QUALITY IMPROVEMENT PROGRAM DESCRIPTION

VANTAGE HEALTH PLAN

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Vantage Health Plan, Inc.

Quality Improvement Program Description

Effective: 11/20/2013	Revised: 12/23/13, 1/29/14, 10/20/2014, 12/10/15 12/29/16, 1/19/18, 1/14/19 Revised by: Teresa Morris, CLS, CPHQ Business Quality Analyst Kim Hartt Business Process Manager

I. Mission Statement

Vantage Health Plan's Quality Improvement Program (QIP) has a mission to provide an effective and measurable plan for monitoring, evaluating and improving the quality of care and services, in a cost-effective and efficient manner, to our members and practitioners.
It is inherent to Vantage Health Plan's philosophy that quality improvement is not the responsibility of any one single individual or department, but the duty of every employee and contracted practitioner/provider. Vantage is committed to using a continuous quality improvement cycle in managing all clinical care and services provided to our members.

II. Purpose

The Quality Improvement Program provides a formal process by which Vantage and its participating practitioners and providers strive to continuously improve the level of care and service rendered to members. It utilizes objective benchmarks and subjective indicators to measure, analyze and evaluate the quality and safety of clinical and beneficiary services provided to members. The program addresses both medical and behavioral health care, and the degree to which they are coordinated. It defines the systematic approach used to identify, prioritize and pursue opportunities to improve services, and to resolve identified problems. The Quality Improvement program is reviewed, updated, and approved by Vantage Health Plan's QI Standards and Scope Committee, including the CEO/Medical Director, annually. It is distributed to NCQA, practitioners, members and other entities as requested.

III. Scope of Program

The scope of the Quality Improvement Program is to monitor care and identify opportunities for improvement of care and services to both our members and practitioners. This is accomplished by evaluating data, and assisting with the identification, investigation, analyzing, implementation, and evaluation of opportunities to improve and measure the quality of clinical and administrative service. This Quality Improvement Program covers all Vantage members. Specific elements of the Quality Improvement Program may include but are not limited to:

- Practitioner accessibility and availability
- Practitioner satisfaction
- Continuity and coordination of care
- Clinical measurement and improvement monitoring
- Chronic Care Improvement Program (CCIP)
- Integrated Care Management (ICM)
- Disease Management (DM)
- Behavioral Health Care
- Credentialing and Recredentialing
- Member safety
- Member satisfaction/grievances
- Under- and over-utilization
- Adverse outcomes/events
- Facility site reviews
- Medical records-keeping practices
- Timeliness of handling grievances/claims/appeals
- Quality Improvement Project (QIP)
- Cultural and linguistic needs of members
- Meeting regulatory requirements

IV. Documentation

Three annually published documents describe Vantages' continuous quality improvement cycle:

- ***Quality Improvement Program Description***: a comprehensive explanation of the Vantage's QI Program structure and objectives, including accountability and reporting relationships; outlines resources dedicated to improvement activities
- ***Quality Improvement Work Plan***: Documents the improvement process to be implemented in the calendar year through detailed performance goals/targets and timetables, addresses clinical and administrative improvement activities throughout the organization and specifies operational accountability; offers rationale for project selection and task priorities. The workplan is updated and distributed monthly to all members of Vantage's QI committees.
- ***Quality Improvement Program Evaluation***: Presents formal assessment of the outcomes of the prior year's quality improvement activities; compares results with baseline rates and benchmarks available at the time of those activities were planned (two years prior); identifies barriers to success; includes recommendations for subsequent years.

Each year, Vantage creates a Quality Improvement Work Plan dedicated to improving the quality of health care and services for its members. The Quality Improvement Work Plan includes initiatives in the following major areas:

- ***Clinical Quality Improvement****:* focuses on improvements in the quality of preventive and acute health care provided to health plan members.

- ***Service Improvement****:* ensures that high quality services are provided to health plan members. Initiatives focus on member complaints and appeals, customer service provided via the telephone and through all other communication channels, and member satisfaction.
- ***Compliance and Calibration Improvement:*** focused on ensuring the consistent and cohesive interpretation, execution, and communication of regulatory standards to provide the highest level of service to our members.
- ***Health Promotion****:* implements Health Education and Wellness programs including group classes and one-on-one consultations for health plan members (and others in the community) on a variety of health care topics, including pregnancy, nutrition, diabetes, heart disease, amongst others. Mailed reminders are also distributed to health plan members to encourage the receipt of preventive health services such as breast and cervical cancer screening, and childhood and adolescent immunizations.
- ***Behavioral Health****:* promotes the coordination of medical and behavioral health issues for health plan members through initiatives in areas, such as depression screening, member education, monitoring psychotropic medication compliance, and follow up after hospitalization for mental illness or substance use disorders. This is performed through the services which include integrated care management programs, behavioral health utilization management, and provides support services in the form of social services case management and transitional care.

V. Goals and Objectives

The following goals and objectives of the QI Program function to support the concepts of continuous quality improvement.

A. Goals

- Build a solid and dedicated quality improvement infrastructure
- Foster communications and partnerships across all departments of Vantage
- Utilize our QI Program description as a framework to advance Vantage's QI efforts, establish a culture of improving quality of care and services provided to our members
- Improve members ability to use quality measures to evaluate and compare our health plan and services to others
- Ensure members receive the highest quality of care and services
- Ensuring members have full access to care and availability of primary care physicians and specialists
- Monitoring, improving and measuring member and practitioner satisfaction with all aspects of the delivery system and network
- Utilizing a multi-disciplinary approach to assess, monitor and improve our policies and procedures
- Promoting physician involvement in our Quality Improvement Program and activities
- Fostering a supportive environment to help practitioners and providers improve the safety of their practices

- Meet and assess the standards for cultural and linguistic needs of our members
- Meeting the changing standards of practice of the healthcare industry and adhere to all state and federal laws and regulations
- Adopting, implementing and supporting ongoing adherence to applicable Departments of Insurance, CMS and NCQA standards/guidelines/laws, and to standards/guidelines/laws of all states in which a Vantage-affiliated health plan is licensed and doing business
- Promoting the benefits of a managed care delivery system
- Promoting preventive health services and case management of members with chronic/complex conditions
- Emphasizing a caring professional relationship between the member, practitioner and health plan
- Ensuring there is a separation between medical and financial decision making
- Seek out and identify opportunities to improve the quality of care and services provided to our members
- Seek out and identify opportunities to improve the quality of services to our practitioners

B. Objectives

- Ensuring that timely, quality, medically necessary and appropriate care and services that meet professionally recognized standards of practice are available to members by the identification, investigation and resolution of problems, focusing on known or suspected issues that are revealed through monitoring, trending and measuring of specific clinical indicators/measures, preventative health services, access to services and member satisfaction, through the use of a total quality improvement philosophy.
- Systematically collect, screen, identify, evaluate and measure information about the quality and appropriateness of clinical care and provide feedback to practitioners about their performance.
- Maintaining a credentialed network based on a thorough review and evaluation of education, training, experience, sanction activity and performance.
- Objectively and regularly evaluate professional practices and performance on a proactive, concurrent and retrospective basis through Credentialing and peer review.
- Ensuring our members are afforded accessible health care by continually assessing the access to care and availability of our network of practitioners (including Primary Care/Specialists/Behavioral Health Care).
- Designing and developing data systems to support Quality Improvement monitoring and measurement activities
- Assuring compliance with the requirements of accrediting and regulatory agencies, included but not limited to applicable Departments of Insurance, CMS, NCQA, and the applicable regulatory agencies of all other states in which a Vantage-affiliated health plan is licensed at doing business.
- Appropriately oversee Quality Improvement activities of our delegated functions
- Ensuring that always the Quality Improvement structure, staff and processes are in compliance with all regulatory and oversight requirements.

- Actively work to maintain standards of quality of care and service
- Establish and conduct focused review studies, with an emphasis on preventive services, high volume practitioners and services and high-risk services with implementation of processes to measure improvements
- Ensuring that mechanisms are in place to support and facilitate continuity of care within the healthcare network and to review the effectiveness of such mechanisms.
- Identifying potential risk management issues
- Effectively interface with all interdisciplinary departments and practices for the coordination of Quality Improvement activities
- Providing a confidential mechanism of documentation, communication and reporting of Quality Improvement issues and activities of Vantage's Quality Committees, Governing Board and other appropriate involved parties.
- Assessing the effectiveness of the Quality Improvement Program and make modifications and enhancements on an ongoing and annual basis.
- Ensuring that Vantage is meeting the cultural and linguistic needs of its members at all points of contact
- Ensuring members have access to all available services regardless of race, color, national origin, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
- Ensuring mechanisms are in place to identify, support and facilitate patient safety issues within the network and review the effectiveness of these mechanisms.

VI. Confidentiality and Conflict of Interest

All information related to the Quality Improvement process is considered confidential. All Quality Improvement data and information, inclusive of but not limited to, minutes, reports, letters, correspondence, and reviews, are housed in a designated, secured file on the H:/ drive. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee All Quality Improvement activities including correspondence, documentation and files are protected by the federal Medical Information Act SB 889 and the Health Information Portability and Accountability Act (HIPAA) for patient's confidentiality. No person shall be involved in the review process of Quality Improvement issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated.

VII. Program Structure

A. Program Structure Governing Body

The Plan's Governing Body is Vantage's Governing Board. The Governing Board reviews and directs all Quality Improvement activities.

B. CEO/Medical Director

The Chief Executive Officer/Medical Director has overall responsibility for oversight of the Quality Improvement Program. The CEO/Medical Director reports activities monthly/quarterly to the Governing Board. The Medical Director is a physician who

holds a current license to practice medicine with the Medical Board of Louisiana. The Medical Director is the Governing Boards designee responsible for implementation of the Quality Improvement Program activities. The Medical Director works in conjunction with the QIC to develop, implement and evaluate the Quality Improvement Program. The Medical Director is Chairperson of the Credentialing Committee and the Utilization Management Committee. Responsibilities include but not limited to:

- Ensuring that decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management
- Ensuring that the medical care provided meets or exceeds the community standards for acceptable medical care
- Ensuring the medical protocols and rules of conduct for plan medical personnel are followed
- Developing and implementing medical policy
- Actively participating in the functioning and resolution of the grievance procedures
- Providing support and clinical guidance to the program and to all physicians in the network
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to: CMS, LDOI, HCFA, NCQA, and the applicable regulatory agencies of all other states in which a Vantage-affiliated health plan is licensed at doing business, etc.
- Ensuring that the Quality Improvement and Utilization Management departments interface appropriately to maximize opportunities for quality improvement activities
- Directing the implementation of the Quality Improvement process
- Overseeing the formulation and modification of comprehensive policies and procedures that support the Quality Improvement operations
- Analyzing Quality Improvement data
- Reviewing all clinical grievances and direct corrective actions to be taken, including peer review, if required
- Reviewing Quality Improvement Program, work Plan, Annual Evaluation and other reports
- Assisting with the development, conduct, review and analysis of HEDIS® and CAHPS® studies
- Ensuring practitioner participation in the QI program through planning, design, implementation and review

C. Business Process Dept.

The Business Process Dept. oversees the operations of the Quality Improvement Program, manages the day-to-day operations and is responsible for the execution and coordination of all Quality Improvement activities. The Business Process Dept. helps to plan, develop, organize, monitor, communicate, and recommend modifications to the Quality Improvement Program and all QI policies and procedures. It is the Business Process Dept.'s responsibility to interface with other departments on Quality Improvement issues. Business Process Manager reports any areas of concern to the Medical Director and/or QI Committees. Additional responsibilities include but not limited to:

- Performing statistical analysis relevant to quality improvement functions and goals
- Developing an/or revising annually the Quality Improvement Annual Evaluation and Work Plan and presenting for review and approval
- Developing QI activity progress reports
- Developing and/or revising annually Quality Improvement policies and procedures
- Ensuring that quality trends and patterns are monitored, quality issues are identified, and corrective action plans are developed
- Monitoring and reporting to the QI Committees the resolution of quality improvement activities in accordance with the Quality Improvement Program
- Overseeing compliance required by regulatory agencies
- Interfacing with all internal departments to ensure compliance to the Quality Improvement Program and policies and procedures
- Acting as a liaison with each delegate, practitioner and providers regarding Quality Improvement issues
- Assuring compliance with all Quality Improvement related requirements with accrediting and regulatory agencies, including but not limited to LDOI, CMS, NCQA, and to the applicable regulatory agencies of all other states in which a Vantage-affiliated health plan is licensed at conducting business.
- Serving as a Liaison with regulatory agencies for Quality Improvement activities
- Monitoring and follow up with all applicable Quality Improvement activities
- Ensuring staff collects and monitors data and report identified trends to the Medical Director and QI Committee Meetings
- Ensuring that HEDIS®, QIP, CCIP and CAHPS® studies are conducted appropriately
- Ensuring Member and Practitioner Satisfaction surveys are conducted annually or as needed
- Identifying compliance problems and formulating recommendations for corrective actions
- Ensuring the focus Review studies are conducted appropriately
- Interfacing with the Medical Director for clinical quality of care and service issues
- Serving as a Liaison with LDOI, CMS and other applicable regulatory agencies for investigation, collaboration and resolution of clinical grievances
- Developing policies and procedures in conjunction with the Medical Director
- Serving as a Liaison with departments for investigation, collaboration and resolution of all identified internal quality of care issues
- Preparing QI reports for management, Governing Board and QI Committees
- Participating in the UR Committee meetings regarding presentation and discussion of quality data
- Collaborating with Member Services Department Head and Grievance Committee Chairperson to identify quality of care issues
- Monitoring the delegated Quality Improvement activities to ensure proper performance of Quality Improvement functions in compliance with regulatory and delegation requirements
- Submitting a written report summarizing each annual evaluation
- Tracking compliance with reporting requirements and provide reports for QI Committees

- Ensuring appropriate resources and materials are available and ordered to meet the department's needs
- Ensuring practitioner participation in the QI program through planning, design, implementation and review

D. Quality Improvement Staff and Resources

The Quality Improvement Department has multidisciplinary staff to address all aspects of the department functions including the gathering, disseminating, and reporting of HEDIS data. Vantage has staff and resources to conduct statistical and data analysis sufficient to establish quality controls and improvement projects. Data analysts are capable of developing databases relevant to specific functions and pulling appropriate information relevant to specific studies. The staff includes but is not limited to:

- Clinical Quality Review RN's
- Clinical Quality review LPN's
- System Analyst
- Interdepartmental HEDIS® support

E. Quality Improvement Committees

The Quality Improvement Committees (QIC) were established and are charged with the development, oversight, guidance and coordination of all Quality Improvement activities. The QI Committees have been delegated the responsibility of providing an effective Quality Improvement Program. The QIC monitors QI activities, identifies problems, recommends corrective action, and guides the education of practitioners to improve health outcomes and quality of service. The Quality Improvement Committees are a coordinated compilation of four uniquely designed sub-committees that include:

- The QI Clinical Quality Committee,
- The QI Service Quality Committee,
- The QI Compliance Calibration Committee, and
- The QI Standards and Scope Committee

The scope of the QIC includes, but is not limited to, the following:

- Directing all Quality Improvement activity
- Recommending policy decisions
- Reviewing, analyzing and evaluating Quality Improvement activity
- Ensuring practitioner participation in the QI program through planning, design, implementation and review.
- Reviewing and evaluating reports of Quality Improvement activities and issues arising from its standing subcommittees (Pharmacy & Therapeutics, Credentialing, Utilization Management, Compliance and Appeals & Grievances)
- Monitoring, evaluating and directing the overall compliance with the Quality Improvement Program
- Annually reviewing and approving the Quality Improvement Program, Work Plan, and the Annual Evaluation

- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to CMS, LDOI, NCQA, and the applicable regulatory agencies of all other states in which a Vantage-affiliated health plan is licensed at conducting business.
- Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols
- Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria
- Developing relevant sub-committees for designated activities and overseeing the standing sub-committee's roles, structures, functions and frequency of meetings as described in this Program. Ad-hoc sub-committees may be developed for short-term projects.
- Reviewing and evaluating reports regarding any/all potentially litigious incidents and adverse events
- Developing and coordinating Risk management education for all Health Practitioners and staff
- Responsibility for evaluating and giving recommendations concerning audit results, member satisfaction surveys, practitioner satisfaction surveys, HEDIS®/CAHPS® audits and QIP/CCIP and other regulatory required studies
- Responsibility for evaluating and give recommendations from monitoring and tracking reports.
- Ensure follow-up, as appropriate

F. Reporting of Quality Activities

The QI Committees, through the Business Process Manager, shall submit a summary report of quality activities and actions for review and approval to the Vantage Governing Board on an annual basis. This is completed by the approval of the annual Quality Improvement report.

G. Composition of QI Committee *(including but not limited to)*

- CEO/ Medical Director
- Executive Vice President
- Chief Financial Officer
- General Counsel (In-House Legal Counsel)
- Compliance Officer
- Business Process Manager
- Compliance Director
- Commercial Compliance Coordinator
- Medicare Compliance Officer
- Utilization Management Medical Director
- Health Management Medical Director
- Quality Improvement Director
- Medical Management Director
- Medical Management Supervisor
- Member Services/Marketing/Enrollment Director

- Marketing Administrative Supervisor
- Health Risk Management Director
- Integrated Care Director
- Integrated Care Manager
- Integrated Care Supervisor
- Chief Information/Security Officer
- Claims Director
- Controller
- Clinical Services Coordinator
- Chief Human Resources Officer
- Medical Management Supervisor
- Member Services/Enrollment Director
- Credentialing Supervisor
- Network Development Director
- Provider Services Manager
- Pharmacy Disease Management Program Manager
- Human Resources Director
- Wellness Program Coordinator
- Other members appointed at the discretion of the Medical Director/QIC Chairperson

H. Quality Improvement Committee Meetings

The QI Committees are dynamic, working committees that meet with regular frequency throughout the year based on the outlined scope for each team. The Medical Director(s) may act on the Committees' behalf on issues that arise between meetings.

I. Confidentiality/Ethics

All QIC and Sub-Committee members and participants, including network Practitioners, consultants and others will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. Activities and minutes of the QIC/Sub-Committees are for the sole and confidential use of Vantage Health Plan and are protected by applicable federal and state law.

J. Recording of Meeting and Dissemination of Action

- All QIC minutes are dated and reflect all committee decisions made.
- Meeting minutes and all documentation used by the QIC are the sole property of Vantage and are strictly confidential
- A written agenda, usually in the form of the Work Plan, will be used for each meeting
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up required and evaluation of activities
- All unresolved issue/action items are tracked in the minutes until resolved
- The minutes and all case related correspondence are maintained in the QI Department

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

The dissemination of QIC information and findings to practitioners may take various forms. These methods may include but not limited to:

- Informal one-on-one meetings
- Formal medical educational meetings
- Vantage newsletters
- Provider Relations and Physician Reports
- Vantage Practitioner Secured Web Site
- Minutes of relevant QIC meetings to the Governing Board
- Participation and reporting to the Vantage Utilization Review/Quality Management Committee

VIII. Sub-Committees

A. Compliance Committee

The Compliance Committee is involved in implementing, maintaining, and revising the compliance program under the leadership of the Medicare Compliance Officer. The Compliance Committee is also responsible for overseeing the organization's fraud, waste, and abuse program. The members of the committee include individuals with a variety of backgrounds who understand the vulnerabilities within their respective areas of expertise. Scope (includes but not limited to):

- Develop strategies to promote compliance and the detection of any potential violations
- Monitoring and auditing of any potential regulatory environment and/or specific risk areas within Vantage
- Reviewing existing policies and procedures and assisting in the development of new policies and procedures as warranted
- Developing the Code of Conduct for all staff of Vantage (executive, management, and support staff) including the facilitation of organization-wide communication regarding adherence to the Code of Conduct, operational policies and procedures, and state and federal laws and regulation
- Recommending and monitoring the development of internal systems and controls to reduce compliance violations
- Assist with the creation and implementation of the monitoring and auditing work plan
- Ensure that compliance and fraud, waste and abuse training and education are appropriately administered to employees, first tier, downstream, and related entities ("FDRs"), and Business Associates, as applicable
- Assist in the creation of effective corrective action plans and ensure that they are implemented and monitored
- Support the Medicare Compliance Officer's needs for sufficient staff and resources to carry out his or her duties

- Ensure there is a system for employees, FDRs, and Business Associates to report potential compliance violations and/or instances of fraud, waste or abuse confidentially or anonymously (if desired) without fear of retaliation
- Review and approve the Compliance Plan and other related compliance oversight activities (i.e. audit calendar)
- Ensure that training and education are appropriately completed
- Provider regular and ad hoc reports on the activities and status of the Compliance Program, including issues identified, investigated, and resolved by the Compliance Committee with recommendations to Vantage's Board of Directors to ensure the governing body is knowledgeable about the content of operation of the Compliance Program so that the Board is able to exercise appropriate oversight with respect to the implementation and effectiveness of the Program

The Director of Compliance and the Medicare Compliance Officer shall co-chair the Compliance Committee.

Membership
Standing members of the Compliance Committee include, but are not limited to, the following:

- Director of Compliance, Co-Chair
- Medicare Compliance Officer, Co-Chair
- Chief Executive Officer
- Executive Vice President
- Chief Financial Officer
- Medical Director
- Director of Medical Management
- Director of Marketing
- Director of Member Services/Commercial Enrollment
- Director of Provider Networking
- Controller
- Chief Human Resources Officer
- General Counsel
- Chief Information Officer
- Product Manager
- Board of Directors Representative

The Compliance Committee shall formally meet on a quarterly basis, or more frequently as necessary. All Compliance Committee activities shall be recorded in minutes that are maintained in files under the direct control of the Medicare Compliance Officer. The Medicare Compliance Officer presents Compliance Committee activities to Vantage's Board of Directors and CEO.

B. Credentialing Committee

The Credentialing Committee is delegated the responsibility of monitoring credentialing, and recredentialing activities. Credentialing verifies that each organizational provider is

accredited. If an organizational provider is not accredited, Vantage (Networking Dept.) performs a site visit. In re-credentialing, if a PCP has not had a site visit in the last 5 years, Vantage performs a site visit; Recredentialing also verifies that each organizational provider is accredited. If not, Vantage performs a site visit. This information is kept in each providers' credentialing file. The scope (includes but not limited to):

1. Reviewing, recommending, approving or denying initial credentialing, recredentialing and continuous monitoring of practitioners/providers
2. Assuring compliance with the requirements of accrediting and regulatory agencies, included but not limited to, CMS, LDOI, NCQA, and the applicable regulatory agencies of all other states in which a Vantage-affiliated health plan would be licensed at doing business.
3. Ensuring approved practitioner reports are forwarded to Vantage's Board of Directors
4. Ensuring Fair Hearing Procedures are offered and carried out in accordance with approved policies and procedures (non-discriminatory actions while the committee members review provider files for approval)

The CEO/Medical Director shall chair the Credentialing Committee.

Membership

- Primary Care Practitioners
- Specialty Care Practitioners
- Medical Directors

C. Network Development Committee

Charged with the responsibility of determining if additional providers of services are needed in the parish or county where Vantage-affiliated health plans are licensed to conduct business. This committee has the authority to recommend mailing applications to potential providers.

At least 4 members:

- Medical Directors
- General Counsel
- Executive Vice President

D. Utilization Management/Quality Management (URQM) Committee

The Utilization Management/Quality Management (URQM) Committee is delegated the responsibility of monitoring both utilization review (Observation, Inpatient, Outpatient, continued stay and focused reviews), review of claim denials and case management. Scope (includes but not limited to):

1. Identify and monitor over-utilization and under-utilization of services
2. Identify and monitor utilization patterns that compromise member health and safety, inappropriately use resources and represent organizational risk
3. Evaluate consistent use of medical necessity including criteria used, information sources and review process used to approve the provision of services

4. Review initial and ongoing eligibility determinations and initial and continued service authorization decisions
5. Provide support to other organizational functions
6. Review and discuss quality data; identify potential QI projects

Membership

- Medical Management Supervisor
- Medical Management Director
- CEO/Medical Director
- Other qualified, licensed Practitioners from a broad spectrum of specialists

The CEO/Medical Director shall chair the URQM Committee.

E. Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee is delegated the responsibility of recommending policy action related to pharmaceutical management and oversight of the delegated PBM. The scope (includes but not limited to):

1. Minimize the adverse events and side effects of pharmaceuticals
2. Maximize the therapeutic outcomes of pharmaceuticals
3. Evaluate and promote use of cost effective pharmaceuticals
4. Reviewing and making recommendations regarding:
   a. Requests for prescription drug benefit changes
   b. Formulary development, review and maintenance
   c. Criteria for utilization management tools (prior authorization, step therapy, quantity limits)
   d. Practice guidelines as they relate to pharmaceuticals
   e. Responsibilities delegated to pharmacy benefits manager
   f. Drug utilization reviews (DUR) activities
   g. Disease Management programs (Diabetes & Heart Failure)

Membership

- CEO/Medical Director
- Medical Directors
- Pharmacists

The Pharmacy Services Director shall chair the P&T Committee.

F. Dual Special Needs Plan Quality Committee (D-SNP QC)

The Dual Special Needs Plan Quality Committee is delegated the responsibility of developing, guiding and coordinating SNP Case Management quality improvement activities. The SNP Case Management Program serves as the health plan's Complex Case Management Program. The scope (includes but not limited to):

1. Quality oversight of the D-SNP program through monitoring and evaluation of the Model of Care's (MOC) effectiveness

2. Evaluates metrics and goals to ensure they continue to be relevant and applicable to the D-SNP program
3. Assess and track the MOC's impact on member health outcomes
4. Conducts an annual evaluation of the MOC, Health Risk Assessment (HRA), and SNP Case Management Program to measure effectiveness

Membership

- Chief Medical Officer
- Medical Director of Health Management
- Compliance Director
- Medicare Compliance Officer
- Integrated Care Director
- Integrated Care Manager
- Integrated Care Supervisor
- SNP Case Management Coordinator
- Pharmacy
- Behavioral Health/Social Services
- Quality Improvement Specialist/Business Quality Analyst
- Population Health-Nurse Practitioner

The Integrated Care Manager shall chair the Dual SNP Quality Committee.

H. Interdisciplinary Care Team (ICT)

The Interdisciplinary Care Team is delegated the responsibility of assisting in the development, completion, and modification of comprehensive, individualized care plans that include prioritized goals and measurable objectives for each Special Needs Plan beneficiary and other beneficiaries enrolled in other case management programs. The scope (includes but not limited to):

1. Reviews and discusses SNP case management cases for health and resource needs
2. Assists with care plan development and coordination of services and approves care plans for SNP members
3. Identifies and addresses specific barriers to health care
4. Monitor member's progress towards goals and objectives
5. Facilitate timely access to appropriate services by collaboration

Membership

- Medical Director of Health Management
- Integrated Care Director
- Integrated Care Manager

- Integrated Care Supervisor
- SNP Case Management Coordinator
- SNP RN Case Managers
- Population Health--Nurse Practitioner
- Social Services Case Manager
- Behavioral Health Case Manager
- Optional attendees based upon need

The Integrated Care Supervisor shall chair the Interdisciplinary Care Team.

IX. Medical Directors

A team of Medical Directors, primarily Family Practice specialists, serves as expert consultants retained by Vantage. The team reports to Vantage's CEO/Medical Director. Additional expert consultants in other specialties are engaged as needed.

- Internal Medicine
- Behavioral Health
- Neurosurgery
- Orthopedic Surgery
- EENT
- Urology
- Cardiology

Role of Team
Medical Directors guide the development and integration of Medical/Behavioral Management, Care Management and Utilization Management programs. As an aggregate body, the Medical Directors are involved in all clinically-related activities. They provide medical/clinical expertise for utilization and case management questions as they arise in daily operations. The team also assists their peers with interpretation of policies adopted by the Governing Board.

Individual Responsibilities
On an individual basis, Vantage Medical Directors assume responsibility, relevant to their specialty or expertise, for several specific functions:

- Evaluate appropriateness of requests for out-of-plan referrals, inpatient admissions and other pre-certifications
- Review and critiques health education materials developed for physicians and members, and assure consistency of content with approved clinical guidelines
- Review clinical appeals from physicians and members
- Enhance direct communication with providers (e.g. prescription drug profiling, performance feedback, medical expense profiling)
- Participation in selection or development of clinical practice guidelines

- Advise nurse case managers on clinically pertinent aspects of care
- Investigate reported quality of care cases and take/recommend action as appropriate
- Review and critique the Quality Improvement Program Description, Annual Quality Improvement Work Plan, Annual Quality Improvement Program Evaluation, The Utilization/Case management Program Description and NCQA Performance Analytics documentation
- Contribute to implementation of regulatory agencies quality programs (QIP/CCIP/D-SNP/QIS)
- Provide input into the development and review of Medical Policy guidelines for claims payment

Medical Directors also influence Quality Improvement activities by actively participating in leadership/member roles as described with the Quality Improvement Committee, Compliance Committee, Appeals/Grievance Committee, P&T Committee and URQM Committee.

X. Executive/Administrative Staff

Vantage's Executive Team and Administrative Staff is the leadership team responsible for coordinating interdepartmental and cross-product activities, including operations and service improvement activities. The Executive Team consists of Vantage's CEO/Medical Director, Executive Vice President, Chief Financial Officer and General Counsel. The Administrative Staff includes Directors/Supervisors/ Coordinators/Managers. They meet at least bi-monthly as part of the Quality Improvement Committee. These key management positions, with their specific accountabilities are listed below.

A. Executive Team

CEO/Medical Director – Oversight of Administrative Staff/Medical Directors and directs Vantage in its mission and objectives to promote delivery of high quality health care and services to plan members in all markets and is responsible for implementation of the Quality Improvement Program activities. The Medical Director works in conjunction with the Business Process Manager to develop, implement and evaluate the Quality Improvement Program.

Executive Vice President – Assists in directing Vantage in its mission and objectives to promote delivery of high quality health care and services to plan members in all markets; long-range business planning and development. Responsible for maximizing Vantages' operating performance and achieving its financial goals. Has a broad array of responsibilities ranging from communicating with the board of directors to preparing operating budgets to overseeing a strategic plan.

Chief Financial Officer – Accountable for Vantage's financial performance, long-range business planning and development, responsible for accounting and tax functions, subrogation and accounts receivable, consistently administers plan policies, procedures and practices within Financial/Accounting department in accordance with current federal and

state requirements, responsible for assuring adequate resources and staffing is available for the Quality Improvement Program.
General Counsel - General Counsel researches local, state and federal laws that govern health plans. Duties range from developing legal processes that enforce corporate compliance to reviewing practitioner contracts, company publications, real estate contracts, and business purchases for potential liabilities. Works closely with other lawyers, legislative bodies and government officials on the legal rights of our members and Vantage. Also gathers evidence and legal information for court cases, represents Vantage in litigation and recommends courses of action for business transactions related to all Vantage entities.

B. Administrative Staff

Business Process Manager – Provides ongoing and documented assessment of all aspects of the quality improvement program. Directs the organization's compliance regarding NCQA standards. Oversees the Quality Improvement committee meetings and monitors progress with QI initiatives. Provides support about NCQA standard interpretation and serves as liaison between VHP and NCQA.
Medical Management Director – Manages ongoing assessment of all aspects of patient care to ensure coordinated delivery of high quality, safe, and cost-effective medical and behavioral health care to all Vantage members; oversees resolution of problems throughout the member appeal process; ensures member satisfaction with case management; administers plan policies, procedures, and practices appropriately throughout the Medical Management Department.

- Utilization Management Department – The UM Department frequently identifies potential risk management, quality of care issues, and health education needs through case management, inpatient review, utilization review, referrals, etc.

Integrated Care (IC) Director, IC Manager, IC Supervisor– Oversee care management programs administered by the Integrated Care Department. These include: Behavioral Health Care Management, Care Management (for medical conditions), Special Needs Plan Care Management, Social Services Care Management and Transitional Care. Areas of focus for Integrated Care include: improved adherence to treatment recommendations and medication compliance, reduced behavioral health inpatient hospitalization and inappropriate ED utilization, increased self-management of chronic or complex illnesses, and lower healthcare costs.
Home Health Manager—Oversees Home Health program and ensures timely contact with those members and works to manage care in an effort to avoid readmission/hospitalization.
Director of Network Development and Shared Savings – Manages Vantage's provider network of Shared Savings groups and qualified practitioners and provider facilities including contracting for delegated credentialing; ensures responsive, accurate information to provider inquires, responsible for member satisfaction with Vantage's practitioners and providers; consistently administers plan policies, procedures, and practices within Provider Relations. Provider Relations includes Network Development, Provider Services and Credentialing. They provide Facility site review scores and any sanction activity related to these reviews. They also review and manage both Practitioner and Practitioner Office Site

grievances. and assist in obtaining QI information from and disseminating information to practitioners.

Marketing/Member Services/Enrollment Director –

- *Member Services*: Manages operation of large-volume call center for member/provider/broker/personal representative inquiries regarding benefits and coverage; ensure member satisfaction with non-clinical Vantage issues; ensure member reimbursements are processed correctly and timely.
- *Marketing*: Implements strategic marketing plans; maintains brokerage relationships; ensures Vantage's compliance with state specific Departments of Insurance regulations for sales; consistently applies plan policies, procedures, and practices within the Member Services and Marketing Departments.
- *Enrollment:* Manages the operation of Commercial Group Enrollment and Exchange Enrollments; including monitoring data sharing with our pharmacy benefit manager; ensures quality by monitoring error ratio to input as well as adherence to departmental/company policy and procedures.

Health Risk Management (Pharmacy) Director – Manages Vantage's retail pharmacy, responsible for all Disease Management programs; ensures member satisfaction with PBM program; manages, evaluates and promotes the use of cost effective pharmaceuticals; consistently applies plan policies, procedures, and practices within the Pharmacy Department.

- Pharmacy Department – The Pharmacy Department oversees disease management and study projects. The pharmacy department supports the process of conducting pharmacy reports related to the PBM and safety.

Claims Director – Responsible for the processing and payment of claims on the basis of the coverage of the member, ensures claims are valid, resolve claims issues, and consistently manages the Claims Department in accordance with plan policies, procedures, and practices.

Chief Information /Security Officer – Responsible for performance, integrity, security and user satisfaction with the Financial, Medical/Case Management, Pharmaceutical HIT, Telecommunications and networked systems; ensures the automated systems contribute to Vantage's mission; oversees functional operations and compliance with federal, state and local standards, guidelines and regulation governing the facility; maintains practitioner/ provider data base and fee schedules; responsible for claims system configuration, consistently manages the Information Systems Department in accordance with plan policies, procedures, and practices.

Controller/Senior Accountants – Responsible for interpreting the Generally Accepted Accounting Principles (GAAP), responsible for monthly/quarterly/annual close process, consolidated financial statements, is an integral part of the budgeting process, consistently applies policies, procedures, and practices within the Accounting department.

Chief Human Resources Officer – Develops and implements human resource policies and practices that are in concert with Vantage's objectives, philosophy and regulatory requirements, including salary/wage program, staff education/training, morale programs and employee relations, consistently applies policies, procedures, and practices within the Human Resource department.

Additional Operational Management staff members, accountable to either the Executive Team or the directors listed above, include management from Population Health, Product Management, Medicare Benefits, Compliance, Provider Services, Provider Credentialing, and Behavioral Health Manager.

XI. Interdepartmental Coordination of Quality

Interdepartmental coordination is facilitated by each Director. Additionally, all Directors and certain department coordinators/supervisors meet regularly as members of the QI Committees to coordinate activities across departments.

In developing and prioritizing quality improvement initiatives, directors and mangers relay on information from other departments, as well as Vantage's QI Program Evaluation. Following are some of the most commonly referenced information sources and reports:

CAHPS ® Surveys	HEDIS® data
Health Outcome Survey (HOS®)	Provider Satisfaction Surveys
Member Services Survey	Reports from Delegated Entities
Appeal/Grievances	Provider Appeals/Inquiries
Member Complaints	Access and Availability Report
Employer Groups	Case Management Satisfaction
Enrollment Meetings	Prescription Drug Utilization data
Regulatory Agency Projects	UM Program Description

XII. Integration of Quality Improvement with Corporate Goals

Communication is critical to assure that each employee is aware of how his or her contributions meld into Vantage's overall goals for member service and continuous quality improvement. Meetings can be held to share information and keep all employees focused on these goals. Appropriate horizontal communication is encouraged to improve interdepartmental problem solving and to assist in prompt problem resolution for improved customer service and satisfaction.

XIII. Scope of Activities

A. Improvement of Clinical Quality

1. Dual-Eligible Special Needs Plan (SNP) Care Management Program

The purpose of Vantage Health Plan's Dual Eligible Special Needs Plan (D-SNP) Care Management Program is to ensure that SNP beneficiaries' healthcare needs and preferences for health services are met over time. Care management will help to maximize the use of effective, efficient, and high-quality care that will lead to improved health outcomes. The SNP Care Management Program includes the delivery of services and benefits for members who are potentially medically complex, have multiple chronic conditions, and are disabled or facing psychosocial or socioeconomic difficulties. All Vantage D-SNP enrollees are enrolled in SNP

Care Management (SNP CM), but members may choose their level of participation as either an active or passive status.

The SNP Care Management Program includes an annual Health Risk Assessment that is conducted in-home by a Nurse Practitioner, by the member's PCP in his/her clinic, via telephone a comprehensive initial assessment of the member's condition and history by the care manager, determination of available benefits and resources, and the development and implementation of an individualized care plan. Vantage's care management plans consist of performance goals, monitoring of the member's adherence and progress, and follow-up planning for ongoing support. Care management plans are focused on the delivery of appropriate healthcare services for members with complex, acute, and chronic care needs. The program provides an opportunity for early intervention with new and existing members so that services can be provided timely and in a satisfactory manner for the members and the members' physicians.

The care manager manages the member's condition and comorbidities, assesses and identifies issues that directly and indirectly affect the member's ability to access care, and monitors the member's adherence to treatment plans as prescribed. In close collaboration with the member, caregivers, health care providers and the Interdisciplinary Care Team (ICT), Vantage's SNP Care Management Program supports and reinforces the individualized treatment plan, provides education, and coordinates available services. Shared Savings Partners may also assist with providing and documenting care coordination for SNP members who receive healthcare treatment from their providers.

2. **Integrated Care Management Program**

   Care Management programs are designed for members who may have less complicated chronic conditions but have a risk for developing other conditions or complications and have a need for care coordination. Vantage's Care Management programs focus on conditions that require monitoring and education to help members manage their health by providing support, basic education, coordination of services, and assistance locating resources. Enrollment in Care Management is not limited to any particular diagnosis. Members who require assistance to access medical/behavioral health care, coordination of services, health education, and assistance locating resources, may benefit from Care Management. This may include members with chronic or complex heath conditions, including behavioral health and substance use disorders, frequent hospitalizations, inappropriate emergency room use, post-hospital discharge issues, or uncontrolled, unmanaged health issues.

3. **Behavioral Health Care**

   As with all aspects of health care, Vantage utilizes the same quality improvement process described throughout this program description to ensure that behavioral health is targeted as intensely as is physical health. Vantage does not delegate management of behavioral care to any other entity, preferring instead to promote, monitor and coordinate comprehensive clinical care. Vantage works in conjunction with our Medical Director of Health Management to design, implement, monitor and improve behavioral health care policies/procedures and services to our members.

All members have direct access to behavioral health practitioners; however, referral by PCP's is encouraged as a means to coordinate care, especially where medication is concerned. Vantage does not operate a centralized triage service.

4. **Population Health Management**

   The focus of the Population Health Department is to address members' needs across the continuum of care; preventing disease or progression of disease, prolonging quality of life, and promoting health through organized efforts. There are 4 goals:

   1. Keeping members healthy
   2. Managing members with emerging risks
   3. Improving patient safety or outcomes across healthcare settings
   4. Managing multiple chronic illnesses

   For each of these 4 goals, there is a measurable goal, a description of the targeted population, and a description of a program or service provided for each areas of focus. Additional community resources and services are identified to assist in achieving member goals. Current projects include:

   - Increasing the percentage of members who receive an annual wellness exam
   - Increasing the percentage of members who receive an annual flu vaccination
   - Increasing the percentage of female members who receive breast cancer screening
   - Increasing the percentage of members receiving a colorectal cancer screening

5. **Chronic Care Improvement Project (CCIP)**

   The general CCIP had a cycle end date of December 2018 and was previously aligned with the SNP QIP with the element of disease specific focus. The new program for the 2019-2022 cycle is centered on behavioral health diagnoses and will be aligned with company and industry-wide initiatives for managing mental health. The focus of the CCIP is improving medical and behavioral health coordination and continuity of care through a targeted strategy of identifying members diagnosed with behavioral health disorders such as schizophrenia, depression, bipolar disorder, and anxiety then monitoring these members to identify opportunities to improve transitional care. This meets the CMS requirement of promoting effective management of chronic disease, improving care and health outcomes for this population. Effective management of chronic conditions serves to reduce preventable emergency room encounters and inpatient stays, improve quality of life, and save costs for the health plan as well as the enrollee.

6. **Medicare Special Needs Plan (SNP) Quality Improvement Project (QIP) and Chronic Care Improvement Project (CCIP)**

   The focus of this project is improving adherence to statins, oral antidiabetics, and anti-hypertensives in an effort to improve health outcomes and treatment of chronic disease, thereby meeting CMS Quality Strategy Goal #4.

7. **Exchange Quality Improvement Strategy**

   In accordance with the Affordable Care Act section entitled "Rewarding Quality Through Market-Based Incentives", an eligible issuer participating in a Marketplace for two or more consecutive years must implement and report on a quality improvement strategy (QIS). A QIS should incentivize quality by tying

payments to performance measures when providers meet specific quality goals. A QIS may also tie payments to measures related to incentivizing enrollees to make certain choices or exhibit behaviors associated with improved health.
Requirements:

1. Implement a QIS, described as a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees
2. Include at least one of the following in the QIS:
    - Activities for improving health outcomes
    - Activities to prevent hospital readmissions
    - Activities to improve patient safety and reduce medical errors
    - Activities for wellness and health promotion
    - Activities to reduce health and healthcare disparities
3. Report on progress implementing the QIS to the applicable Marketplace on a periodic basis.

The current QIS is a Wellness Coupon Program designed to increase the percentage of annual Wellness exams in this targeted population.

8. Quality of Care

Quality of Care (QOC) is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. On a continual basis, clinically-related complaints and concerns are evaluated according to a defined procedure as a means to maintain the high level of quality in care received by Vantage members.
Along with member complaints and those voiced by practitioners or providers, all employees are responsible for reporting perceived Quality of Care concerns. They are referred to designated staff within the Quality Improvement department and reviewed by the CEO/Medical director. Reported issues (both perceived and realized) are investigated for actual or potential problems, tracked, monitored, and when appropriate, corrective action is initiated.

9. Patient Safety

Vantage promotes a comprehensive strategy to assure patient safety by partnering with members, practitioners, hospitals, ancillary providers and pharmacies. Education and risk-awareness are central to this on-going program, along with assessment of practitioners' patient safety initiatives. Medication safety is evaluated in the PBM report and acted upon accordingly. Drug recalls, market withdrawals, and so forth are monitored on a continual basis and addressed as part of the delegated services delivered by Vantage's Pharmacy Benefit Manager (PBM) – Navitus. In addition, Vantage pharmacists and the P&T committee review concurrent and retroactive drug utilization reports from the PBM as well as review and update the closed formulary on an annual basis.
Comprehensive medication reviews (CMR's) are offered to all members to identify medication-related problems. Interventions may include dosing adjustments, elimination of duplicate therapies, education regarding medication adherence, identification of therapeutic substitution opportunities, etc.
Practitioners utilize a computerized order system for medication orders. Any

potential safety concerns identified by complaints or member surveys are followed up timely. Vantage strives to improve continuity and coordination of care between practitioners and sites of care to avoid miscommunication or delays in care that may lead to poor outcomes; this is being addressed through the use of an electronic health record when available, transitional case management, complex case management, and disease management.

Continuity and coordination of medical/medical to behavioral health care are recognized as integral elements of patient safety, by omission and commission.

10. Cultural and Linguistically Diverse Member Needs

Vantage staff who work directly with members and potential members are educated on using Language Line telephone interpreting services both in the field and the office. Currently less than 1% of Vantage's membership has a primary language other than English. The use of the Language Line is monitored routinely by the Member Services Auditing team to ensure members are getting the information they need in the language they understand. Vantage materials can be professionally translated as needed, and many alternate language health education resources are available as website links and in print from case managers.

Member survey response, as well as any complaints regarding cultural or ethnic issues are reviewed and followed up on timely. The members are assessed annually for cultural, ethnic, racial, and linguistic needs and preferences. U.S. Census data is also reviewed to assist in determining any cultural or ethnic needs on the community.

Upon enrollment into complex case management, care management, diabetes disease management, and heart failure management, members are assessed as to religious, cultural, or language needs or preferences in order to best meet their needs.

11. Promotion of Member Wellness

Education and self-management are essential factors in achieving and maintaining one's well-being, but it is also important to recognize their status quo in order to set goals. Health Appraisal tools (electronic and printed) are available to all Vantage members, along with incentives for completing. Beyond self-assessment, Vantage offers a wide variety of interactive resources/self-management tools for members such as weight management, smoking cessation, blood pressure control, back and neck care, and fitness.

12. Healthcare Effectiveness Data and Information Set ® (HEDIS)

HEDIS® is a core set of performance measures originally developed in response to employers' need to compare health plans and now serving as the industry standard. Through detailed specifications for deriving performance measures, HEDIS ® provides commonly accepted methods for evaluating and trending health plan performance. Although many measures are captured as a hybrid of claims data and medical record reviews, most are collected as administrative-only data from claims and enrollment records. Results of the annual measurements are utilized for a myriad of internal and external performance indicators as described throughout the QI Work Plan and Program Evaluation.

To generate and manage HEDIS ® data, Vantage utilizes NCQA-certified software with abstraction directly into the loaded application. Audited reports are submitted

to NCQA annually for each of Vantage's product lines. The reporting process and results undergo a rigorous external audit by an NCQA-approved auditor each year.

13. Medicare Health Outcomes Survey (HOS ®) and Qualified Health Plans Survey (QHP®)

Annually, the HOS and QHP surveys are conducted as an adjunct to HEDIS®/CAHPS® reporting. The HOS captures a Medicare managed care plan's ability to maintain or improve the health of its member over time. The survey queries member's physical and mental health status, with appropriate risk-adjustment, at the beginning and end of a two-year period. The QHP survey is conducted annually for Vantage's Marketplace membership. This survey provides the opportunity for the member to share their perspective on the services Vantage offers for their plan. Findings from both surveys are used to contribute to the selection and prioritization of health care interventions, process improvements, and quality improvement strategies for Vantage's membership.

14. Disease Management

Vantage has developed a proactive Disease Management Program which is overseen by the Health Risk Management Department. All related policies and procedures and clinical measurements can be found in the Health Risk Management Department. We have two DM programs in place: Congestive Heart Disease and Diabetes. Semi-annual monitoring of one indicator per program and the participation rates are reported and analyzed and an annual evaluation of the three programs along with member satisfaction with the programs are performed.

15. Inter-Rater Reliability

Inter-rater reliability review is performed on UM decisions as needed, at least quarterly, to access the reliability of the application of Interqual criteria to all UM decisions by physicians as well as the nursing staff. As opportunities are identified, potential strategies for improvement are implemented, then the reliability is rechecked based upon those actions.

16. Continuity and Coordination of Care

The Medical Management and Care Management Departments ensures the continuity and coordination of care that our members receive. This is measured through routine Electronic Medical Record (EMR) review, comprehensive assessments, grievance reviews and member satisfaction surveys. This collaborative information is tracked and analyzed to identify opportunities for improvement. When a practitioner discontinues a contract with Vantage a member can continue with that practitioner for care for the remainder of active treatment or 90 days, whichever is shorter. Members with a second or third trimester pregnancy have access to their discontinued practitioner through the post-partum period. As an on-going activity, Vantage notifies members affected by the termination of a practitioner or practice group in general, family and internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, or as soon as possible if a practitioner fails to notify Vantage a minimum of 30 days before the effective date and helps them select a new practitioner. Additionally, as part of the Continuity and Coordination of Care process, the organization assists with a member's transition to other care.

17. Medication Therapy Management Program

Vantage's Medication Therapy Management (MTM) Program aligns closely with the other Vantage drug benefit programs (Vantage Medication Adherence Program (VMAP), Disease Management (DM), St. John Mail Order Pharmacy) to collectively improve our Part D and HEDIS measures. With a strong focus on improving medication adherence, these programs are designed to ultimately prevent the progression of chronic health conditions affecting our Medicare population. MTMP Annual Comprehensive Medication Review (CMR): Annual CMRs are completed as a one-on-one interaction with a qualified MTM provider and are typically completed via telephonic consultation but may also be completed through face-to-face or telehealth means with the beneficiary or their caregiver, provider or other authorized individual. During each interaction, the clinical interviewer reviews each member's medications, conducts a full medication reconciliation, that includes prescription, OTC, vitamins, and herbals, and evaluates appropriateness of therapy. Additionally, other pertinent subjective information is gathered from the beneficiary and gaps in knowledge are filled in for the beneficiary where appropriate. If a clinician determines it is necessary, an outreach for clinical objective information may be made to the member's primary care provider. Information collected provides the qualified MTM provider with the information needed to make an assessment and provide recommendations to optimize the member's care. MTM Program Targeted Medication Reviews (TMRs): All MTM eligible beneficiaries who have not opted out of the MTMP, including those who choose to participate in a CMR as well as those who do not choose to participate in the CMR, are included in ongoing TMR analysis on at least a quarterly basis. TMRs identify potential medication-related problems like non-adherence to prescribed medications, gaps in care to national consensus treatment guidelines, safety concerns and cost savings opportunities through systematic drug utilization review. When care gaps or recommendations exist, prescribers receive a faxed TMR Recommendation letter, regardless of the beneficiary's level of interaction. The TMRs will monitor whether there are any unresolved medication related problems that need attention through the evaluation of pharmacy claims data.

B. Quality Improvement Among Practitioners and Providers

1. Patient Satisfaction with Practitioners

As a complement to access and complaint analyses, Vantage will occasionally survey member's experiences with practitioners. From year to year, the focal practitioners will vary, depending on complaints, current issues, and more. Survey questions will include topics more specific to member's encounters than with CAHPS®, with data attributed to and shared with the relevant practitioners.

2. Public Reporting of Performance

Vantage encourages members and practitioners to avail themselves of publicly reported information on provider performance. Although these sources are not suitable for credentialing, many do offer valuable consumer information.

Examples include CMS "Hospital Compare", The Joint Commission, URAC, NCQA and both Louisiana and Arkansas state medical boards. Selected data from these national sources are occasionally used to compare Vantage practitioners/providers with industry benchmarks and with one another.

3. Practitioner Credentialing

All physicians and non-physician practitioners who require credentialing participate in a three (3) year credentialing cycle and are subject to ongoing review for sanctions, licensure limitations and grievances/complaints.

The Credentialing Committee's recommendations for recredentialing are based on the practitioner meeting established criteria. Consideration is given to these other important quality-related issues:

- Member grievances
- Quality of care issues (number, severity, and responsiveness to correction)
- Review of referral compliance and corrective action issues

4. Provider Contracting and Assessment

A three (3) year assessment cycle, utilized to confirm good standing with state and federal regulatory bodies and current Performance Analytics status, provides assurance that providers meet high levels of quality in the care, patient safety and services they render to Vantage members. Provider facilities include, but are not limited to, Hospitals, Skilled Nursing Facilities, Home Health Agencies, and Free-standing Surgical Centers. They are often referred to as organizational providers.

C. Improving Quality in Administrative Functions

1. Delegated Activities

Vantage delegates responsibilities for specific functional activities in our Credentialing, Pharmacy, and Utilization Management departments. Vantage does not delegate QI activities to any of its contracted delegates.

Vantage maintains accountability and ultimate responsibility for the delegated activities by overseeing performance in the following areas: Utilization Management, Quality Improvement, Credentialing. Delegated functions include, but are not limited to, independent review of medical records, pharmacy benefit management and credentialing/recredentialing. Non-delegated functions include CAHPS® studies. Delegates will be required to have a functioning quality improvement program in place. Vantage retains the right to revoke any delegated function if compliance with standards is not met.

Vantage has a process in place to assess and ensure that the delegates have the capability to perform the delegated function/activity. The regulations and requirements of NCQA, LDOI, CMS, and the applicable regulatory agencies of all other states in which a Vantage-affiliated health plan is licensed to conduct business are used to evaluate and determine the delegate's potential for delegation of functions/activities. An initial assessment is conducted pre-contractually to determine the delegate's ability to provide delegated services and at least annually thereafter.

The Credentialing, Pharmacy Services and Utilization Management departments

continuously monitor the delegates' compliance with required submission of all corrective action plans, reports, audits, studies, and evaluations. All submissions are reviewed for quality, timeliness, and completeness of required information. It is the responsibility of the appropriate Vantage department to monitor implementation of corrective action plans. Each Vantage department with delegated functions maintains individual files on each delegate to document all submissions and correspondence.

Vantage promotes a collaborative, supportive, relationship with its contracted delegates. Each department works closely with its delegates to facilitate effective delegation oversight. Any compliance issues are reported to the appropriate committee for recommendations and action.

2. Availability of Practitioners

In creating and developing our delivery system of practitioners, Vantage takes into consideration assessed special and culture needs and preferences of our members. Vantage established availability of primary care, specialty care, behavioral health, hospital based and other healthcare practitioners by:

a. Ensuring that standards are in place to define practitioners who serve as primary care practitioners (Family Practice, Pediatrics, General Practice and Internal Medicine)
b. Ensuring standards are in place to define practitioners who serve as specialty practitioners (OB/GYN, Cardiovascular Disease, Gastroenterology, neurology, ENT, etc.)
c. Ensuring that standards are in place to define practitioners who serve as behavioral health care practitioners (Psychiatrists, LMFTs, Counselors, Clinical Social Workers, etc.)
d. Each member can choose their PCP but for those who do not they must be assigned to a practitioner within 60 miles of their home unless specially requested by the member or family
e. Each member should be referred to a specialist within 60 miles of their home unless specially requested by the member or family
f. Ensuring a database is in place which analyzes practitioner availability and ability to meet the special culture/linguistics need of our members
g. Ensuring members are within 15 miles or 15 minutes of a contracted hospital and ancillary service
h. Members are directed to transportation services where available
i. Vantage has processes in place for member requests of special culture and linguistic needs
j. Vantage will annually review and measure the effectiveness of these standards through specialized studies.

3. Access and Availability of Clinical Services

Accessibility and availability are evaluated annually for practitioners in high volume specialties including, but not limited to, obstetrics/gynecology and behavioral health. The combined Practitioner Availability and Access to Medical and Behavioral Health Care report is presented annually to the QI Standard and Scope Committee and Governing Board.

Access is defined as the extent to which a member can obtain available services at the time they are needed. This refers both to telephone access and the ability to obtain appointments. Access standards have been developed and adopted in accordance with NCQA Standards and include access to general medical care as well as behavioral health care. Vantage publishes the access standards in newsletters, on the website, and in member handbooks to ensure that members and practitioners are aware of these expectations. Compliance is assessed from patient satisfaction survey results, complaints and grievances, HEDIS® access measures, CAHPS® data, and other vehicles, such as an occasional secret shopper survey for appointments. Standards include, but not limited to:

- Preventive care appointments
- Regular and routine appointments
- Urgent care appointments
- Emergency care
- After hours care
- Wait times
- Member services by telephone
- 24-hour Nurse Line

Availability is the extent to which Vantage has secured the services of practitioners and providers of the appropriate types and number distributed geographically to meet the needs and preferences of the membership. Vantage monitors availability through several methods. Targets have been set for the percent of primary care practitioners with open practices and the continued recruitment of practitioners in all parishes. Data on practitioner-used languages other than English are routinely captured and published as a searchable field in the directories. If at any time an urgent case-specific or availability issues is identified, it is referred to the UM/CM Department for immediate resolution. Other member specific or practitioner/ provider specific issues are handled by the quality of care process described earlier.

4. Utilization of Health Care Services

A valuable tool for managing health care quality is a reliable system by which to balance volume of the services and resources delivered. Overutilization is wasteful and can even be harmful, such as excess exposure to radiation due to repeated diagnostic procedures. Underutilization can be an indication of poor use of resources, carelessness or other signals of less than acceptable health care quality.

5. Member Privacy and Confidentiality of Personal Health Information (PHI)

Vantage respects its members' right to privacy and is committed to protecting personal health information. Policies and procedures have been established to prevent unauthorized access to and use or disclosure of member information in accordance with HIPAA. Vantage maintains physical, electronic and procedural safeguards to protect members' health information. Internally, only authorized personnel who provide services to member accounts have access to PHI. Employees are trained to properly handle PHI and are required to sign an attestation, upon hire and annually, agreeing to abide by Vantage confidentiality policies.

Practitioners and third parties who perform contracted or delegated services are required to abide by terms set forth in their contracts with Vantage, a separate Business Associate Agreement and/or Confidentiality Agreement. Transmission

of PHI must be secured using accepted health information industry procedures such as encryption and passwords, for signature-required delivery of packages. Vantage reserves the right to share member information as allowed by law, i.e. Vantage can use and disclose PHI for treatment, payment and health operations activities. A member's written authorization is required prior to use or disclosure of PHI for any other purpose. Rights and responsibilities for PHI are shared with members and practitioners annually.

6. Complaints, Grievances, and Appeals

All members have the right to appeal an adverse decision associated with his or her care and/or file a grievance regarding any aspect of their health plan experience. Vantage maintains detailed policies and procedures specific to the complaint, grievance and appeal processes, ensuring they are compliant with regulations and legislation. The Appeals Team fully investigates all administrative appeals before presenting them for a determination. All clinical appeals are evaluated by our Medical Directors who issue rendering decisions concerning the appeal. The Grievance Team is responsible for researching all aspects of a member grievance. They collaborate with all operating teams within the company to investigate the grievance and issue a resolution to the member.

The complaint, grievance and appeals process is an important component of the Vantage Quality Improvement program. Through appropriate categorization of appeals, complaints and grievances, Vantage can differentiate between isolated problems and issues that are more systemic in nature. Annual reporting is provided as part of this analysis. These reports, with recommendations for mitigation and/or improvement, are reviewed by Vantage's QI committees.

7. Consumer Assessment of Healthcare Providers & Systems (CAHPS®)

Vantage utilizes various surveys to evaluate member satisfaction with their overall health care experience including the CAHPS®, QHP, and HOS Survey. An NCQA prescribed protocol defines the sampling and administration of the surveys, identifies approved vendors, requires an external audit of the process and outcomes, and specifies data submission to NCQA and the National CAHPS® Benchmarking Database (NCBD). All three survey administrations for Vantage members is conducted by NCQA–accredited MORPACE.

A summary of member satisfaction findings is reviewed by Vantage's Executive Administrative Staff, Quality committees and Governing Board, to enable the following tasks.

a. Identify and investigate sources of member dissatisfaction
b. Identify and implement follow-up action steps on the findings
c. Inform practitioners and members the survey results
d. Evaluate the effects of the interventional activities

8. Member Satisfaction with Vantage Health Plan's Services

Post-enrollment surveys are conducted by the Marketing Department staff to assure sufficient and appropriate information is shared with new members. In addition, complaints from new members are distinguished in order to identify possible opportunities to increase member understanding of the rights, benefits and Vantage procedures.

9. Quality of Care and Practitioner Office Site Satisfaction

The PR Credentialing Manager, Medical Director and Member Services management team review any grievances/complaints expressed regarding Quality of Care and Quality of Practitioner Office sites. Responses to these grievances/complaints are responded to by the Medical Director and are reviewed for compliance with Vantage's office practice standards.

10. Physician/Office Manager Satisfaction with Vantage

Vantage conducts Practitioner and Office Manager Satisfaction surveys. The Provider Relations Department sends the surveys annually to all credentialed practitioners. Responses to surveys are analyzed for opportunities to improve, with review by the Credentialing Committee.

The survey addresses topics such as the following:

- General satisfaction with Vantage
- Satisfaction with Inquiries, Credentialing and Re-credentialing, Claims Processing, appeals, Medical Review and Practitioner communication and Education
- Promptness and accuracy of claims payment

11. Operational Efficiency Strategies

Vantage works to identify potential projects, researching feasibility, and initiating change to improve operational efficiency. Examples of recent initiatives identified and implemented include a new internal claims workflow system for examiner routing and the enhanced portal functionality for our member, provider, and broker portals.

D. Support of Community Health Status and Public Health Goals

Vantage collaborates with community and government agencies to improve the health of its members and the community at large. This approach is demonstrated by Vantage's delivery or support of numerous community programs.

- Conduct senior health and wellness presentations as well as topics of interest twice monthly at the Council on Aging sites and Vantage Tower Banquet Room. Some of the topics include "Surgical and Non-Surgical Treatment of Hip and Knee Arthritis", "Age-Appropriate Nutritional Needs", "That Time of Year: Sinusitis and Rhinitis", "Neck Pain: Origins and Answers with Neuro Surgeon Alvernia".
- Present educational seminars at local gyms in a partnership with the SilverSneakers program. SilverSneakers is a fitness program provided at no cost by more than 70 health plans nationwide.

E. External Quality Improvement Programs

One of the goals of Vantage's Quality Improvement Program is to coordinate its activities with the requirements of state and federal regulatory bodies, such as the Louisiana Department of Insurance (LDOI), Centers for Medicare and Medicaid

Services (CMS), National Committee and Quality Assurance (NCQA), and any additional mandated industry reporting.

F. Ongoing Clinical Monitors and Studies

Based on data analysis and recommendations from the QIC and other related committees/work groups, relevant quality initiatives and monitors are identified for inclusion in the QI program. All departments are responsible for the QI processes (quantitative measurements, implementation of interventions, etc.) relating to these initiatives.