, Quality Disease and Case Management (co-chair); Director, Quality Measurement and Improvement (co-chair); Director, Case and Disease Management (Commercial and Medicare); Director, Utilization and Case and Disease Management (Medicaid); Director, Behavioral Health; Medical Director, Behavioral Health; Director, Benefit Administration and Compliance; Director, Pharmacy, Quality and MTM; Director, Servicing; Director, Utilization Quality Improvement Management; Manager, Account Services and Wellness; Director, Provider Relations and Engagement; and VP, Marketing.

### **Pharmacy & Therapeutics Committee**

The Pharmacy and Therapeutics Committee (P&T) is responsible for the development and maintenance of Independent Health's drug formularies. 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.
- 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;
  - Quarterly update and reprinting of formulary publication. 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.
- Membership of the Pharmacy and Therapeutics Committee includes practicing physicians and pharmacists, appointed by the Pharmacy and Therapeutics Committee chairperson. The committee members represent a cross-section of primary care physicians and specialties from Independent Health's practitioner panel.

### **Credentialing Committee**

The Credentialing Committee (CC) is a sub-committee of QROC and meets at minimum quarterly, with ad-hoc meetings if required. The CC is responsible to assure that providers meet the applicable requirements for initial credentialing and re-credentialing activities. The CC membership includes medical directors both internal to plan and external network physicians, and key plan team members.

- 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.
  - Credentials and recredentials of physicians and providers are reported to QROC on a quarterly basis.
  - Provides input and makes recommendations to the HCQ Committee for those physicians and providers who do not meet all criteria for credentialing/recredentialing.
  
- Membership of the Credentialing Committee includes Medical Director, Clinical Performance Management; Director, Provider Network Administration; Manager, Credentialing; Administrative Coordinator, Network Contract Management; Senior Deputy Legal Counsel; and community physicians and counsel. Community physicians represent primary care (internal medicine and pediatrics) and the specialty areas of orthopedic surgery, OBGY, cardiology, ophthalmology, otolaryngology and neurology.

### **Peer Review Committee**

The Peer Review Committee (PRC) is a multi-disciplinary physician committee chaired by the Medical Director, Physician Engagement, and meets ad-hoc. The key functions of the PRC include, but are not limited to: Peer review of provider issues which may be individual cases or trended issues; collaborative discussion with invited MD with peer participants to explore concerns and share knowledge, best practice; recommendations post Peer Review discussion to Chair to address identified concerns, including education, placement of limitation, non – renewal and termination. The Peer Review Committee is assigned to provide a summary of actions taken by the committee and is obligated to provide this summary to the QPC, Credentialing, and P&T Committees. A copy of all determination decisions will be placed in the recredentialing file of any physician participating in Peer Review as part of the Network Evaluation review that is incorporated into the recredentialing process.

### **Health Care Policy Review Committee**

The Health Care Policy Review Committee (HCPRC) is composed of the Medical Director, Associate Medical Directors, and internal Independent Health staff with expertise and/or professional interest in the review of new and annually updated medical, behavioral health and health care compliance policies. Key functions include the review and approval of new and annually updated medical, behavioral health and health care compliance policies as they apply to various Independent Health departments. HCPRC meets bi-monthly. HCPRC reports directly to QPC, providing policy decisions and meeting minutes through this channel.

### **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 and who is not the subordinate of any person involved in the initial determination. The member has the right to appear by conference call, or by other appropriate technology. The committee membership includes consumer representation from the IH Board, who serves as chair; other consumer representatives and IH team members also participate. This committee is not report into QROC, though information and data are shared with QPC on an ad hoc basis.

### **Clinical Member Appeals (Sub) 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 and who is not the subordinate of any person involved in the initial determination. The member has the option to participate by conference call, or by other appropriate technology. This committee does not report into QROC, though information and data are shared with QPC on an ad hoc basis.

## Quality Management Program Resources

Although most departments and functional areas at Independent Health are involved in quality management activities, there are several that are deemed to be most critical to the Program’s overall success, and which actively participate and collaborate in the Quality Management Program. Table 1 outlines the resources that will actively contribute to the Quality Management Program for 2018:

**Table 1. 2018 Quality Management Program Resources**

Resource Title	Department	Focus Area Impact	FTE Count
Chief Medical Officer (CMO)	Executive Team	Responsible for all medical associate & medical directors and Health Care Services	1
Chief Clinical Improvement Officer	Executive Team	Responsible for PHM Strategy and chairs QROC	1
Chief Operating Officer (COO)	Executive Team	Responsibility for operations and IT	1
Chief Engagement and Servicing Officer	Executive Team	Responsibility for member/provider engagement and servicing	1
VP - Health Care Services	Health Care Services	Accountable for UM/CM/DM/BH/QMI clinical and quality improvement	1
Medical Director - Medical Policy & Utilization Management	Office of Medical Director	UM, Medical Policy	1
Associate Medical Director	Office of Medical Director	Utilization Review, Appeals	2
Medical Director–Quality, Disease & Case Management	Office of Medical Director	Case and Disease Management, Population Health, Quality	1
Medical Director-Clinical Performance Management	Office of Medical Director	Credentialing, Quality of Care complaints/concerns, Provider Evaluation, Education	1
Director, Behavioral Health	Office of Medical Director	Behavioral Health; position currently vacant; to be filled 3/5	0.5
Director -QMI	Quality Measurement & Improvement (QMI)	Accountability QMI Team, QPC; QI Cycle and Measurement	1
Manager - Quality Review & Measurement	QMI	HEDIS Cycle & MRR management	1
Quality Management Specialist	QMI	MMR and HEDIS Cycle assistance	2
Clinical Quality Excellence Review Nurse	QMI	Oversees and promotes QI, PIP QIP	1
Program Manager - Quality Management/Strategies	QMI	NCQA Accreditation, QI oversight, Performance Trending	2
Clinical Quality Investigator	QMI	Utilization trends, clinical protocols and guidelines	.5
Director-Utilization, Case and Disease Management	HCS	Responsible for UM/CM/DM	2
Administrative Coordinator	HCS	Operational & administrative support	1
Manager - UM	HCS	Acute inpatient, IRF, SNF/SUB; Outpatient prior authorization	3
Supervisor - UM	HCS	Acute inpatient, IRF, SNF/SUB; Outpatient prior authorization	3
Utilization Review Nurses	HCS	Review of clinical prior authorization	36
Utilization Management Assistants	HCS	UM prior authorization process, reviewing for eligibility and benefit	19
Director - Health Care Services Operations (HCSO)	Health Care Services Operations (HCSO)	Reporting & technology and project management; Vendor management and QA	1



## 2018 QUALITY MANAGEMENT PROGRAM DESCRIPTION

Manager - Quality Assurance	HCSO	Oversight of training, clinical vendor delegation, policy management & QA	1
Clinical Trainer	HSCO	Coach and training process improvement	1
Clinical Delegated Vendor & Quality Manager-	HCSO	Clinical Delegated Vendor & Quality Managers	3
Clinical Quality Excellence Review Nurse/	HSCO	Quality of care/physician performance review, clinical protocols and guidelines	3
Quality Auditor	HSCO	Audit of compliance UM requirements	2
Provider Performance Improvement Specialist	HSCO	Quality of care/physician performance review	1
Program Manager	HSCO	Process improvement and project management for HCS	3
Administrative Assistant	HSCO	Operational & administrative support	1
Manager-Reporting & Technology	HSCO	Management of technology and reporting for HCS	1
Business and System Analysts	HSCO	HCS Application enhancement and system and reporting administration	3
Capacity Planner	HSCO	Allocation of UM resources	1
Program Manager	HSCO	HSC Delegation oversight	1
Account Manager	HSCO	Vendor delegation functions	2
Director - Case and Disease Management (CM/DM)	HCS	Accountability complex case and disease management program design interventions	1
Clinical Manager - CMDM	HCS	Chronic Conditions, Complex & Episodic, palliative care	4
Clinical Supervisor - CMDM	HCS	Chronic Conditions, Complex & Episodic, palliative care	3
Case Managers - CMDM	HCS	Day to day management of member interventions and interactions	27
Care Coordination Assistant - CMDM	HCS	Assist in transitions of care and navigation of healthcare system	6
Health Home Coordinator - CMDM	HCS	Assist in transitions of care and navigation of healthcare system	1
Nurse Assessor - CMDM	HCS	-	1
Facilitator - Community Resources - CMDM	HCS	-	1
Administrative Assistant	HCS	Operational & administrative support	1
Director - Behavioral Health (BH)	HCS	Accountability Behavioral Health Program	1
Clinical Supervisor (BH)	HCS	Oversight of BH case management functions	1
Case Managers (BH)	HCS	Case management of BH members	5
Director - Benefit Administration (BA)	BA	Accountable for oversight of Appeals and Grievances	1
Supervisor - BA	BA	Management of Appeals and Grievances process and resources	1
Clinical Reviewer - BA	BA	Review clinical appeals and grievances clinical in nature	6.5
Review Specialist - BA	BA	Review contractual appeals and grievances	6
Coordinator - BA	BA	Operational, administrative and compliance support	3
Manager - Account Services	Health Promotion and Wellness (HPW)	Responsible for prevention and low level member engagement	1
Wellness Specialist	HPW	Execution of member outreach and low level interventions	5
Account Service Representative	HPW	Group engagement in HPW initiatives	7
Director - Provider Relations &	Provider Relations &	Oversight of Physician innovation and	1

## 2018 QUALITY MANAGEMENT PROGRAM DESCRIPTION

Engagement	Engagement	engagement initiatives	
Physician Engagement Specialists	Provider Relations & Engagement	Provider liaison and support	4
Health Engagement Coach	Provider Relations & Engagement	Community Partnerships and outreach in health promotion	2
Manager - Provider Relations	Provider Relations & Engagement	Management of provider servicing	1
Provider Relations Support Representatives	Provider Relations & Engagement	Interface with provider community and point of contact for inquires	8
VP - Service & Health Care Operations	Servicing	Accountable for member servicing	1
Director	Servicing	Responsible for member servicing	1
Manager	Servicing	Responsible for oversight of member servicing activities	3
Supervisor	Servicing	Responsible for management and coaching oversight of member servicing associates	9
Customer Service Representatives	Servicing	Member experience and barriers	96
VP - Network Contract Management	Network Contract Management (NCM)	Accountable for Network contracting and performance	1
Director - Network Administration	NCM	Responsible for administration of network	1
Director - Provider Network	NCM	Responsible for provider contracting	1
Director - Network Contract Management	NCM	Responsible for network management	1
Manager	NCM	Responsible of various functions of network management activities	4
Manager Credentialing	Credentialing	Investigation & monitoring physicians and credentialing process oversight	1
Credentialing Analyst	Credentialing	Network adequacy and performance monitoring	1
Credentialing Specialist	Credentialing	Facilitation of Credentialing Process	3
Credentialing Assistant	Credentialing	Facilitation of Credentialing Process	1
VP - Pharmacy Services	Pharmacy	Accountable for Pharmacy services, help desk, Formulary, MTM and PBM oversight.	1
Director - Pharmacy, Quality and MTM	Pharmacy	Responsible for MTM program	1
MTM Pharmacist	Pharmacy	Administer MTM programs	10
MTM Supervisor	Pharmacy	Manages Coordination of MTM program	1
MTM Coordinator	Pharmacy	Coordinates MTM program	3
Clinical Pharmacist	Pharmacy	Formulary Administration and clinical pharmacy needs	7
Manager - Prior Authorizations	Pharmacy	Responsible for PA process	1
Clinical Review Pharmacist	Pharmacy	Review Prior Authorization for Clinical needs	7
Manager - Pharmacy Operations	Pharmacy	Responsible for Pharmacy help desk and prior authorization management	1
Supervisor - Pharmacy Helpdesk	Pharmacy	Supervises associates tasked with member interactions'	1
Pharmacy Help Desk Representatives	Pharmacy	Service member pharmacy benefit needs	12
Supervisor - Pharmacy Prior Authorization	Pharmacy	Supervises prior authorization for non-clinical	1
Prior Authorization Associates	Pharmacy	Operate day to day operations of prior authorizations	14

## 2018 QUALITY MANAGEMENT PROGRAM DESCRIPTION

Pharmacy Government Specialists	Pharmacy	Oversee government program pharmacy compliance	4
VP-Clinical & Business Informatics	Informatics	Accountable for oversight and guidance of Quality Integration Analytics, Informatics Reporting and analysis	1
Director, Analytics	Informatics	Responsible for Quality analytics and reporting	1
Manager, Analytics	Informatics	Responsible for Quality analytics	1
Program Manager, Quality	Informatics	Responsible for HEDIS/QARR/Star Reporting	1
Research Analysts, Quality and Member Engagement	Informatics	Performs analytics on quality improvement and member engagement opportunities	5

### Quality Management Program Metrics

Progress towards meeting the Quality Management Program goals and objectives are monitored regularly through functional area reporting at the Quality Performance Committee (QPC) for review. The table below represents a summarization of key quality indicators for 2018.

**Table 2. 2018 Quality Management Program Key Indicators**


Domain	Indicator	2018 Performance Goal
Key Quality Indicator	NCQA Health Plan Rating	≥4.5
	NCQA Health Plan Accreditation Score	≥45
	NCQA Health Plan Accreditation Rating	Excellent
	Provider Voice of the Customer Satisfaction Rating	≥85.0%
Continuity and Coordination of Care	Specialists to PCPs	≥90%
	OB/GYN to PCPs	≥90%
	Behavioral Health to PCPs	≥90%
	Between different settings of care	≥90%
	Following transitions of care	≥90%
Member Satisfaction	Member Satisfaction with Behavioral Health Services	Establish baseline with new survey
	Member Satisfaction with Case Management	Maintain/improve previous level of satisfaction
	CAHPS Marketplace Member Survey	Maintain/improve previous level of satisfaction
	CAHPS Commercial HMO/POS Member Survey	Maintain/improve previous level of satisfaction
Provider Access	Network Management GeoAccess and Provider Ratio Study	Meets access standards

**Review and Revision of the Quality Management Program**

Independent Health conducts an annual review of its Quality Management Program Description, with updates to occur more frequently, as appropriate. The Quality Performance Committee is accountable for approving the Quality Management Program Description and work plan during the first quarter of each calendar year. The Quality Review Oversight Committee is presented the approved plan at the first meeting of the calendar year for review and approval.

  
\_\_\_\_\_  
John Antkowiak, MD  
Chairman, Board of Directors

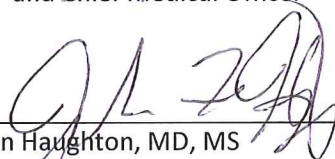
4/17/18  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Michael Cropp, MD, MBA  
President and CEO

4/17/18  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Thomas Foels, MD  
EVP and Chief Medical Officer

4/16/18  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
John Houghton, MD, MS  
SVP and Chief Clinical Improvement Officer

4/16/18  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Vanessa Johnson, RN  
VP, Healthcare Services

4/16/18  
\_\_\_\_\_  
Date

Last Revision and Review      02/18