2018 Quality Management Program Description

Medicare Advantage

Gold, Platinum, and Elite Plans

Originally Approved by Virginia Premier Health Plan, Inc. Board of Directors and Healthcare Quality & Utilization Management (HQUM) Committee
(date)

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Effective: January 1, 2018

Purpose

Virginia Premier Health Plan's mission is to meet the needs of underserved and vulnerable populations in Virginia by delivering quality-driven, culturally sensitive, and financially viable healthcare. The Virginia Premier Health Plan Quality Program has an ongoing commitment to promote excellence in health care to all members, enhance personal wellness, continuously improve member experiences and outcomes, and to provide access to care in a safe, and culturally sensitive manner.

The Quality Management Program is designed to monitor and evaluate the care and services delivered by contracted practitioners, and affiliated providers across the full spectrum of services and sites of care. To ensure this purpose, Virginia Premier has implemented a comprehensive Quality Management Program for the Medicare Advantage population. The Quality Program described in this document strives to meet all standards set forth by the Centers for Medicare and Medicaid Services (CMS) and the Department of Medical Assistance Services (DMAS) in guiding the organization in its delivery of services to the Medicare population.

Oversight of the Virginia Premier Quality Program is provided by the Board of Directors through the Quality Committee structure. The committees' roles are to review, recommend, develop and implement best practices, to include clinical and service initiatives and improvement programs.

Scope

The Quality Program defines the strategy and framework needed to advance the CMS and DMAS quality efforts including defining the quality culture, model, and programs aligning with the CMS Quality Strategy and the Institute of Healthcare Improvement's Triple Aim. The Quality Program integrates aligned goals and objectives within clinical and non-clinical services provided to Virginia Premier's members across the continuum of care. The primary function of the program is to achieve improvement using the CMS mandated approach of Plan, Do, Study, Act while applying LEAN and Six Sigma principles and techniques. The Quality Program uses CMS, DMAS, and NCQA standards and guidelines to shape the Quality Program efforts.

Key Accomplishments for 2017

In 2017, the Medicare Advantage and Prescription Drug Plan (MAPD) kicked off with their first year with enrollment in the Elite plan which is a dual eligible Special Needs Plan (SNP). While enrollment was very low, starting in January with 11 members, it grew to over 170 members by December and jumped over 1,700 effective enrollment of January 1, 2018. The Gold and Platinum plans were launched with open enrollment beginning in October of 2017 for plan year 2018. This was a major accomplishment for Virginia Premier which has traditionally been dedicated to the Medicaid population.

Resources were added across the company to enable successful implementation of the new line of business including five full time employees in the Quality Department. Plans were developed to support all the needed services for a fully functioning MAPD plan. Some services were

delegated such as prescription benefit management (PBM), behavioral health services, dental and vision services, and others. Collaborative efforts ensured adequate provider and network access for primary care in all counties served and specialty care in the majority.

The Elite plan's Model of Care (MOC) achieved a score of 100 which is a rare accomplishment. The MOC was implemented with the 2017 members. Of the 172 active members, 98 were enrolled with active eligibility dates between January 1 and October 1 making them eligible for the HRA in 2017. Of the eligible members, 93% had a completed health risk assessment (HRA) and 67% with a completed plan of care (POC).

Changes to the 2018 Program Description

There are multiple changes to the program description. The primary change was the expansion of the description to include all three plans under the MAPD contract with interventions that span across all three where applicable. Where the interventions are specific to the Elite plan, it is indicated in the documentation. CMS views all three plans as one contract for reporting and quality management with the exception of the MOC quality improvement plan which has its own description.

Alignment of the Virginia Premier Quality goals and objectives with the CMS Quality Strategy was also added in this document. Revisions to roles and responsibilities were made along with a Quality Committee structure update. Several sections were expanded to include CMS requirements. Some general revisions to wording and information flow were also made.

2018 Quality Program's Goals

The ultimate goal of the Virginia Premier Medicare Advantage Quality Program is to achieve a five (5) Star Rating by ensuring the delivery of high quality culturally competent health care, particularly to members with identified health care disparities. This will be accomplished through operationalizing the following goals:

- Continuously strive to meet the organization's mission
- Continuously meet regulatory and accreditation requirements
- Create a system of improved health outcomes for the populations served
- Improve the overall quality of life of members through the continuous enhancement of comprehensive health management programs including:
    - Chronic Care Improvement Program
    - Quality Improvement Project
- Make care safer by reducing variation in practice and enhancing communication across the continuum
- Strengthen member and caregiver engagement in achieving quality health outcomes
- Ensure culturally competent care delivery through assessment of practitioner cultural education, and provision of information, training and tools to staff and practitioners to support culturally competent communication.

Each of these goals have objectives defined in this document and further defined in the Annual Work Plan attached to this description. Every objective has a measureable outcome with a defined target where known.

2018 Key Metrics and Initiatives

Ongoing data monitoring is a critical function for success in achieving a five Star Rating. Monitoring all data that is used by CMS to score the plan must occur on a daily or monthly basis. This allows Virginia Premier to make course corrections and implement improvement plans while there is still time to influence the measure year outcomes. The first priority will be building reports and a Star Rating dashboard that will guide activities throughout the year. There are 34 Part C and 15 Part D measures that will be monitored on the dashboard.

Quality Improvement activities with outcome measures are required by CMS for the following:

- Chronic Care Improvement Program (CCIP)
  - Decreasing the risk of cardiovascular disease among members with Diabetes
- Quality Improvement Project (QIP)
  - Decreasing all-cause 30 day readmissions through use of enhanced care coordination during transition

Requirements for data submission to CMS include:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Health Outcomes Survey (HOS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Part C Reporting Elements per CMS Technical Specifications
- Part D Medication Therapy per CMS Technical Specifications

Corporate History

Virginia Premier Health Plan, Inc. (Virginia Premier) has been serving Medicaid beneficiaries in the Commonwealth of Virginia since the managed care program began in 1996. Virginia Premier is owned by the Virginia Commonwealth University Health System Authority, a political subdivision of the Commonwealth of Virginia. In 2010, Virginia Premier became not-for profit. The National Committee of Quality Assurance (NCQA) accredited the organization in 2007 at which time it only provided Medicaid services. Virginia Premier contracts with the Virginia Department of Medical Assistance Services (DMAS) and the Centers for Medicare and Medicaid Services (CMS) to provide managed care services. Effective January 2018, services are being provided to 170,000 Medicaid members, 1,730 Dual Eligible Special Needs (DSNP) members, and over 42,000 members in Medicaid Long Term Services and Supports (MLTSS) in the Capitated Financial Program throughout Virginia. In addition, there are 850 members in the new Medicare Advantage and Prescription Drug (MAPD) Plans and another 6,348 in the Virginia Coordinated Care program for uninsured individuals sponsored by Virginia Commonwealth University Hospital System.

Virginia Premier has the largest service area of any Medicaid managed care organization (MCO) in Virginia composed of more 100 counties in Central, Eastern, Western, Northern and Southwestern Virginia. Its corporate office is located in Richmond, Virginia. The DSNP plan is available in 130 counties and cities and the MAPD Gold and Platinum plans are available in 24 counties. Virginia Premier also has regional offices located in five (5) other communities in the Commonwealth: Bristol, Winchester, Roanoke, Charlottesville, Lynchburg and Chesapeake. Effective January 2018, Virginia Premier offers services for members enrolled in the following:

Medallion 3.0 Medicaid

- Family Access to Medical Insurance Security (FAMIS)
- Low Income Family and Children (LIFC)

Medicare Advantage and Prescription Drug Plan (MAPD)

- Gold Plan (traditional MAPD with $0 premiums)
- Platinum Plan (traditional MAPD with additional premiums)
- Elite Plan for Dual Eligible Special Needs Plan (Medicare and Medicaid benefits)

Managed Long Term Support Services (MLTSS)

- Medicaid Services
- Aged Blind and Disabled (ABD)
- Health and Acute Care Program (HAP)
- Waivers

Our Commitment

Virginia Premier meets the needs of underserved and vulnerable populations in Virginia by delivering quality-driven, culturally sensitive, and financially viable healthcare. The Virginia Premier Health Plan Quality Program has an ongoing commitment to promote excellence in health care to all members, enhance personal wellness, continuously improve member

experiences and outcomes, and to provide access to care in a safe, and culturally sensitive manner.

The program is designed to monitor and evaluate the care and services delivered by contracted practitioners, and affiliated providers across the full spectrum of services and sites of care. To ensure this purpose, Virginia Premier has implemented a comprehensive Quality Management Program for the Medicare Advantage population. The Quality Program strives to meet all standards set forth by CMS in guiding the organization in its delivery of services to the Medicare population.

Virginia Premier's Mission

Inspire healthy living within the communities served by VCU Health System, in Virginia and beyond, through innovation, strategic partnerships, and industry-leading healthcare, with a focus on underserved and vulnerable populations.

Vision

Our vision is to constantly deliver, monitor and evaluate high quality services to our members and:

- Engage members and providers to achieve improved healthcare outcomes and increase satisfaction
- Track performance measures and identify areas for improvement continuously
- Pioneer and implement new models of health care delivery as adopted by the Agency for Healthcare Research and Quality (AHRQ) in support of improving efficiency and achieving health care reform

Our Values

- **Compassion**
  - Put people first by providing respect and instilling trust
- **Collaboration**
  - Collaborate with providers, community partners, members, and VCUHS to achieve our mission
- **Quality**
  - Achieve quality through excellence that is data-driven
- **Innovation**
  - Foster innovation by enabling entrepreneurial, technological, resourceful, and academic creativity
- **Accountability**
  - Expect accountability through a commitment to financial stewardship and integrity

Community First Guiding Principles

The efforts that Virginia Premier engages in will be executed in a manner in which we consider the needs of the Community First. The work that is performed is for the ultimate goal of improving the health and lives of the people that the health plan serves. To emphasize the Community First philosophy, principles were developed to guide the organization in how it approaches its strategic initiatives.

Community First Principle	Description
Engagement	Promote and enable healthy lives for the populations we serve through individualized attention, utilizing industry best practices, and demonstrating heartfelt compassion.
Service	Invest in human capital that embodies the spirit of our health system, university, state, and mission.
Expansion	Explore new care models and business opportunities.
Innovation	Develop and deploy cutting edge health care and health promotion methods utilizing industry leading technology innovations.
Accountability	Ensure activities are ethically and financially secure.

Accreditation

Virginia Premier recognizes the importance and value of achieving accreditation with the National Committee for Quality Assurance (NCQA), an independent not for profit organization that ranks health insurance plans throughout the nation.

NCQA evaluates how health plans manage all parts of their delivery systems —physicians, hospitals and other providers in order to continuously improve health care for its members. Accreditation surveys include rigorous on-site and off-site evaluation of over 600 standards and selected performance measures.

Accreditation is not a one-time event, but an ongoing journey to support quality services for customers, members and practitioners. Virginia Premier is committed to excellent service to our customers and have an ongoing plan to monitor the progress towards the goal of excellence. Virginia Premier earned an "Accredited"accreditation status for the Medicaid Product line on July 11, 2016. This accreditation will expire on July 11, 2019. Virginia Premier will be seeking accreditation for the Medicare Advantage line of business in 2019 in addition to reaccreditation for the Medicaid Program and LTSS Distinction.

Virginia Premier Quality Management Program

The Virginia Premier Quality Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety and effectiveness of care and service. A multidimensional approach enables the organization to focus on opportunities for improving operational processes as well as health outcomes and satisfaction of members and practitioners. The Virginia Premier Quality Program is essential to ensure that all medical care and service needs of members are being met and insures activities and strategies planned by the organization are "value added" benefits to our members. The Quality Program is formulated on three foundational structures including the Quality Management Program Description, an Annual Work Plan, and an Annual Evaluation.

- **Quality Management Program Description:** The Quality Management Program Description (QMPD) provides the structure, framework, and governance used to guide the

formal and informal processes for evaluating and improving the quality focusing on these aspects

- The appropriateness of health care services
- The effectiveness of care and care outcomes for the populations served
- Responsible cost and utilization management
- The member experience of care

In addition to the QMPD, other documents required to develop the comprehensive program consist of the Utilization Management (UM) Program Description, the Care Management Program Description, and Disease Management Program Description. Each will provide trend reports for monitoring, evaluation, and improvement efforts. The appropriate Quality Committees separately vet and approve these foundation documents.

Key elements included in the QMPD for MAPD are

- Program specific goals and objectives
- Description of the MAPD-specific population
- Quality Improvement Activities required by CMS
    - Chronic Care Improvement Program
    - Quality Improvement Project (QIP)
    - Health Outcomes Survey
    - CAHPS®
    - Part C Reporting Elements
    - Part D Medication Therapy

- **Quality Program Work Plan:** The Quality Work Plan documents and monitors quality improvement activities throughout the organization for the upcoming year. The work plan includes goals and objectives based on the strengths and opportunities for improvement identified in the previous year's evaluation and in the analysis of quality metrics. The work plan is updated as needed throughout the year to assess the progress of initiatives.

- **Quality Program Evaluation:** The Annual Quality Program Evaluation is an evaluation of the previous years' quality improvement activities and provides a mechanism for systematically completing an analysis of performance. It defines meaningful and relevant quality activities implemented for our members. Through a structured review of the various clinical, service, administrative and educational initiatives, the program evaluation serves to emphasize the accomplishments and effectiveness of the Quality Program as well as identify barriers and opportunities for improvement. The program evaluation includes these elements:
    - Quality of Physician and Behavioral Health Care Rendered
    - Population Health Assessment
    - Provider Network Adequacy
    - Provider Cultural Competency
    - Provider Satisfaction Survey
    - Provider and Call Center Access
    - Provider Appointment Availability
    - Provider Credentialing Activity
        - Delegation reports

- Care management results
  - Health Risk Assessment and Plan of Care completion rates
  - Care Transitions Protocol
  - Care Management Effectiveness
- Clinical practice guidelines adoption and compliance
- Behavioral Health Utilization Performance Measures
- Enrollee appeal and grievance analysis

The annual QI Program Description, QI Program Evaluation and QI Work Plan are reviewed and approved by the Quality Improvement Committee (QIC) and the Healthcare Quality & Utilization Management (HQUM) Committee with summary approval by the Continuous Quality Improvement Committee (CQIC) at the top executive level.

Quality Program Vision

The Virginia Premier quality vision is aligned with the Triple Aim which is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. The premise of the Triple Aim is to simultaneously pursue three dimensions (which are called the Triple Aim).

IHI Triple Aim	
Aim 1	Improving the patient experience of care including quality and satisfaction
Aim 2	Improving the health and outcomes of populations
Aim 3	Reducing the per capita cost of healthcare

Additionally, the quality vision and strategy is aligned with the CMS Quality Strategy which includes three aims and six priorities.

CMS Quality Strategy (2016)	
Aim 1	Better Care: Improve the overall quality of care by making healthcare more person-centered, reliable, accessible, and safe
Aim 2	Healthier People, Healthier Communities: Improve the health of Americans by supporting proven interventions to address behavioral, social, and environmental determinants of health, and deliver higher-quality care
Aim 3	Smarter Spending: Reduce the cost of quality healthcare for individuals, families, employers, government, and communities
Achieve these aims by focusing on these priorities (Goals)	
Goal 1	Make care safer by reducing harm in the delivery of care
Goal 2	Strengthen person and family engagement as partners in their care
Goal 3	Promote effective communication and coordination of care
Goal 4	Promote effective prevention and treatment of chronic disease
Goal 5	Work with communities to promote best practices of healthy living
Goal 6	Make care affordable

Virginia Premier's vision is to constantly deliver, monitor and evaluate high quality services to our members and:

- Engage members and providers to achieve improved healthcare outcomes and increase satisfaction
- Track performance measures and identify areas for improvement continuously
- Pioneer and implement new models of health care delivery as adopted by the Agency for Healthcare Research and Quality (AHRQ) in support of improving efficiency and achieving health care reform

Scope of the Quality Program

The scope of the Quality Program is integrated within clinical and non-clinical services provided for the Virginia Premier members. The program is designed to monitor, evaluate and continually improve the care and services delivered by contracted practitioners and affiliated providers, across the full spectrum of services and sites of care. The program encompasses services rendered in ambulatory, inpatient and transitional settings and is designed to resolve identified areas of concern on an individual and system wide basis. The Quality Program will reflect the population served in terms of age groups, disease categories and special risk statuses and diversity. The Quality Program includes monitoring of community-focused programs, practitioner availability and accessibility; coordination and continuity of care; and other programs or standards impacting health outcomes and quality of life.

The scope of the Quality Program includes oversight of all aspects of clinical and administrative services provided to our members, to include:

- Program design and structure
- Quality improvement activities that comply with CMS, NCQA, DMAS and other regulatory requirements
- Care management (to include complex case management, behavioral health, care transitions and end of life planning) and disease management programs that are member centric focused and address the health care needs of members with complex medical, physical and mental health condition; assessments of drug utilization for appropriateness and cost-effectiveness
- Utilization management, focus on providing the appropriate level of service to members
- Member appeals and grievances
- Implementation of high quality customer service standards and processes
- Benchmarks for preventive, chronic and quality of care measures
- Credentialing and Recredentialing of physicians, practitioners, and facilities
- Compliant with NCQA Accreditation standards
- Audits and evaluations of clinical services and processes
- Development and implementation of clinical standards and guidelines
- Measuring effectiveness
- Evidenced based care delivery
- Potential Quality of Care and Safety concerns

Quality Performance Indicators

The performance indicators provide a structured framework in which to target and concentrate organizational (clinical and service) efforts. Through assessment and implementation of member-focused interventions, outcomes are measured. Virginia Premier will maintain clinical and service improvement project and activities that relate to key indicators of quality and utilizes data that are statistically valid,

reliable, and comparable over time. All performance indicator outcomes are reported through the quality committee structure, at least annually.

Clinical Indicators

- Selected CMS Star Rating Measures
- NCQA Medicare HEDIS®® Measures
- CAHPS® and HOS Survey Measures
- Part C and D required reporting elements
- Medication Therapy Management (MTM) outcomes
- Disease Management outcomes
- Provider and practitioner practice audit outcomes

Service Indicators

- Selected CMS Star Rating Measures
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®®)
- Provider Satisfaction Survey
- Provider Access and Appointment Availability
- Member Operations Call Center Timeliness and Accuracy
- Board Certification of Practitioners
- Member Grievances and Complaints

Quality Management Program Goals

The ultimate goal of the Virginia Premier Medicare Advantage Quality Program is to achieve a five (5) STAR rating by ensuring the delivery of high quality culturally competent health care, particularly to members with identified health care disparities. Our healthcare modalities will emphasize medical, behavioral health, and pharmaceutical services. The Quality Program concentrates on evaluating the quality of care offered, as well as the appropriateness of the care provided.

- Continuously meet organization's mission
- Continuously meet regulatory and accreditation requirements
- Create a system of improved health outcomes for the populations served
- Improve the overall quality of life of members through the continuous enhancement of comprehensive health management programs including:
  - Chronic Care Improvement Program
  - Quality Improvement Project
- Make care safer by reducing variation in practice and enhancing communication across the continuum
- Strengthen member and caregiver engagement in achieving quality health outcomes
- Ensure culturally competent care delivery through assessment of practitioner cultural education, and provision of information, training and tools to staff and practitioners to support culturally competent communication.

Quality Management Program Objectives

The primary objective of Virginia Premier's Medicare Advantage Program is to continuously improve the quality of care provided to members to enhance the overall health status of the members. Improvement in health status is measured through Healthcare Effectiveness Data and Information Set (HEDIS®) information, internal quality studies, and health outcomes data with

defined areas of focus. Virginia Premier has defined objectives to support each goal in the pursuit of better outcomes.

Virginia Premier MAPD Goal	Supports CMS Quality Goal(s)	Objectives
Continuously meet the organization's mission	Goal 5	- Conduct an assessment of the MAPD population including demographics, socioeconomic status, healthcare behaviors, and most common health conditions - Use the assessment to create collaborative relationships with community partners and providers with the focus on improved health outcomes
Continuously meet regulatory and accreditation requirements	Goal 1 Goal 2 Goal 4	- Design, develop and implement a Stars Improvement program - Create and implement a project plan including all the regulatory and accreditation requirements ensuring that each item is addressed in policy, procedure and practice - Conduct mock audits to assess readiness - Design, develop and implement a Stars Improvement Plan including a Stars dashboard that is updated monthly
Create a system of improved health outcomes for the populations served	Goal 1 Goal 2 Goal 3 Goal 4 Goal 5	- Create data collection processes to monitor health outcomes for selected populations (HEDIS® and other clinical data) - Use analysis of the data to identify opportunities for improvement - Design and implement processes to achieve improved outcomes - Include member and provider education and collaboration in the redesigned processes - Assist with conducting a provider access adequacy assessment (Geo Access report and Provider ratios per county) - Collaborate with Network Development to improve access where needed - Establish and disseminate evidence-based guidelines, audit for compliance
Improve the overall quality of life of members through the continuous enhancement of comprehensive health management programs	Goal 4 Goal 5	- Develop and implement a Chronic Care Improvement Program (CCIP) - Develop and implement a Quality Improvement Project (QIP) - Develop and implement a Preventive Care Program - Develop and implement a Behavioral Health Program
Make care safer by reducing variation in practice and enhancing communication across	Goal 1 Goal 2 Goal 3	- Assist Care Management in implementing a Care Transition process from acute care to community - Evaluate provider and practitioner performance against selected evidence based practice guidelines

the continuum		- Create and implement provider and member education related to the selected practice standards and guidelines (tool kits) - Design and implement a process to identify and review potential quality of care concerns or issues - Design and implement the required Medication Therapy Management (MTM) Program, evaluate effectiveness and outcomes annually - Improve member access to appropriate medications designing the P&T approved formulary to meet the member needs - Improve member access to appropriate therapies and treatment through utilization management processes - Appropriately credential all practitioners and providers, monitor complaints and quality concerns by individual, practice, and facility; take action as needed when a quality issue is identified
Strengthen member and caregiver engagement in achieving quality health outcomes	Goal 2	- Use the teach back method for conducting member education where possible - Refer members to appropriate Disease Management programs - Design outreach efforts to include multiple avenues of communication such as telephonic, written, web based, and social media when possible - Annually conduct the CAHPS® and HOS surveys, using results to improve processes and programs
Ensure culturally competent care delivery through collection of practitioner cultural education, and provision of information, training and tools to staff and practitioners to support culturally competent communication	Goal 2 Goal 3	- Complete a cultural assessment of the MAPD population - Complete an organization assessment related to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care found at https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf - Create and implement an improvement plan based on the assessed needs of the organization
Make care affordable by encouraging appropriate utilization	Goal 6	- Monitor hospital admission and readmission rates ensuring all admission criteria (Interqual) are met - Trend admission for preventable conditions, identify opportunities and create action plans to address issues - Monitor Emergency Department utilization, identify opportunities, create action plans to address issues

Elite Plan (DSNP) Model of Care Goals

Virginia Premier MAPD Goal	Supports CMS Quality Goal(s)	Objectives
Improving access to essential services such as medical, pharmacy, mental health and affordable care	Goal 4 Goal 5 Goal 6	- Monitor utilization of out of network providers - Evaluate access to providers, time to be seen after request for an appointment - Evaluate practitioner network adequacy - Monitor number of member grievances and post service appeals - Evaluate the percent of Rx dispensing generic medications
Improving coordination of care and ensuring appropriate delivery of services with alignment of the Health Risk Assessment, Care Plan and Care Team Meetings	Goal 3	- Measure satisfaction with Care Manager - Monitor the Health Risk Assessment completion rate within 90 days of plan enrollment - Monitor the percentage of Care Plans completed - Evaluate the member satisfaction with the care team meetings
Improve seamless transitions of care across health care settings, providers and health services	Goal 1 Goal 2 Goal 3	- Monitor monthly readmissions - Evaluate Emergency Department utilization - Follow up after hospitalization for mental illness within 30 days - Evaluate the percentage of medication reconciliation completed within 30 days of discharge
Improve access to preventive services	Goal 1 Goal 4	- Ensure access to preventive care - Promote appropriate preventive screening such as breast cancer screening, colorectal cancer screening and flu vaccines

Quality Management Program Functions

The following are identified functions of the Quality Management Program:

- Provide the organization with an annual Quality Program Description, Work Plan, and Annual Evaluation
- Coordinate the collection, analysis, and reporting of data used in monitoring and evaluating care and service, including quality, utilization, member service, credentialing and other related functions managed at the plan level or delegated to vendor organizations
- Identify and develop opportunities and interventions to improve care and services
- Identify and address instances of substandard care including patient safety
- Track and monitor the implementation and outcomes of quality interventions
- Evaluate effectiveness of improving care and services
- Oversee organizational compliance with regulatory and accreditation standards
- Improve health outcomes for all members by incorporating health promotion programs and preventive medicine services into the primary care practices

Quality Improvement Methodology

The Virginia Premier Quality Program uses a variety of Quality Improvement (QI) methodologies for improvement opportunities. This is done through continuous assessment and utilizing quality improvement concepts such as Lean Six Sigma, Root Cause Analysis, and Plan, Do, Study, Act (PDSA) cycle.

Virginia Premier's Quality Management Program utilizes the Lean Six Sigma methodology to improve processes. The five phases of the Lean Six Sigma methodology are: Define, Measure, Analyze, Improve and Control (DMAIC). The QMP incorporates continuous QI methodology that focuses on the specific needs of multiple customers (members, health care providers, and community agencies). The QI process methodologies are:

- Organized to identify and analyze significant opportunities for improvement in care and service.
- Fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
- Focused on QI activities carried out on an ongoing basis to promote efforts support the identification and correction of quality of care issues

The Plan, Do, Study, Act (PDSA) model defined by the Institute of Healthcare Improvement (IHI) is the overall framework for continuous rapid cycle process improvement. In a PDSA cycle, the goal is to test a particular change (intervention) on a small scale, learn what you can, and improve with each application. Each test result is compared to baseline to measure whether or not change is actually an improvement toward the targeted aim.

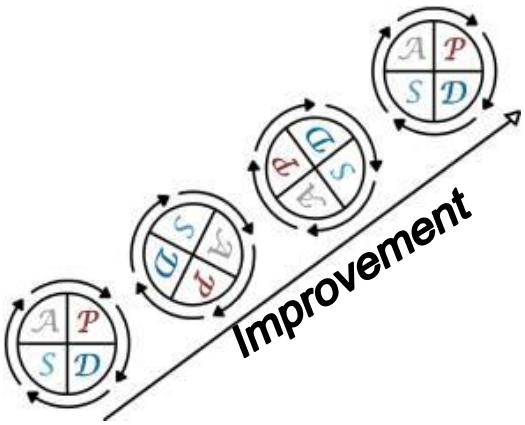
Each step in the process has defined functions that occur which map closely to the DMAIC methodology:

Plan
1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do
5) Communicate the change and action plan
6) Implement change plan

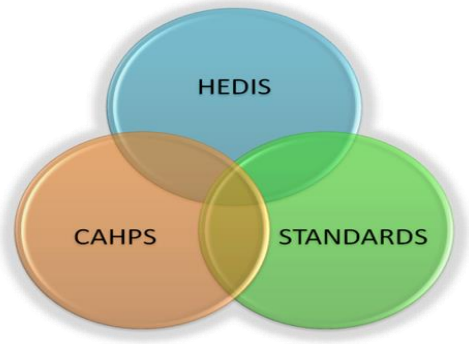
Study
7) Review and evaluate results of change
8) Communicate progress

Act
9) Reflect and act on learning, either return to the plan stage or
10) Standardize process and celebrate success



CMS requires MAPD plans to have at least one Quality Improvement Project (QIP) and one Chronic Care Improvement Program (CCIP) using the PDSA model. These are three year improvement activities which provide a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service of plan selected member conditions. These activities utilize a multidimensional approach which enables Virginia Premier to focus on opportunities for improving operational processes as well as health outcomes and satisfaction of members and practitioners/providers. Additional improvement projects are introduced throughout the year based on identified needs using the defined methodologies described above. Each of these activities promote the culture of quality and accountability to all employees and affiliated health personnel to provide quality of care and services to members.

Virginia Premier strives for performance based accreditation which utilizes NCQA and CMS Standards, HEDIS® measures and CAHPS® (member experience) surveys. Interlocking these three components enhances the integration of quality and accountability leading to continuous quality improvement to insure that activities conducted meet or exceed identified goals and measures.



Data Sources

Quality Improvement is a data driven process. The Quality Management Program continually monitors performance through established benchmarks and performance goals (internal as well as regulatory direction). Enterprise Data Warehouse (EDW) developers create programs to extract the data used to produce results for key clinical, utilization, and service quality indicators. Data collection and review is a year-long process which allows the Quality team the ability to make corrections and address areas of concern to improve care and services for our members resulting in better quality outcome scores.

Virginia Premier maintains a data warehouse repository usable by staff across the organization for analysis and reporting. Part of that maintenance requires pulling data from original source systems such as claims into warehouse tables. In addition, for various applications or reporting needs, an enterprise reporting system is available and developed with specific information needs.

The Information Systems Department's internal and external customers make business decisions every day that depend on timely, valid and accurate data. Therefore, software-driven report generation capabilities are utilized to their fullest extent. Standard and ad hoc reports are routinely generated from the core application databases. Virginia Premier's reporting subsystem consists of standard reports and flexible, ad hoc report creation tools. The Information Systems Department is responsible for the coordination, development, and production of these reports. Reports are generated from three major sources including claims, enrollment, and medical management data. Most operational reports are generated from these sources. Other utilization, quality and decision support reports are generated from the data warehouse. These reports include HEDIS® provider profiling, and other statistical and quality measures.

Virginia Premier maintains a systematic approach to gathering data appropriate to provide tracking and trending of multiple data sources. This is essential for implementing the QIP, CCIP and other improvement activities. These data sources and service activities include, but are not limited to:

- Quality Improvement studies
- Trended data from sentinel events
- Quality of care and service events
- Member Surveys
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Health Outcomes Survey (HOS)
- Practitioner Experience Surveys
- Access and availability studies
- Medical record reviews
- HEDIS® annual and supplemental data
- Grievances and Appeals data
- Over and under-utilization data
- Quality site visit outcomes
- Pharmacy utilization
- Population demographics
- Behavioral health utilization
- Care gap reporting
- Clinical management system data
- Disease and Case Management data and outcomes
- Member Advisory Committee information
- New Member follow-up calls
- Internal Care Management and documentation system
- Claims and Encounter Data
- CMS supplied data such as the monthly membership detail files, risk adjustment data

Data from outside organizations, including Medicare or Medicaid data, data from other managed care organizations, laboratory data and local or national public health reports on conditions or risks for specified populations are collected for comparison and benchmarking.

Measuring Program Effectiveness

Virginia Premier focuses on reviewing data from the following areas to evaluate the effectiveness of the overall program:

- Population demographics

- Health status and outcomes of the population and sub-populations
- Health Risk Assessment Tool (HRAT) or Risk Adjustment data when available
- Utilization of services
- Pharmacy utilization including adherence, Medication Therapy Management (MTM), and appropriate use of select medications
- Disease Management and Care Management data
- Enrollee Surveys such as CAHPS® and HOS

Data is analyzed on multiple levels, including review of sub-populations. Sub-populations include, but are not limited to:

- MAPD both Gold and Platinum plans
- DSNP population
- Members of different cultural and ethnicity populations
- Members with behavioral health conditions
- Members with multiple chronic conditions
- Members receiving end of life care

Data is analyzed at county or region level and rolled up to the total population level. The purpose of this data breakdown is to determine if health disparities exist in certain populations to support the creation, or continuation, of member-centric programs focused on certain populations. Virginia Premier's goal is to identify and mitigate any barriers for its members in an effort to provide seamless, streamlined care, by continually monitoring data to identify and support these subgroups.

Outcomes

Virginia Premier maintains processes to measure the level of effectiveness of member health outcomes. This is done using the following sets of data and information:

- Annual collection of HEDIS® data
- Annual CAHPS® survey
- Annual HOS survey
- Quarterly Enrollee Advisory Council (EAC) feedback
- Internally developed member satisfaction surveys
- Internally develop process measures

Outcomes are benchmarked both externally with other MAPD plans and internally year over year as well as across the Virginia Premier lines of business. In the case of negative findings, corrective actions are identified and specific improvement plans are implemented based upon data analysis. Deficient elements of the HEDIS®, CAHPS® and survey measures are targeted for process improvement using Six Sigma principles and other methods of continuous quality improvement (such as brain storming, cause and effect diagrams, and process mapping). Virginia Premier will continue to address negative findings using the Plan, Do, Study, Act (PDSA) cycle, until such time as the negative result has been mitigated.

HEDIS®

One primary component of the program evaluation will be the use of HEDIS® data. Industry-standard HEDIS® measurement and evaluation allows Virginia Premier to observe and report

changes year over year (YoY) within the plan and to understand our performance and provide industry standard comparison data, both internally and externally. Virginia Premier also uses HEDIS® to ensure the quality, cost and utilization data is produced in a consistent way so that regulators, accreditors and Virginia Premier can compare performance across health plan regions. Virginia Premier uses these YoY comparative analytics to understand the trends in our population in a forward looking manner in order to build programs designed to impact trends in all applicable HEDIS® measures.

The CMS Star Rating Measures utilizes HEDIS® outcomes for scoring in 17 measures currently. Additional HEDIS® outcomes are also used in determining Display Measure results. Both are of critical importance to the MAPD plan and are indicators of the overall quality of care being delivered through the Virginia Premier network.

CAHPS®

Virginia Premier evaluates the overall effectiveness of its member communication and assesses the perceived quality and appropriateness of care though the annual Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey. Virginia Premier consistently has member satisfaction scores in their Medicaid lines of business that demonstrate above-average member satisfaction with the newsletters and communication from the plan. These efforts will be duplicated with the MAPD population ensuring similar success. The goals of the CAHPS®® survey are to:

- Evaluate effectiveness and satisfaction with plan communications
- Assess member's experience of care related to quality, coordination, and appropriateness
- Help identify problems and improve overall quality
- Enhance the ability to monitor quality of care and performance
- Provide data to evaluate value-based purchasing options

CAHPS® surveys are administered to a sample of plan members selected by CMS and administered by independent survey vendors, following CMS data collection protocols, specifications, and timelines. The third party vendor fully manages CAHPS® surveys through all the required steps of administration including design and printing, sample development, mailing, survey scanning, phone follow-up through our on-site call center, data collection, analysis, and a comprehensive final report of results. The CMS Star Rating Measures utilize CAHPS® outcomes in 8 of the measures.

HOS

In order to evaluate health plans effectiveness in influencing member perception of their health status, Virginia Premier will conduct Medicare Health Outcomes Survey (HOS). The goals of the HOS survey for Virginia Premier is to gather meaningful data to use in implementing targeted quality improvement activities. The HOS is used to collect four HEDIS® effectiveness of care measures:

- Management of Urinary Incontinence in Older Adults

- Physical Activity in Older Adults
- Fall Risk Management
- Osteoporosis Testing in Older Women

In addition, two additional Star Measures are collected through the HOS Survey including:

- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health

CMS Star Ratings

CMS created the Star Rating system in order to give Medicare beneficiaries a mechanism to evaluate the quality and effectiveness of the different plans in which they might enroll. The Star Ratings are a standardized method of evaluating MAPD plans across the nation. Low scoring plans may lose their contracts with CMS if unable to improve their scores. Other sanctions and penalties may also ensue based on specific quality outcomes.

CMS uses the plan's Star Rating Score to determine if the plan is eligible for bonus payments. If plans are successful in achieving a 4 or 5 Star Rating, they will receive bonus money with each per member per month (PMPM) payment. Additionally, CMS uses aggregate data to help define and refine policy, regulations, and program requirements in effort to improve the care quality and costs across the population.

For 2018 data collection, there are 34 Part C measures and 14 Part D measures that are used to calculate the MAPD overall Star Rating Score. In addition to HEDIS®, HOS and CAHPS® data as sources for Star Measure scoring, CMS uses CMS Administration data and prescription drug event (PDE) data for scoring measures. Virginia Premier will receive one combined score for all three of the MAPD plans including the Elite, Gold and Platinum plans as they are all under one contract number.

There is a delay between the Measure Year and the Star Rating Year and Bonus year. Here is an explanation of how the timing is structured.

Measure Year	2018	Care activities provided to members
Reporting Year	2019	Data gathered from measure year, submitted to CMS per their requirements
Star Rating Year	2020	Published in the Medicare Plan Finder for viewing for Plan year 2020
Bonus Year	2021	Year the plan gets any additional PMPM payment based on score (if applicable)

It is important to understand that the cut points for scoring are adjusted every reporting year by CMS after the data has been collected. CMS standardizes the data and adjusts cut points based on national performance. As plans across the nation improve, the cut points generally go up making it more difficult to achieve the 4 and 5 stars required to receive bonus money. In recent years, CMS has added a Categorical Adjustment Index (CAI) designed to adjust for the differences in plan population demographics. The value of the CAI varies based on percentages of members with Low Income Subsidy/ Dual Eligible and disability status. It is believed that this adjustment makes the scoring more fair between plans across the nation. Star Rating scores

by plan and individual measure are published every year by CMS and may be used for benchmarking and identifying opportunities for improvement.

Display Measures

While Display Measure results are gathered from the same data sources as the Star Measures, they are not used in the calculation of the Star Rating score. They are additional quality indicators that are used by CMS in the overall evaluation of quality provided by a health plan. When changes are made in Star Measures or new ones developed, they are usually place on the display measure list for at least one year to allow time to evaluate the effectiveness of the measure changes. Some of the display measures have never migrated over to the Star Measure list but continue to be important in evaluation of the quality of care outcomes for the Plan's population.

Currently, there are 18 Part C and 18 Part D measures on the Display Measure list. CMS publishes these results every year along with an average score across all MAPD plans for benchmarking purposes. It is expected that plans will review these scores and identify additional opportunities for improvement activities.

Quality Improvement Strategy

To meet the vision, goals and scope of the program, quality improvement activities as reflected in Work Plan, are focused on the improvement of the health status of our plan members at the population level. The QI strategy will encompass the NCQA Standard *QI 1: Program Structure* outlining how Virginia Premier plans to improve the quality and safety of clinical care and services. This includes each of the following components:

- A solid Quality Program infrastructure with
  - Defined functional areas and their responsibilities
  - Descriptions of reporting relationships of the Quality Department staff and the Quality Committees
  - A listing of dedicated resources and analytical support
  - Descriptions of collaborative quality improvement activities
- Behavioral healthcare and its coordination with Medical care
- Patient safety and error avoidance
- Involvement of a designated physician in the Quality Program
- Involvement of a Behavioral Healthcare practitioner in the behavioral aspects of the program
- Oversight of Quality functions of the organization by the Quality Committees
- An annual work plan with the following elements:
  - Yearly planned goals, objectives and activities for improving:
    - Quality of clinical care
    - Safety of clinical care
    - Quality of service
    - Members' experience
    - The time frame for each activity's completion
    - Designated staff members responsible for each activity
- Ongoing monitoring activities of previously identified issues and improvements
- Evaluation of the overall program includes
- Defined objectives and activities for serving a culturally and linguistically diverse membership

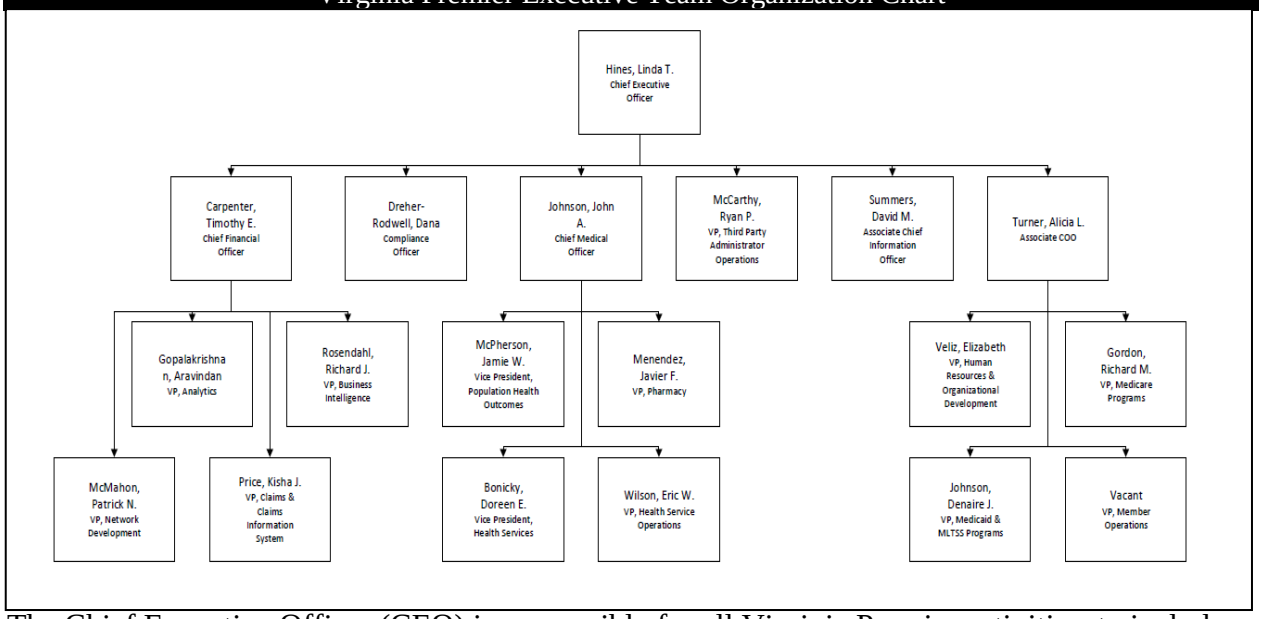
- Defined objectives and activities for serving members with complex health needs including a risk stratification process allowing efforts to be focused on those most at risk for poor outcomes

Quality Program Infrastructure

The Virginia Commonwealth University (VCU) Board of Directors has ultimate responsibility for the Quality Management Program and related processes and activities. The Board provides oversight by reviewing and approving the Quality Program Description, Annual Evaluation and Work Plan on an annual basis. The Board of Directors has delegated to the Continuous Quality Improvement Committee (CQIC) responsibility for ensuring the quality improvement processes outlined in this plan are implemented and monitored.

Below are organizational charts depicting key staff of the health plan related to the Quality Management Program, followed by brief descriptions of senior level and Quality Management positions. The QI Program has the necessary organizational infrastructure in place to support the needs of its members.

Virginia Premier Executive Team Organization Chart



The Chief Executive Officer (CEO) is responsible for all Virginia Premier activities, to include but not limited to, oversight of the implementation of the Quality Management Program. The CEO is responsible for monitoring the results of the health plan's quality of care and services, assuring that fiscal and administrative management decisions do not compromise the quality of care and service provided by Virginia Premier. Findings and outcomes are discussed within the quality committee structures and at the CQIC meetings, at least annually.

Chief Medical Officer

The Chief Medical Officer (CMO) or designee is responsible for the oversight, direction and strategic leadership of the Medical Management Department which includes Health Services, Pharmacy, Population Health, Credentialing and Medical Directors. Also, the CMO is

responsible for providing direction for the development and implementation of the Health Quality Utilization Management (HQUM), and Credentialing Committee programs.

Medical Directors

The Medical Directors have substantial involvement with participating practitioners on a regular basis, acting as a clinical liaison, educator, role model and mentor to assist participating practitioners in achieving the Quality program's goals and objectives. The Medical Directors report to the CMO and assist the CMO in carrying out all responsibilities and duties. Medical Directors are responsible for peer review activities, and for collaboration with practitioners on the development and implementation of the Quality Management Program.

Behavioral Health Medical Director

The Behavioral Health Medical Director serves as a peer reviewer on behavioral health cases. He or she also assists in the development and implementation of quality improvement activities related to behavioral health by identifying member focused interventions to promote improved behavioral health outcomes, and other related matters. Additionally, The Behavioral Health Medical Director attends the CQIC, as needed and participates in the HQUM Committee.

Chief Operations Officer

The Chief Operations Officer or designee is responsible for the daily operation of the company and reports to the Chief Executive Officer. The COO has oversight responsibility for the following operational areas: Human Resources and Organizational Development, Medicare Programs, Medicaid and Medicaid Long Term Support Services, Member Operations, and Initiative Management. The COO works collaboratively with the CMO to yield satisfactory clinical and service outcomes related to quality initiatives.

Chief Financial Officer

The Chief Financial Officer (CFO) is responsible for the oversight, direction and strategic leadership of the Finance Operations, accounting, analytics, medical informatics, medical economics and payroll. The CFO has daily oversight and operating authority for Virginia Premier fiscal responsibilities. The CFO ensures consistency of its processes/procedures with other programs throughout Virginia Premier, including the Quality Program when applicable.

Associate Chief Information Officer

The Associate Chief Information Officer (ACIO) provides technology vision and leadership in the development and implementation of the organization-wide information technology (IT) program. The ACIO leads the health care network in planning and implementing enterprise information systems to support both distributed and centralized clinical and business operations and achieve more effective and cost beneficial enterprise-wide IT operations. He or she provides leadership, integrative management to include organization-wide strategic planning, budgeting for information technologies, and coordination and integration of all Virginia Premier IT matters. The ACIO is responsible for the management of multiple information and communications systems and projects, including voice, data, imaging, and office automation.

Vice President, Health Services

The Vice President of Health Services (VPHS) is responsible for oversight and management of integrated health services within the medical management department which encompasses Population Health Management, Utilization Management, Case Management, and Disease Management for all Virginia Premier regions and lines of business. He or she works collaboratively with the Chief Medical Officer to develop and implement processes to effectively manage clinical policies set by the Medical Management Department to meet healthcare cost and quality targets. This position interprets key performance metrics to develop plans, mobilize the work force, and achieve the organization's medical management outcomes relative to the Triple Aim. The VPHS works with the Health Services team to develop and implement effective and efficient standards, protocols, processes, decision support systems, reporting and benchmarks that support ongoing improvements of clinical operations functions and promote quality, cost-effective health care for Virginia Premier Health Plan members. The VPHS is responsible for developing effective working relationships with regulatory and community agencies, provider communities, hospitals, and departments within Virginia Premier to improve operations, member outcomes and health plan expansion through growth opportunities. The VPHS also serves as part of the executive leadership team and has shared accountability for an integrated approach to meeting overall department and company goals.

Vice President, Population Health Outcomes (Quality)

The Vice President of Population Health (VPPH) is responsible for meeting the requirements of CMS and DMAS for Medicare and Medicaid lines of business. Working collaboratively with the Chief Medical Officer and other key leaders within the leadership team to develop and implement a quality strategy which supports ongoing systemic process improvement. Core functions and services include oversight of the HEDIS®, CAHPS®, HOS, STARS and Plan accreditation process from data collection and interpretation to implementation of programs and processes designed to improve population health outcomes for Virginia Premier membership and ensure we meet or exceed contractual benchmarks for the quality performance targets. The VPPH is responsible for effective working relationships with regulator and community agencies, providers, hospitals, and departments within Virginia Premier to improve quality, member outcomes and health plan expansion through growth opportunities. The VPPH serves as part of the executive leadership team and has shared accountability for an integrated approach to meeting the overall department and company goals.

Leading the strategic clinical plan development and the Quality Management for all lines of business, the position is responsible for developing and coordinating all Quality Program-related activities, objectives, and analyses including conducting quality improvement studies. He or she provides ongoing development, maintenance and evaluation of quality systems and strategies focused on NCQA, HEDIS®, CAHPS®, HOS, for all products and services. Additionally, the VPPH provides oversight and strategic development for the CMS Star Rating Program. He or she establishes annual work plans and program evaluations, policies, and procedures at all levels to ensure quality programs will meet or exceed guidelines. This position will not only strategically direct the programs and services that support Virginia Premier Health Plan’s relationships with its members, providers, staff members, network, and community, but also align with the overall corporate goals and strategies of VCU Health System.

Vice President, Health Services Operations

The Vice President of Health Services (VPHS) is responsible for providing strategic leadership, quality driven project management services through planning, monitoring and involvement in the implementation of operations ensuring that deliverables are met in a timely manner for all lines of business. Additional responsibilities include coordinating, conducting and documenting simple to complex medical management projects and operational procedures and identification of process. Also responsible for creating a strategic vision, processes, tools and procedures to assure ongoing visibility to operational performance of the department and company and clinical applications management.

Vice President, Pharmacy

The Vice President of Pharmacy (VPP) is responsible for the monitoring, management and oversight of pharmacy data and costs at Virginia Premier. The VPP ensures consistency of its Program with other programs throughout the organization, including the Quality Management Program when applicable. Additionally, the VPP is responsible for ensuring all Part D operations, programs, and reporting requirements are met.

Vice President, Medicare Programs

The VP of Medicare Programs is Virginia Premier's expert resource regarding the operations for the MAPD members. The VP provides leadership, support and expertise to the clinical, provider network, marketing, operations and quality department staff as it relates to the MAPD program. Ensures appropriate prioritization of initiatives and good resource management to fulfill program goals.

Vice President, Network Development and Contracting

The Vice President of Network Development and Contracting (VPND) has daily oversight and operating authority for provider services, contracting, recruitment, and retention activities/functions. The VPND ensures consistency of the Network Development/Contracting Program with other programs throughout Virginia Premier, including the Quality Management Program. Provider Relations include managing communications with network providers. The Credentialing Committee works with Provider Relations and guides remedial action plans and communication with network clinicians. The VPND monitors standards associated with ongoing monitoring and remedial action for non-compliance with access standards as necessary. Network Development/Contracting ensures the network is sufficient in number and type of practitioners to assure accessibility, availability, after-hours coverage and care is delivered in a culturally sensitive manner across the network.

Vice President, Member Operations

The Vice President of Member Operations (VPMO) is responsible for the direct administrative and supervisory activities of Enrollment, Member Services, Mail Operations and special projects. The VPMO ensures consistency of the Member Operations Program with other programs throughout Virginia Premier, including the Quality Program. The VPMO will facilitate the integration of various operational systems within the organization. Member rights and responsibilities are published and distributed to both members and practitioners. The Member Advisory Committee (MAC) and annual CAHPS®® survey are avenues for incorporating member suggestions and concerns into quality initiatives. The Member Operations Department

is represented on the Quality Satisfaction Committee, which oversees quality improvement efforts aimed at increasing member satisfaction.

Vice President, Claims

The Vice President of Claims (VPC) is responsible for the oversight, direction and strategic leadership of the Claims Department, which includes claims operations, configuration and cost containment. The VPC ensures consistency of the Claims processes/procedures with other processes throughout Virginia Premier, including the Quality Management Program when applicable. The VPC is responsible for oversight of resources responsible for the timely and accurate adjudication of claims as well as the creation and submission of encounter files to regulatory agencies. These areas function to support the overall success of timely and accurate claims adjudication and to provide key assistance to our provider and vendor network regarding claims.

Vice President, Human Resources and Organizational Development

The Vice President of Human Resources and Organizational Development (VPHROD) is responsible for the oversight, direction and strategic leadership of the Human Resources Program, which includes training, development, recruitment and retention of qualified personnel. The VPHROD ensures consistency and integration of its policies and standard operating procedures with other programs throughout Virginia Premier, including the Quality Management Program when applicable.

Vice President, Strategic Planning and Business Integration

The Vice President of Strategic Planning and Business Integration (VPSP/BI) is responsible for the oversight, direction and strategic leadership for Virginia Premier, which incorporate strategy and business development. The VPSP/BI ensures consistency and integration of its activities and strategic planning with programs throughout the organization, including the Quality Management Program when applicable.

Assistant Vice President for Information Systems

The AVP is responsible for the design, development, release and maintenance of technology systems and services for all enterprise business functions. This technical, operations-centered senior management IT role is seen as the most trusted partner of the VP in leading IT to become a business-oriented organization. With the role focusing on the "run" aspect of IT, this enables the VP to focus on the "grow" and "transform" aspects of IT, through working with customers, building strong relationships with senior management and key stakeholders, driving innovation and differentiated IT strategy, and improving the business value of IT.

Program Integrity Office, Government Relations

The Program Integrity Officer and Government Relations (PIO) is responsible for the oversight, direction and strategic leadership of the Compliance Program, which includes compliance to the regulatory contracts, ensuring that all Protected Health Information (PHI) remains secure and confidential, organizational information (e.g., minutes) are confidential, proprietary and protected from discovery under the Health Care Quality Act of 1986. The PIO ensures consistency of the Program Integrity Department with other programs throughout Virginia Premier, including the Quality Program. The PIO is also the regulatory liaison and responsible

for submitting all regulatory reports to CMS and DMAS, as required per the State and Federal contracts. The PIO ensures that cconfidential materials are stored in secure files or areas, as deemed appropriate.

Director of Quality for MAPD and Stars

The Director of Quality for MAPD and Stars, under the direction of the Vice President of Population Health, is responsible for oversight of the implementation of the MAPD Quality Management Program, including monitoring quality of care and service complaints and evaluation of quality improvement initiatives involving member and provider outreach. The Director of Quality is also responsible for oversight of interventions and initiatives designed to increase performance on HEDIS®® and Stars measures, preparation of the annual QI program documents, oversight of submission of quality regulatory reports, oversight responsibility for implementation of quality improvement studies and patient safety initiatives, oversight of delegated vendors and managing the Health Plan Quality Improvement infrastructure. The Director of Quality is responsible for the CAHPS® and HOS Surveys. The Director is responsible for coordinating the NCQA Health Plan Survey, Quality Improvement Projects, Chronic Care Improvement Programs and other activities and compliance audits. The Director of Quality for MAPD and Stars is a point of contact for regulatory inquiries and works with the Compliance Officer to assure compliance with regulatory and accreditation standards. The Director works collaboratively with the Health Services team and CMO to provide oversight for the Quality Management Program, Evaluation and Work plan.

Senior Quality Manager for MAPD and Stars

The Senior Quality Manager (SQM) is responsible for leading and coordinating clinical quality improvement activities, assisting in the development of the Annual Quality Program Description and Work Plan, analysis and reporting on continuous monitoring of clinical quality. The SQM supports the Health Plan's NCQA survey and annual regulatory surveys. Management of the Stars Improvement Program is a critical function for this position. The SQM provides leadership for clinical and non-clinical staff guiding development and performance. The Quality Manager reports to the Director of Quality for MAPD and Stars.

Quality Registered Nurses (Quality RNs)

The quality nurses are licensed registered nurses who support Quality Management activities at the Health Plan level. The Quality RN functions are geographically distributed throughout the state. They report to the Senior Quality Manager and communicate routinely with the Medical Directors regarding issues related to Quality of Care and Service. The quality nurses compile and maintain report data in a standard format to support the quality program. The quality nurses are also responsible for educating providers and internal staff about reporting and investigation of Critical Incidents and Care and Service complaints as needed. Additionally, they provide support and resources to practitioners and providers facilitating implementation of evidence based practice. Oversight of these activities is reviewed within the quality committee structure.

Stars Standards Specialist

The Stars Standards Specialist is responsible assuring ongoing regulatory and accreditation readiness. Core functions also include full responsibility for all quality related activities to include, but not limited to, accreditation and regulatory efforts associated with or required by the

NCQA and the CMS Star Rating Program. The Stars Standards Specialist performs internal mock audits, maintains interdepartmental communication and provides education related to quality standards. This role serves as the liaison for both CMS and DMAS regulatory standards as well as accreditation requirements among the various Virginia Premier departments and reports to the Senior Quality Manager.

Director of Population Health

The Director, Population Health Outcomes has overall responsibility for leading the year round daily operations of the HEDIS® analytics team within the Quality Department. This key position collaborates across departments, administration, and leadership bodies to ensure organizational improvement efforts align with accrediting, licensing, and legal requirements. The Director provides guidance and support for complex analytics and reporting in support of the annual HEDIS® submission for Virginia Premier. This position collaborates with the Vice President of Population Health Outcomes to coach, mentor and lead a team to ensure timely and accurate reporting to meet regulatory requirements, and performance measure targets.

HEDIS® Operations Manager

The Manager of HEDIS®® Operations is responsible for management of the internal analysis and review of quality outcomes at the provider level, provider education on quality programs, monitoring and reporting on key measures to ensure providers meet quality standards and implementation of pay for performance initiatives. The HEDIS® Operations Manager reports to the Director of Population Health Outcomes.

HEDIS® Nurses

The HEDIS® Nurse Reviewer and Auditor role will be responsible for the coordination, on-site and telephonic data collection, and data entry and/or uploading of HEDIS® data abstracted from medical records. This incumbent is also responsible for yearlong auditing and conducting over-reading of HEDIS® medical records. The sole purpose of this position is for HEDIS® data management and related activities, as assigned.

Provider Engagement Coordinators

The Population Health Outcomes Provider Engagement Coordinators (PECs) will support the Manager and all related activities that result in the closing of HEDIS® care gaps. PECs are responsible for member education face to face in provider offices, distributing incentive gift cards for closing targeted care gaps based on approval for line of business. In addition, they will collect medical records for HEDIS® abstractions to support year -long HEDIS® efforts and refer members to Case and/or Disease management when needed.

HEDIS® Data Analyst

The HEDIS® Analyst I position provides support with the HEDIS® reporting application, developing an extensive expertise in collection and analysis of data, and collaborating with the Quality and Pay for Performance Team. In this analytical position, you will support continuous improvement in all technical and reporting aspects of HEDIS® and all related activities. This position will assist with the planning, and developing enhancements to the application by working with vendors as well as applying upgrades, service packs and hot fixes. The HEDIS®

Analyst I will also assist management with design issues, running reports for the Population Health Outcomes Department and any other technical problem solving.

Biostatistician

The Biostatistician position is responsible for moderately complex statistical analysis, to include but not limited to, coordination and statistical analysis of large datasets and programmatically restructure databases to facilitate analyses. Provides information to Directors, Vice Presidents and other levels of management. Writes detailed specifications for analysis files for CMS, the State and other regulatory or accrediting entities. He or she consistency checks tables and figures communicating with business partners regarding statistical analysis issues. Interprets analyses and writes statistical sections of quality reports. This position does not perform any direct bench or clinical (patient) research.

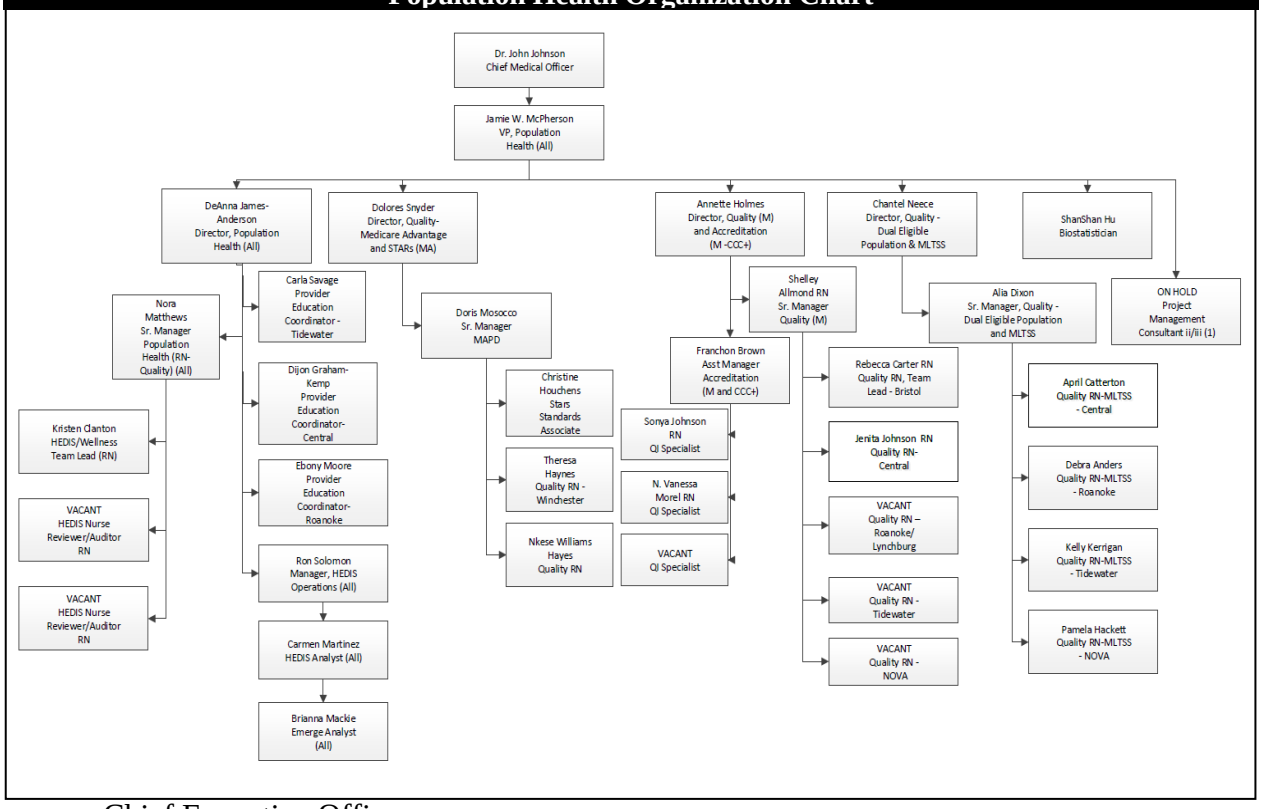
Quality Resource Allocation

In addition to the quality improvement committees, the positons listed below are directly allocated for the Virginia Premier quality management activities.

Positon Across All Lines of Business	Number FTEs	Percent Dedicated to Quality
Chief Medical Officer	1	25%
Medical Directors	4	35%
Behavioral Health Medical Director	1	25%
VP Population Health Outcomes (Quality)	1	100%
Directors of Quality	4	100%
Senior Managers	4	100%
Manager – HEDIS®	1	100%
Assistant Manager – Accreditation	1	100%
Quality RNs	11	100%
Specialists	4	100%
HEDIS® Nurses	3	100%
HEDIS® Temporary Nurses (3 months per year)	12	100%
Provider Engagement Coordinators	4	100%
HEDIS® Data Analyst	1	100%
Biostatistician	1	100%
Administrative Support	0.5	100%
Total Direct FTEs	53.5	100%

Virginia Premier's Quality Department has 5 dedicated FTEs for the MAPD Population. There additional resources that may be drawn upon as needed to support the quality functions and programs dedicated to this population. The HEDIS® and Wellness Team functions across all lines of business as does Accreditation. Analytics, Health Services, Care Management, Project Management, and many more are involved providing services to the MAPD population. Virginia Premier uses a collaborative approach to manage the population and is integrated across the organization to ensure excellent outcomes for our members.

Population Health Organization Chart



- Chief Executive Officer
- Chief Operating Officer
- Chief Financial Officer
- Vice President, Medicaid Programs
- Vice President, Network Operations/Development
- Vice President, Claims and Encounters
- Vice President, Information Technology
- Vice President, Human Resources and Organizational Development
- Vice President, Member Operations
- Vice President, Strategic Planning and Business Development
- Program Integrity Officer
- Vice President of Pharmacy

Ensuring Quality Care – Programs and Services

Virginia Premier has fully developed programs and services to support improved health outcomes of our members. The following sections describe these programs and their expected impact on population outcomes, experience of care, and costs.

Behavioral Health Program

The program outlines Virginia Premier's efforts to monitor and improve behavioral health care. The behavioral health medical director acts as a consultant and provides feedback at the various quality committee meetings. Covered benefits include physician, outpatient and inpatient services for behavioral health. Beacon Health Options (Beacon) is the contracted provider that coordinates the behavioral health benefits including crisis management, inpatient and outpatient services. The Utilization Management (UM) functions for behavioral health have also been delegated to Beacon who conducts prior authorization for selected behavioral health services when a practitioner or outpatient treatment service submits a request prior to rending services. Retrospective authorization requests will only be reviewed in cases when emergency services were rendered.

Program Goals

- Coordinate and provide high-quality managed behavioral healthcare services
- Sustain a formal Committee comprised of practitioners representing all Virginia Premier geographical regions and numerous specialties including behavioral health
- Meet minimum requirements of the National Committee for Quality Assurance (NCQA®) and strive to meet the national 75th percentile for the all Behavioral Health (HEDIS®®) measures
- Improve the impact of behavioral health treatment on physical health status
- Improve member satisfaction with care provided and all aspects of the delivery system

Program Scope

The scope of the Behavioral Health Program will include all services from emergent crisis management to acute care and outpatient care for all Virginia Premier members.

Care Coordination

Licensed, behavioral healthcare case managers manage behavioral healthcare services for all plan members who are in need of services.

Addiction and Recovery Treatment Services (ARTS)

The following overview of the ARTS Benefit was retrieved from the Virginia's Addiction Treatment Services Delivery System Transformation, Concept Paper: 1115 Waiver for Addiction Treatment Services, July 1, 2016

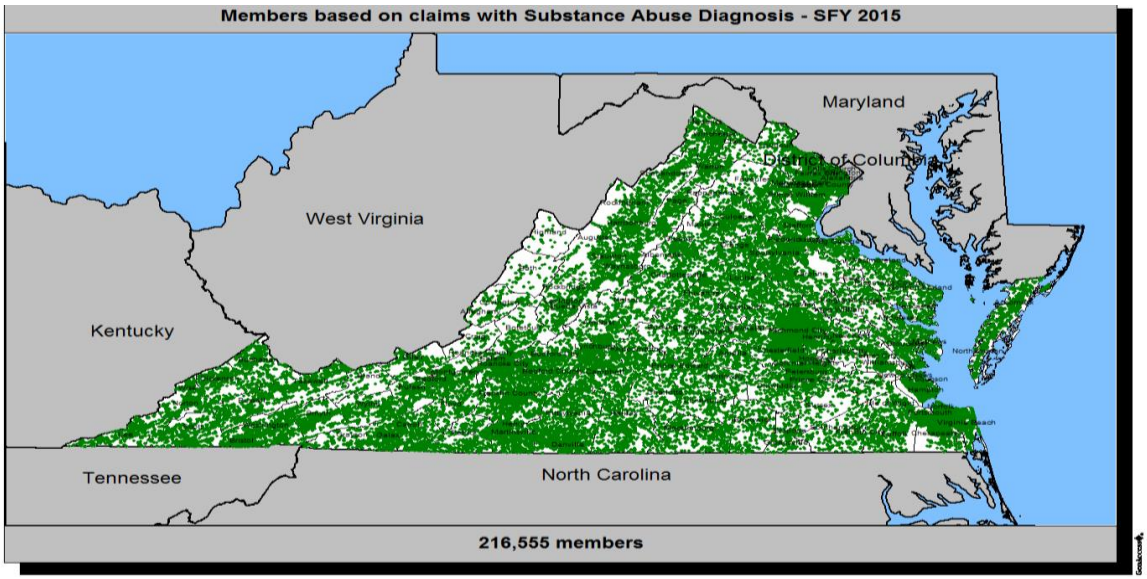


Figure 1: Virginia Medicaid Members with Claims with a SUD Diagnosis, SFY2015

Virginia is experiencing a substance use crisis of overwhelming proportions. The human cost and financial impact of this epidemic are significant. In 2013, Virginia's Medicaid program spent $26 million on opioid abuse and misuse and an additional $28 million on Medicaid members diagnosed with Substance Use Disorder (SUD) who were admitted to hospitals or Emergency Departments. DMAS identified 216,555 members with a claim that included a substance use disorder (SUD) diagnosis in state fiscal year 2015.

In response to the epidemic, Governor Terry McAuliffe created a bipartisan Task Force on Prescription Drug and Heroin Addiction. This Task Force issued dozens of recommendations to address prescription drug abuse and opioid use disorder. A major recommendation was to increase access to treatment for opioid addiction for Virginia's Medicaid which includes the MAPD Elite members by increasing Medicaid reimbursement rates.

To implement this recommendation, DMAS worked with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to develop a comprehensive Medicaid SUD Treatment Benefit. This benefit expands short-term inpatient detox and residential treatment to all Medicaid members, significantly increases rates for the full continuum of community-based addiction treatment services, and adds a new peer support service to support long-term recovery (see Figure 2). Furthermore, this benefit

Figure 2: Medicaid SUD Treatment Benefit Passed by Governor & General Assembly, March 2016

promotes a comprehensive transformation of Virginia's SUD delivery system by "carving in" the community-based addiction treatment services into Managed Care Organizations (MCOs) to promote full integration of physical health, traditional mental health, and addiction treatment services. This benefit was included in the Governor's budget and passed the General Assembly with strong bipartisan support. To ensure the successful implementation of the Medicaid SUD Treatment Benefit on April 1, 2017, DMAS seeks a SUD Delivery System Transformation 1115 Demonstration Waiver. The waiver is essential to achieving the expansion of residential treatment capacity required to meet the needs of Virginia's Medicaid population, including those in Dual Eligible Programs such as the Virginia Premier Elite Plan.

Under this demonstration, Virginia will pursue a broad and deep transformation of the Commonwealth's delivery system to ensure a comprehensive continuum of addiction treatment based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria including withdrawal management, short-term inpatient and residential treatment, partial hospitalization, intensive outpatient treatment, outpatient treatment including Medication Assisted Treatment (MAT), and long-term recovery supports. DMAS is partnering with DBHDS and MCOs to ensure that licensing aligns with ASAM, SUD providers are credentialed using ASAM criteria, and providers are trained to deliver addiction treatment services with fidelity to ASAM criteria.

Virginia will also use the demonstration to support reforms and practice changes including:

- Promoting strategies to identify individuals with SUD
- Disseminating evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and MAT
- Increasing use of quality and outcome measures and developing value-based payment models with the MCOs
- Developing innovative care coordination models to link individuals to SUD providers, primary care, community resources, and long-term recovery support services and ensure seamless care transitions between different levels of SUD care and primary care
- Implementing strategies to address prescription drug abuse and opioid use disorders including promoting the CDC Opioid Prescribing Guidelines
- Increasing the MAT provider workforce through intensive education and training statewide; and conducting a robust evaluation with outside academic experts to assess the impact of the demonstration

Virginia Premier will leverage, and expand as necessary, our existing quality management infrastructures, quality improvement processes, and performance measure data systems to ensure continuous quality improvement of SUD services. We will use the results of our performance on the SUD quality measures to improve outcomes. Quality improvement processes will include both rapid cycle quality improvement as well as larger system improvements.

In addition to the demonstration project at the State level, CMS also has a focus on substance abuse for MAPD populations. They have updated formulary requirements to allow better coverage for medication treatment programs and have revised opioid overutilization measures to encourage more timely interventions. All Part D plans are required to implement an Opioid

Overutilization Monitoring program which helps identify early abuse and requires intervention by the health plan.

The quality improvement processes put in place include the following as part of the PDSA cycle:

- Monitoring system-wide issues and performance metrics
- Identifying opportunities for improvement
- Determining the root causes
- Exploring alternatives and developing an approved plan of action
- Implementing the plan, measuring the results, evaluating effectiveness of actions, and modifying the approach as needed

Virginia Premier will assist providers in delivery of services in a manner that demonstrates cultural and linguistic competency. Members will be able to select programs and providers within those programs that meet their needs for self-determination, recovery, community integration, and cultural competency.

Utilization Management Program

The Utilization Management (UM) Program is designed to ensure that medical services rendered to members are medically necessary and/or appropriate, as well as in conformance with the benefits of the MAPD plans. The program encompasses services rendered in ambulatory, inpatient and transitional settings. The Quality and UM Programs work collaboratively to ensure members are receiving optimal care by identifying opportunities for improvement, prioritizing interventions and reassessing the intervention to determine the effectiveness.

The Medical Management Department is responsible for determining medical necessity of services as defined by CMS and DMAS for health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards including:

- Medical services
- Behavioral health and psychosocial services (delegated function)
- Mental health and substance use disorder (SUD) services, and addiction recovery and treatment services (delegated function)
- Services defined as reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary in accordance with regulations
- Services furnished can reasonably achieve their purpose
- Services are related to the ability to attain, maintain, or regain functional capacity
- Services is defined as an item or service provided for the diagnosis or treatment of a patient’s condition consistent with standards of medical practice
- Services are no more restrictive than medical necessity determinations used in the Medicare or Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Federal an dState statues, plans, or policies.

Full details of the Utilization Management Program can be found in the UM Program Description.

Case Management for Complex Health Needs

Virginia Premier's Case Management Program provides integration and coordination of medical and behavioral health case management provided by one case manager. It is a continuum of care model consisting of two (2) levels of care defined by the expected intensity and duration of services for the individual member. This model matches members with the resources they need to improve their health status. Members are identified for case management and then stratified to one of the levels of care. The case management program is an opt-out program and members have the right to participate or decline participation.

Annually Virginia Premier performs an assessment to determine the characteristics and needs of its member population and relevant subpopulations including members from each of the MAPD plans. Based on the analysis, updates to the case management program are made to align resources and identify creative approaches to meeting the needs of our vulnerable and complex members.

The goals of the CM Program are to improve the health of our members, improve the member's experience of care (including quality and satisfaction) and reduce health care costs. The case management program conducts a comprehensive assessment of the member's condition, determines available benefits and resources, and develops and implements a person-centric care plan with performance goals that includes monitoring and follow-up.

Case management procedures address any issue(s) that may be an obstacle or barrier to the member receiving or participating in the case management plan. A barrier analysis can identify issues such as language or literacy; lack of or limited access to transportation; lack of understanding of health condition; lack of motivation; cultural or spiritual beliefs; visual or hearing impairment; and psychological impairment. Full details of the program is documented in the Case Management Program Description.

Disease Management Program

Virginia Premier employs multifaceted strategies to identify members with specific high risk conditions or diseases and enroll them in the disease management program. Members are also identified to enroll in the disease management program by the following internal and external resources on a daily basis:

Internal Referrals

- Medical Outreach
- Case Managers
- Nurse Helpline
- Member services
- Quality Management Coordinators
- Medical Directors
- Health Educators
- Utilization Management
- Health Risk Assessment
- Pharmacy data and reports

External Referrals

- Practitioner office
- Hospital staff
- Caregivers and family members
- Member's self-referral
- State agencies
- CMS
- Local health departments
- Community service organizations

Virginia Premier uses the engagement method to enroll members in the Disease Management program. This "opt-out" model identifies members at all stages of health status and allows appropriate interventions based on member's needs. During the initial contact with the member the Disease Management Coordinator will discuss the member's right to choose not to participate, ensure that the member is making decisions based on full disclosure and provide information about what to expect from the Disease Management program if they participate. Information on the programs are also included in the Member Handbook as well as on the Virginia Premier member website.

Virginia Premier's disease management program includes a process for stratifying a population of eligible members into groups to identify interventions based on their level of risk and personal needs. The stratification of members includes both utilization and clinical data to determine risk level and subsequent appropriate interventions for the member. The Disease Management programs include strategic interventions focused on members identified as having one or more of the following conditions:

- Asthma
- Diabetes
- Heart Disease
- Mental Health
- Cancer
- COPD
- End Stage Renal Disease (ESRD)

Full details about the Disease Management Programs are in the Disease Management Program Descriptions.

Medical Outreach Activities and Health Education

Virginia Premier has ongoing outreach and health education efforts to ensure members are informed of quality outcome results. The organization promotes health education and preventive health care with our members through our Health and Wellness Program.

Our Health and Wellness program is for members of all ages. It works with the Disease Management and Care Management teams to promote healthy living. The program helps members find ways in their everyday life to meet their wellness goals.

As part of Health and Wellness, we offer Living Healthy programs. Each Living Healthy program includes a one-on-one phone consultation with a Health Educator. They will give members information, tools and resources to meet their needs. Some of the Living Healthy programs we offer:

- Eat Smart: Learn about food labels, portion control, and meals that lower your cholesterol and blood pressure. We'll provide recipes, food logs, mailings and classes.
- Go Smoke-Free: We offer Nicotine Replacement Therapy (NRT), and we'll send mailings with tips and tools to help you quit smoking. We also promote Quit Now Virginia, which offers free phone counseling and tools for all ages.
- We Like to Move It Move It: We can get you moving with suggestions on physical activities and exercises to improve members' well-being.
- A Monthly National Health Observances Calendar is utilized to provide education to members at events, baby showers, Member Advisory Committee meetings and health events
- Education for providers on coordinating care to meet the patient's need during one visit such as if a member is there for a sick visit, some preventive care may also be addressed in the same visit.

Credentialing and Recredentialing

Virginia Premier conducts credentialing and recredentialing activities for practitioners to include doctors of medicine, doctors of osteopathy, doctors of podiatry, doctors of obstetrics and/or gynecology, family nurse practitioners, licensed clinical social workers, psychiatrists, psychologists, and other licensed practitioners with whom it contracts to provide services to members.

The Credentialing Committee makes the final approval or denial decision on every practitioner. Upon approval or denial, a letter is mailed out within 60 calendar days of the decision, signed by the CMO or their designee. Credentialing and recredentialing includes primary source verification in accordance with organization's policies and procedures set forth by NCQA. Site visits are conducted for complaints involving physical accessibility, physical appearance and adequacy of waiting and examining room space. Site visits are also be conducted on a random basis for all network practitioners to ensure Virginia Premier's office site standards are met.

At the time of recredentialing, the individual practitioner performance profile is evaluated through consideration of information from licensure sanction reports, Medicare/Medicaid sanction reports, adverse actions, member grievances, site visits, medical records reviews, quality improvement projects, member satisfaction and utilization management data. Practitioners have access to an appeals process in the event of an adverse credentialing decision.

The Health and Human Services Office of Inspector General (OIG) is responsible for excluding individuals and maintaining a sanctions list that identifies those practitioners and providers who have participated or engaged in certain impermissible, inappropriate, or illegal conduct to include, but not limited to fraudulent billing and misrepresentation of credentials. The OIG's List of Excluded Individuals and Entities (LEIE) provides information on all individuals and entities currently excluded from participation in the Medicare, Medicaid, and all other Federal health care programs.

Credentialing Peer Review Activity

Peer review is conducted according to the regulatory, accreditation, and Virginia Premier established standards and/or laws and regulations. The CMO, with the assistance of the Medical Directors, manages the peer review process. Cases requiring peer review are identified through member, practitioner, or provider grievances and other sources. Peer review may be performed directly or arranged for review by an appropriate committee physician or external physician reviewer in accordance with Virginia Premier's policies and Procedures. Remedial and disciplinary action shall be taken in a timely manner in accordance with the Plan's policy.

Virginia Premier contracts with Medical Evaluation Specialists (MES) to provide external reviews for cases requiring specialties not represented by Virginia Premier Medical staff or committee.

Practitioner Golden Globe Award

Virginia Premier values quality and safety first, especially when coordinating and managing care for members. The Practitioner Golden Globe Award (PGA) program was established to recognize, promote, enhance and salute excellence in the Virginia Premier network of practitioners. Practitioners can be recognized if s/he has received an award and/or special designation in his/her field, appointment to a health related local, state or national committee, has received any of the National Committee for Quality Assurance recognition awards to include the Diabetes Physician Recognition Program, the Heart/Stroke Physician Recognition Program or the Physician Practice Connection designation. A practitioner can be nominated for the award by himself or herself, a member or a colleague. The PGA Program meets the intent of NCQA standard QI 1 – the organization has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members. This PGA program specifically addresses patient safety improvement. Also, this is a way of engaging the providers and recognizing their value to the health plan.

There is one award recipient per fiscal year based upon the following criteria: Practitioner must have an unrestricted, current and valid license, be in good standing with VA Premier, no founded grievances or quality issues within the last 12 months, and no legal issues. Practitioners are encouraged to proudly display the award in their office. Members, colleagues, and the public can access information about this program and the award recipients via member and provider newsletters and the VA Premier website: www.vapremier.com.

Contractual Arrangements

Non-delegated Credentialing – Provider and Practitioner Contracts

By signing the Practitioner Addendum to any of the provider or practitioner contracts, the signee is agreeing that they will:

- Abide by the policies and procedures of the Virginia Premier Quality Management Program
- Participate in peer review activity as requested
- Provide credentialing information as specified
- Serve on the HQUM, Credentialing or specialty peer review committees, as requested
- Allow Virginia Premier to collect information for the purposes of quality assessment and

improvement
- Cooperate with quality, disease, and case management, and/or grievance resolution, as necessary

Delegated Credentialing Functions

When Credentialing functions are delegated to contracted organizations, the delegated entities submit reports at least twice a year and undergo comprehensive audits of processes and files (as applicable) at least annually to ensure they are meeting Virginia Premier's requirements. Entities that Virginia Premier has entered into contractual arrangements with are responsible for monitoring and evaluating the contracted services. Delegated entities are required to provide routine reports on quality findings and results of quality improvement activities. The delegated entity develops its own Quality Program, in accordance with Virginia Premier, NCQA, and CMS Managed Care standards and guidelines, when applicable.

Any delegation of responsibility for Quality, UM, Credentialing, or other activities must be approved by Virginia Premier's CEO and the appropriate quality committees. The delegated activities will be conducted only after a written and signed agreement between the CEO of Virginia Premier and the designated executive with signature authority of the delegated organization is completed. Any such agreement shall specifically state the terms of the delegation and the policies and methods for oversight by Virginia Premier. Oversight of delegated entities shall be at least annually, announced and unannounced, and in accordance with standards set forth by the NCQA, DMAS, CMS and Virginia Premier policies and procedures.

The Quality Committees are responsible for oversight of the delegated quality functions. Findings and outcomes related to delegated functions are reported to the Credentialing, QIC, HQUM, and CQIC committees, as appropriate at least annually.

The *Partners State-Wide Conference Call* meeting was established in November 2011. Meetings are held quarterly to ensure an ongoing exchange of information between Virginia Premier and its quality and credentialing partners. The content of the meetings include Virginia Premier policies and procedures (new, revised or terminated), accreditation outcomes, regulatory requirements and other pertinent information. Streamlining and simplification of activities and processes are also discussed during these meetings.

Delegation Oversight Functions

Virginia Premier is ultimately responsible and accountable for all functions that are delegated to any of its Subcontractors (Medicaid) and First Tier, Downstream, and Related Entities (FDRs) (Medicare). Prior to delegating work to a Subcontractor or FDR, the Health Plan evaluates the prospective Subcontractor or FDR's ability to perform the activities to be delegated.

Virginia Premier implements and executes an oversight framework to monitor internal compliance within the operational areas along with compliance of its FDRs in an effort to ensure adherence with contractual obligations with the Health Plan including applicable State and Federal, Medicare and Medicaid laws and regulations. In addition, Virginia Premier provides staffing and technical support to State and Federal agencies as needed to conduct audits.

The framework consists of ongoing monthly reporting via a dashboard to the Senior Management Team (SMT). The dashboard include department specific metrics with a primary focus on highlighting any areas of non-compliance and operational deficiencies. The metrics are a mix of cost, spend and quality measures that are appropriate for the delegated entity's responsibilities. Outliers are identified and the SMT along with Program Integrity will review the issue and implement a corrective action plan as needed. Any issues identified as non-compliant will be rolled into the Risk Assessment process. Audits are conducted prior to the delegated entity beginning services and at least annually but may be any time thereafter if an issue has occurred or the entity is considered a risk.

Audits include the following elements:

- Collaborating with Compliance to get an understanding of the high risk areas to include in the audit
- Preliminary information gathering sessions with the business owners or Subject Matter Experts (SMEs) to identify key risk areas
- Review of Policies and Procedures including those related to code of conduct, Fraud, Waste, and Abuse, Privacy and confidentiality, Safeguarding protected information, and others
- Review of the contractual guidelines and regulatory guidelines
- Leading sessions which may include system's review, the business owners demonstrating the ability to perform the processes
- Outcome reviews if appropriate

The following services and functions are delegated:

- Behavioral Health Services, benefit administration, and utilization management
- National Imaging Associates for coordination of radiology and imaging services
- DentaQuest for UM and care coordination of dental services
- Vision Service Plan
- Selected Member Health Services
  - Home visits for annual wellness visit if needed
  - Nursing home care by nurse practitioners
  - Health Risk Assessment
  - Nurse Advice Line
- Pharmacy Benefit Management for Part D

In addition to the delegation oversight provided by the Delegation Oversight Team, Pharmacy Benefit Management (PBM) functions are overseen by clinical pharmacist and pharmacy team at Virginia Premier. Daily and monthly reports are reviewed by this team which are in constant communication with the delegated entity.

Member Safety Program

Virginia Premier is committed to providing quality services, enhancing the safety of members, practitioners, providers and staff while preserving its financial integrity and stability to continue its mission. The Member Safety Program (MSP) proactively identifies, evaluates and resolves potential safety issues. Virginia Premier is not a direct provider of care and, therefore, has a

special role in improving patient safety that involves fostering a supportive environment to help practitioners and providers improve the safety of their practices and the care they deliver. Practitioners who participate on the various quality committees also play an integral role in the MSP. A multidisciplinary team approach is utilized to implement the program. The team includes participants from the following departments:

- Quality and Accreditation
- Credentialing
- Utilization Management
- Medical Outreach, Health Education
- Case Management
- Disease Management
- Member Operations
  - Enrollment, Member Services, Transportation, and Mailroom
- Network Operations
  - Contract Management and Provider Relations
- Claims
  - Claims System Configuration, Cost Containment, Customer Service, Electronic Data Exchange
- Information Systems and System Integration Team
- Program Integrity
  - Compliance, HIPPA Compliance
  - Grievances and Appeals
- Human Resources and Organizational Development
- Business Performance Analytics and Financial Analytics

According to the Agency for Healthcare Research and Quality (AHRQ), patient engagement in outpatient safety involves two related concepts: first, *educating* patients about their illnesses and medications, using methods that require patients to demonstrate understanding (such as "teach-back"); and second, *empowering* patients and caregivers to act as a safety "double-check" by providing access to advice and test results and encouraging patients to ask questions about their care. Many research efforts have demonstrated use of these methods in engaging members to be better informed and able to self-manage their conditions through better decision making. Virginia Premier considers these concepts as foundational building blocks in our overall approach to improving care outcomes and member experience.

Goals of the MSP

- Enhancing the safety, quality, efficiency, and effectiveness of health care to ensure a safe and suitable healthcare environment
- Involve and engage members and practitioners in the process
- Educate members and practitioners
- Obtain feedback that will result in significant improvements in healthcare delivery by:
  - Conducting health care assessments on new enrollees
  - Conducting surveys (i.e., CAHPS®® and HOS), interviews, and focus groups
- Improve outcomes related to disease management programs or associated initiatives, i.e., diabetes, depression, pain management and asthma outcomes, heart failure, COPD, and ESRD

- Investigate grievances and appeals in a timely and accurate manner
- Validate practitioner and provider credentials in a timely and accurate manner
- Enhance prevention efforts across the continuum of care
- Comply with all requirements related to safety and quality per state, federal, and other accrediting agencies standards and guidelines

Scope of the MSP

Scope of the Virginia Premier MSP is broad-based and comprehensive. It includes but not limited to:

- Member outreach by mail
- Facilitating members ability to communicate with their doctor through use of self-help guides and education
- Provider and practitioner outreach by phone, text or email
- Quarterly newsletters mailed and posted on website
- Recognizing practitioners and providers who are leaders in quality and safety
- Dissemination of national safety priorities and preventive care guidelines using multiple methods including in person visits with practitioners, mail, email, fax blasts, and inclusion of Virginia Premier recommendations in the Provider Manual
- Including internal and community practitioners on the various quality committees providing insight into current clinical practice
- Providing Quality Toolkits to providers that provide resources on patient safety including:
    - Summary of the guidelines
    - Quick reference guide
    - Patient education materials
    - Patient self-management tracking tools when appropriate
- Conducting quality office site visits to insure providers are meeting standards related to safety and evidence based practice

The program description is presented to Quality Committees annually. Goals are set each year and outcomes are evaluated annually.

Member Safety Initiatives (MSI)

The following activities are ongoing initiatives that help assure Virginia Premier enrollees receive the best healthcare on a continuous basis. The Plan assesses health care safety by using readily available administrative data (survey, claims, etc.), grievance data, and medical record data.

The MSIs are based on a set of indicators providing information on adverse outcomes following surgery, procedure, or childbirth. The indicators also include occurrences that are unusual or may indicate a concern in quality of care or service in either an inpatient or outpatient setting. The MSIs serve as the core factors that are reported monthly, quarterly, and/or annually as applicable. The indicators are screened, investigated, analyzed, trended and monitored by the Quality Department. Indicators developed are followed by an in-depth assessment by the quality

department and medical informatics departments. Outcomes are aggregated and reported at least annually. The Virginia Premier MSIs are further defined below.

Sentinel Event Reviews

Virginia Premier defines a sentinel event (also known as a quality of care indicator) as one of the following:

- Trauma suffered while in a healthcare facility/provider's office/HMO site
- Surgery on wrong body part
- Surgery on wrong patient
- Loss of function not related to illness or condition
- Rape in 24 hour care facility
- Suicide in 24 hour care facility
- Infant abduction or discharge to wrong family
- Death

Sentinel events are identified through a variety of mechanisms including, but not limited to:

- Claims review
- Utilization Management referrals
- Case Management referrals
- Complaints and Grievances
- Provider and practitioner notifications
- Medical record reviews

Each sentinel event is investigated by a licensed, registered nurse in the Quality Department. Investigation assists in detecting omissions in the process that occur during the delivery of care. Conducting root cause analyses on adverse events, such as sentinel events, enables the Plan to implement systemic modifications to prevent the event from reoccurring.

Quality of Care Indicators

Any adverse event that is investigated by a nurse in the quality area. A Medical Director and/or the quality committees, if necessary, review indicators. The indicators are used to help the Plan identify potential adverse events that might need further study. Conducting root cause analyses on adverse events enables the Plan to implement systemic modifications to prevent the event from reoccurring. Indicators are received from various sources and include grievances, medical record reviews, provider complaints, practitioner office site audit, or regulatory agency. Grievance defines the overall system that includes grievances and appeals that are handled at the managed care organization level. Once a grievance is received it is screened for potential Quality of Care concerns and investigated by a Quality RN. The investigation results are then forwarded to the assigned Medical Director who acts as a first level peer reviewer. These issues are presented to the Quality Committees in an aggregated form.

All unresolved cases at the first level peer review will be submitted for second level peer review for determination of severity level and appropriate corrective action. Final determinations regarding any serious disciplinary actions will require approval by the HQUM and CQIC. Virginia Premier will adhere to the reporting requirements of the State Medical Board, Office of Inspector General (OIG), the National Practitioners Data Bank (NPDB), and Virginia Premier Policies and Procedures.

Credentialing

The process of verifying the credentials of a practitioner or provider ensures that each member is treated by a practitioner or provider licensed to conduct business in the Commonwealth of Virginia and an approved Medicare Provider. Any practitioner that is on the Office of Inspector General list will not be paneled to the plan or will be terminated upon identification.

Medical Record Review

The objectives of the Medical Record Review (MRR) are to:

- Evaluate the structural integrity of the medical record
- Evaluate the medical record for the presence of information that is necessary to provide quality care and determine the appropriateness and continuity of care
- Evaluate the medical record for documentation that conforms to good medical practice
- Assess and improve medical record keeping practices of practitioners who provide primary care
- Conduct focused follow-up to improve medical records of practitioners who do not meet Virginia Premier medical record standards

Clinical reviewers are trained in the use of the MRR tool to collect data. Data summaries and opportunities for improvement are reported to the plan's Quality Committees at least annually. MRR results are also disseminated to the practitioners and follow-up reviews are conducted as necessary and per the established plan policy.

All instances of suspected fraud, waste or abuse at the practitioner and provider level will be referred to the Compliance Department for investigation within 24 hours of identification.

Grievance and Complaints

The objectives of grievance monitoring are to:

- Trend, evaluate and monitor grievances
- Effectively resolve member or practitioner grievances within the defined timeframe
- Identify opportunities for improvement in the quality of care and services provided to Virginia Premier members and practitioners

Issues are tracked, trended and aggregated by the Quality Department. All provider care, treatment, and access grievances are forwarded to a nurse in the quality department to investigate and review for quality issues and then may be referred for follow-up to Case Management or Provider Services. The Quality Department policies and procedures ensure timely response and resolution. Cases scored at a higher severity level are forwarded to a Medical Director for review. Cases with higher severity may also be reviewed by the Quality Committees and corrective action planning if appropriate.

Data related to administrative and quality of care or service issues are collected, reviewed and analyzed in aggregate form for trends and opportunities for improvement. The aggregated data is presented to the Quality Committees at least annually.

A Medical Director conducts the final review of investigation outcomes. Members and practitioners are informed of investigation outcomes in writing or by phone.

When members are not satisfied with the outcome of a grievance, an appeals process allows for inclusion of additional information and reconsideration of the issue. During the grievance resolution process, members are notified in writing of their right to file an appeal at any time, and provided the necessary information to file the appeal.

Providers also have appeal rights which are defined in the Provider Manual.

Management of Quality of Care Complaints

All grievances or issues generated by members, practitioners, providers, Virginia Premier staff, state agencies, and other entities that involve quality of care are handled appropriately per established policy that includes response to grievances. Member contacts concerning access for a current illness or condition are routed to a clinician in utilization management department. The clinician is accountable for timely assessment and resolution. Virginia Premier's Medical Staff perform an objective review of all quality of care complaints and issues in accordance with Virginia Premier's Policies and Procedures.

Medical Errors

Medical errors are one of the Nation's leading causes of death and injury. A report, *To Err is Human: Building a Safer Health System*, by the Institute of Medicine estimates that as many as 44,000 to 98,000 people die in U.S. hospitals each year as the result of medical errors. This means that more people die from medical errors than from motor vehicle accidents, breast cancer, or AIDS. The report concludes that the majorities of these errors are the result of systemic problems rather than poor performance by individual practitioners, and outlined a four-pronged approach to prevent medical mistakes and improve patient safety.

- Establish a national focus to create leadership, research, tools, and protocols to enhance the knowledge base about safety
- Identify and learn from medical errors through both mandatory and voluntary reporting systems
- Raise standards and expectations for improvements in safety through the actions of oversight organizations, group purchasers, and professional groups
- Implement safe practices at the delivery level

Pharmacy Quality and Safety Initiatives

Virginia Premier follows the CMS guidelines when implementing Drug Utilization Review (DUR) controls and Safety Edits in the Part D program. The application of formulary benefit management tools, point-of sale (POS) DUR and safety edits will be administered by the Pharmacy Benefit Manager (PBM), Envision. Additionally, the organization has instituted an effective approach to comply with the Centers for Medicare and Medicaid (CMS) Overutilization Monitoring System (OMS), Sponsor Identified Potential Overutilization Issue (SPI) and Patient Safety Reports in accordance with 42 C.F.R. §423.153 et seq (HPMS memo, July 5, 2013).

Utilization management and safety edits are applied at the POS. Utilization management edits will include:

- Prior Authorization (PA);
- Step Therapy (ST)
- Quantity Limits (QL)
- Screening for potential drug therapy problems due to therapeutic duplication
- Age/gender-related contraindications
- Over-utilization and underutilization
- Drug-drug interactions
- Incorrect drug dosage or duration of drug therapy
- Drug-allergy contraindications
- Clinical abuse or misuse
- Opioid Overutilization
- Acetaminophen Overutilization

Virginia Premier Pharmacy staff maintains oversight processes to ensure the implementation of the utilization management edits by, at minimum, reviewing daily rejects, quality review of monthly formulary tools such as, online searchable formulary tool, monthly PDF formulary drug list, sample test claims, and quality review of excel formulary reports.

Virginia Premier will have access to monthly Patient Safety Drug Adherence reports via Acumen website to compare their performance to overall averages and monitor their progress in improving the prescription drug patient safety measures. These actionable reports include summary contract-level Patient Safety Reports for each measure, additional detail-level reports, and outlier reports. Virginia Premier holds the care of the member as its upmost priority and use of Patient Safety Drug Adherence reports will aid in coordinating proper medication adherence care.

National Patient Safety Goal for Ambulatory Care – 2018

The **2018 National Patient Safety Goals (NPSG) for Ambulatory Care** promotes specific improvements in patient safety. The goals highlight fundamental areas affecting member safety. Virginia Premier educates our practitioners on the goal(s) associated with this safety initiative and a list of problematic abbreviations. The National Patient Safety Goals that are routinely provided to network practitioners and providers. The goals in their entirety can be located at: https://www.jointcommission.org/assets/1/6/2018_AHC_NPSG_goals_final.pdf

The Joint Commission

During site visits, the Quality Staff educates and distributes The Joint Commission's National Patient Safety Goal "Do not use abbreviations." Annually, the "Do Not Use List" is communicated to the practitioners via the Provider Newsletter.

The National Patient Safety Goals, (NPSG) promote specific improvements in patient safety. The goals highlight fundamental areas affecting member safety. The following list includes "Do Not Use" abbreviations that are often the cause of medical errors. Virginia Premier educates our practitioners on the goal(s) associated with this safety initiative and a list of problematic abbreviations.

In 2001, The Joint Commission issued a Sentinel Event Alert on the subject of medical abbreviations, and just one year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "do not use" list of abbreviations as part of the requirements for meeting that goal. The purpose of the goals is to promote specific improvements in patient safety. The goals, in their entirety, can be located at: http://www.jointcommission.org/standards_information/npsgs.aspx

Each year, Virginia Premier highlights the "***Do Not Use"*** list**,** which is included under NPSG – 2B. In May 2005, The Joint Commission affirmed its "*Do Not Use*" list of abbreviations, acronyms, symbols and dose designations. The list was originally created in 2004 by the Joint Commission (formerly JCAHO) as part of the requirements for meeting NPSG requirement 2B (Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization). Participants at the November 2004 National Summit on Medical Abbreviations supported the "do not use" list. Summit conclusions were posted on the Joint Commission website for public comment. During the four-week comment period, the Joint Commission received 5,227 responses, including 15,485 comments. More than 80 percent of the respondents supported the creation and adoption of a "do not use" list. Virginia Premier supports the use of this list and encourage all practitioners and providers to utilize it in practice.

Official Do Not Use List[1]

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)[1] Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO 4 and MgSO 4	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

[1]The list applies *to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms. Webpage last updated in June 2017.*
Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Annually, Virginia Premier reviews The Joint Commission National Patient Safety Goals for relevance to the care and services related to practitioner and provider networks. For more information, go to https://www.jointcommission.org/standards_information/jcfaq.aspx

Preventive Care Guidelines Review

The objective of the Preventive Care Guideline Review is to monitor the use of scientifically based preventive care guidelines for improving the quality of care provided. Virginia Premier continuously monitors the effectiveness of adopted preventive care guidelines. The Quality Committees review and approve these guidelines based on the most current and reasonable medical evidence available from the US Preventive Services Task Force, the CDC and Healthy People 2020, National Health Promotion and Disease Prevention Objectives, as well as the state

requirements. Findings and distribution schedule of the guidelines are discussed at the Committee meetings.

Clinical Practice Guidelines

The Quality Department develops the clinical practice guidelines tools based on evidence. The guidelines must have been peer reviewed and will be developed in areas in which evaluation reveals the greatest need for such guidelines. Guideline dissemination is approved by the appropriate Quality Committees and are then shared in summary form or as part of a Provider Toolkit. Practitioners are educated regarding clinical practice guidelines via the Provider website, Provider newsletters, the Provider Manual, and in person visits as requested. Practitioners are informed that they may receive a paper copy of the guidelines upon request.

New Technology or Procedures

It is the standard operating procedure of Virginia Premier to develop and implement medical payment polices (MPP) based on current evidence based guidelines. The Medical Management department identifies when a new policy is needed from a request for services, industry best practice or regulatory changes. Once a need is identified, the Medical Directors will perform research to determine the appropriateness of the request based on evidence based guidelines, health plan benefits, and federal and state regulations. If the benefit is an exclusion based on Medicare regulations, the policy will be denoted as a non-covered benefit. The assigned Medical Director will complete the policy with appropriate references and present the new policy to the Health Quality, Utilization Management (HQUM) committee for review and approval.

Over and Under Utilization

Over and underutilization of services are monitored to ensure that members are receiving necessary care and service in the most appropriate setting. Data are gathered from the following sources:

- Member and provider satisfaction surveys
- Grievance and appeals data
- Provider utilization data based on claims
- Pharmacy utilization reports
- Utilization management reports
- Quality of care reports
- Medical record/site visit reviews
- HEDIS®® outcomes

Data is trended and analyzed at least annually and more often if needed. Action plans are created and implemented based on the analysis. There is specific focus for the MAPD population on the following:

- Opioid overutilization
- Annual wellness visit (underutilization)
- PCP and Specialist visits
- Emergency Department utilization
- Hospitalization for preventable conditions
- Hospital readmission within 30 days of discharge

Network Development

Network Development focuses on exploring and implementing opportunities to improve member access to care and services. Data are continuously gathered and analyzed throughout the organization to ensure that our Network(s) meet these needs and is able to deliver quality healthcare to our members. Some examples of analysis include but are not limited to the following:

- Our Practitioner Golden Globe Award Program, which is designed to identify and recognize the highest quality participating physicians for their contribution in delivering quality care to our members. This program rewards certain physicians through acknowledgement as well as an enhanced fee schedule on an annual basis.
- Annual geo-access reporting that identifies any potential network deficiencies that we would need to recruit into our network(s).
- An appointment availability analysis to ensure that members have access to needed providers and that they are getting desired appointments within the required timeframes.

Results from these activities are presented to the Quality Committees at least annually.

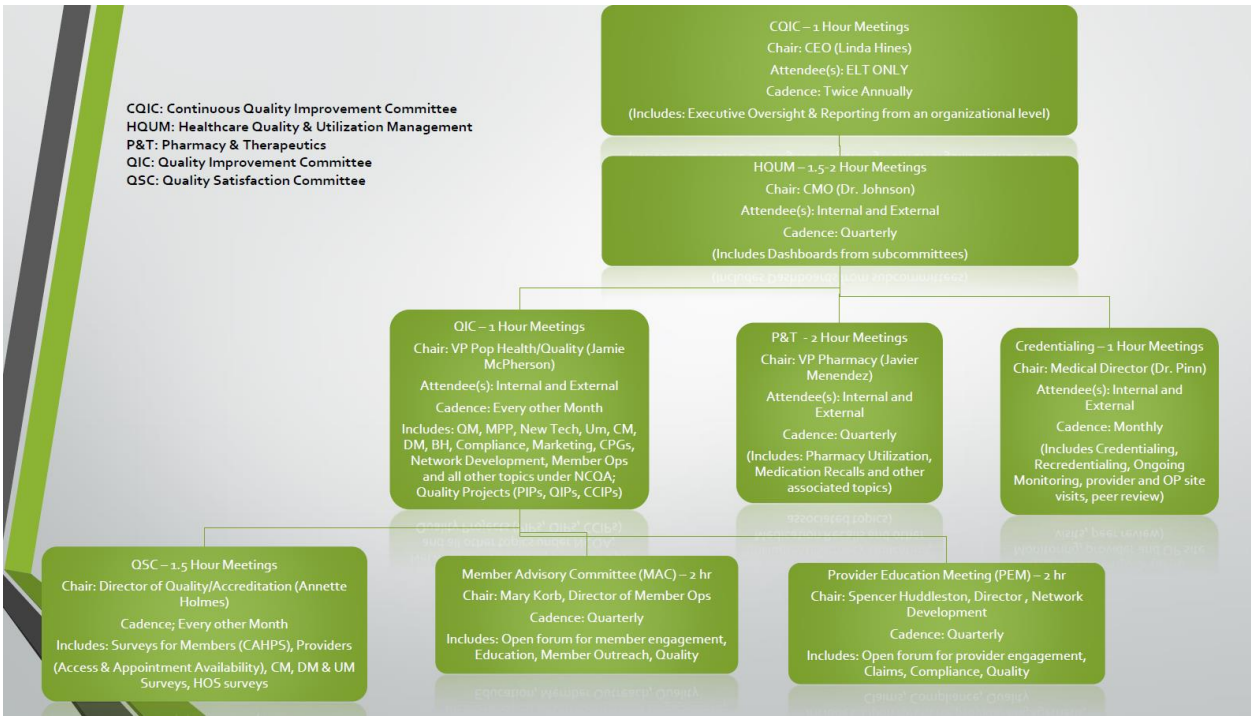
Customer Service

Member Services seeks to establish and maintain effective communication with members in order to deliver the highest level of service. Member satisfaction is evaluated from data which includes phone performance, member complaint handling, and member/provider satisfaction surveys (CAHPS® and other internally developed surveys). Survey data are reviewed monthly, and continuous process improvements are developed to optimize service levels in areas such as first call resolution, Average Speed of Answer, information accuracy and content of written materials (health literacy). Member satisfaction, complaint and appeal information are used to identify opportunities for improvement, review root cause and define “end to end” processes to provided excellent outcomes as warranted.

Committee Oversight & Functions

Virginia Premier’s Board of Directors (BOD) has delegated program oversight to the Continuous Quality Improvement Committee and subcommittees; however, the Board has ultimate authority, accountability and organizational governance for the Quality Program. The Quality Committee structure was designed to provide appropriate oversight of all quality functions by reviewing and approving annually the Quality Program Description, Annual Evaluation and Work Plan for the subsequent year. Additional functions include review and approval of reports and ad- hoc studies. The Quality Committees meet regularly as defined below in each description.

Committee Structure



Continuous Quality Improvement Committee (CQIC)

The CQIC, chaired by the Chief Executive Officer (CEO), has ultimate authority, accountability and organizational governance for the Quality Program. The CQIC consists of the Executive Staff of Virginia Premier and all members have voting privileges. Appointment to the Committee is by virtue of Executive Staff position. The CQIC meets at least twice per year. The CQIC approves policies and provides direction for all activities described in the Quality Program and Quality Work Plan, including delegated Quality activities. Additional responsibilities of the Committee include:

- Advising the Health Quality and Utilization Committee (HQUM) and subcommittees on quality initiatives and give recommendations for improving practices
- Reviewing targeted instances of potential poor quality, and provide guidance as needed
- Ensuring that the appropriate agencies receive required reports and any additional information as outlined by governmental regulators
- Reviewing and acting on requirements/recommendations of external quality review organizations
- Reviewing summary data with comparison to industry standard benchmarks and providing recommendations as appropriate
- Providing input on incorporating quality improvement throughout the organization and evaluating the effectiveness of continuous quality improvement activities across the organization

Healthcare Quality and Utilization Management (HQUM) Committee

The HQUM is chaired by the Chief Medical Officer (CMO) and is responsible for the development, implementation and management of quality and utilization improvement processes

as well as providing overall direction to Virginia Premier staff and providers on appropriate use of covered services. The HQUM meets every other month and the findings and outcomes are reported to the CQIC. The committee will meet at least six times per year, the committee members includes the following:

- Chief Medical Officer (voting) – Chair
- Medical Directors (voting) – Richmond
- Participating Primary Care Physicians (voting)
- Participating Specialty Care Physicians (voting)
- Behavioral Health Physician, Associate Medical Director (voting)
- Vice President, Population Health Outcomes (Quality) (voting)
- Vice President, Health Services (voting)
- Vice President, Health Services Operations (voting)
- Vice President, Pharmacy (voting)
- Resource staff (as needed non-voting)

Functions of the HQUM Committee:

- Oversee, evaluate and analyze data for improvement opportunities. The types of data (dashboards) that will be collected and reviewed include:
  - Star Ratings
  - Healthcare Plan Effectiveness Data and Information Set (HEDIS)
  - Consumer Assessment of Healthcare Providers and Services (CAHPS®)
  - Health Outcomes Survey (HOS) results
  - Home and Community Based Services (HCBS) Experience Survey results
  - A quality of life survey, such as the Young and Bullock 2003 survey, adapted for general populations
  - Appeals (upheld and overturned)
  - Patient safety data
  - Grievances (quality of care and quality of service)
  - Pharmacy utilization data
- Track and trend outcomes and report and provide feedback and recommendations to subcommittees on improvement
- Oversee all activities related to pharmacy, utilization management and new technology
- Approve clinical performance standards and practice guidelines
- Ensures provider participation in and compliance with the Quality Improvement Program
- Review summary data of utilization management trends, Sentinel Events, Critical Incidents, Serious Reportable Events, and over- and under-utilization of services and evaluate opportunities for improvement
- Review and approve utilization management criteria for decision-making
- Approve clinical practice guidelines
- Monitor and oversee delegated Utilization Management functions
- Review and render decisions on grievances resulting from denials or modifications in requests for medical services from providers based upon medical necessity and treatment protocols.
- Medical Record Review outcomes are discussed at the HQUM committee and shared with the practitioners in the network to ensure ongoing compliance and facilitate

improvement. Deficient elements, related to the CAHPS® Survey or the Medical Record Reviews, regardless of activity, are targeted for process improvements.

Quality Improvement Committee (QIC)

The QIC chaired by the Vice President of Population Health Outcomes (Quality) is the foundation of the Quality Management Program (QMP). The QIC assists the CMO and administration in overseeing, maintaining, and supporting the QMP and Work Plan activities. The purpose of the QIC is to monitor and assess that all Quality activities are performed, integrated, and communicated internally and to the contracted network providers, practitioners and partners to achieve the end result of improved outcomes and services for members.

Committee membership includes Vice Presidents and Directors from across the organization. This provides an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program and drives actions when opportunities for improvement are identified. The QIC meets, at a minimum, every other month, or more often as needed.

Functions of the QIC:

- Approve and monitor the progress of the Quality Management Program Description, Annual Work Plan and Evaluation
- Approve and monitor the progress of the Utilization Management Program and Annual Evaluation
- Approve and monitor the progress of the Case Management Program Description and Annual Evaluation
- Approve and monitor the progress of delegated entities program descriptions and annual evaluations
- Share outcomes with the members and providers at least annually
- Evaluate member and plan information compiled by the Quality Department
- Select and schedule initiatives based upon the needs of the population, external requirements, and likelihood of effective interventions
- The HQUM reviews the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and provider satisfaction data and then the data are shared with both the members and practitioners by way of newsletters, advisory meetings and site visits. Outcomes are monitored, tracked over time and reported to the committee at least annually, when required. Data and service activities include, but are not limited to:
    - Quality Improvement studies
    - Trended data from sentinel events
    - Quality of care and service data
    - Member and Practitioner Satisfaction Surveys
    - Access and availability assessments
    - Medical record reviews
    - Appeals data
    - Grievance data
    - Over and under-utilization data

Pharmacy and Therapeutics Committee

The organization's Pharmacy and Therapeutics (P&T) Committee, chaired by the Vice President of Pharmacy, provides guidance in pharmaceutical product selection, evidence-based appropriate use criteria, guidelines, algorithms, and cost-effectiveness of formulary choices for the organization's lines of business and the Drug Utilization Reviews (DURs). The P&T Committee oversees:

- The development, implementation, maintenance of formulary strategies
- Access to medications by members
- Other drug utilization controls for the organization's customers

The P&T committee bases formulary decisions on cost factors only after safety, clinical efficacy, and therapeutic need is established and supported by evidence-based data and clinical guidelines.

The committee includes a multidisciplinary team of physicians, pharmacists, and other health care professionals and administrators comprising at least 50% non-organization employed health professionals. The P&T Committee meets, at a minimum, quarterly, or more often as needed.

Credentialing Committee

The Credentialing Committee is responsible for oversight of activities of the Plan's Credentialing Program and Peer Review. Policies and procedures related to Credentialing are reviewed and approved by the HQUM. The committee meets at least 12 times per year and includes representation from the HQUM support committees, with the addition of a voting Virginia Premier Network Development staff member responsible for contracting.

Committee Members:

- Chief Medical Officer – (voting) –Chair
- Medical Directors (voting)
- Participating Primary Care Physicians (voting)
- Participating Specialty Care Physicians (voting)
- Behavioral Health Physician (voting)
- Vice President, Network Development or designee (voting)
- Manager of Credentialing (non-voting)
- Resource staff (as needed non-voting)
- Statistician (as needed non-voting)

Functions of the Credentialing Committee:

- Reviewing all practitioner applicants to ensure compliance with credentialing requirements and ultimately making recommendations for approval or denial. If denied, the appeals process is offered.
- Reviewing all practitioner applicants for the following prior to recredentialing:
  - Selection criteria suitability
  - Medical record standards compliance
  - Member grievance trends
  - Results of quality review studies
  - UM activities

- Member satisfaction survey results if available
- Reviewing independent practitioners prior to credentialing and recredentialing
- Giving periodic updates and annual evaluation of the credentialing program to the CQIC
- Reviewing delegated credentialing activities
- Sanctions and/or limitations related to state licensure and Medicaid and Medicare

Quality Satisfaction Committee

The Director of Quality & Accreditation or designee, who reports to the Vice President of Population Health Outcomes (Quality), chairs and is responsible for the Quality Satisfaction Committee. The committee includes representatives from operational departments that have a direct impact on accreditation, member compliance, and member and practitioner/provider satisfaction. The committee ensures that there is a coordination of activities, a reduction or elimination in duplication of efforts, and streamlined activities to ensure maximum output and outcomes. This includes sharing of information that could be beneficial to all related satisfaction activities that could adversely impact the satisfaction level of members, practitioners/providers, consumers, regulators, or accrediting organizations as well as a review and audit of processes, procedures, activities and programs. This committee also makes certain that collaboration and sharing of information occurs periodically to improve organization, membership and network-wide satisfaction. The organization annually makes information about its Quality Program available to member and practitioners.

The Virginia Premier Quality Satisfaction Committee has been developed in response to growing internal, CMS, DMAS, and NCQA requirements/standards and the need for a more streamlined and collaborative process that encompasses organizational-wide satisfaction. The committee meets at a minimum, on a quarterly basis.

Member Advisory Committee (MAC)

The MAC meetings provide a forum that allows members to provide the organization with feedback and gives the organization an opportunity to share information about what we have to offer and this reinforces collaboration with the members. A member representative is selected to be “the voice” of the members to bring forth any issues or concerns regarding our program. There is a Quality Forum where members are given the opportunity to inform us of any service issues or concerns they may be experiencing. This is a forum to provide health education, organizational updates and engage members in quality improvement. The MAC Meetings occur quarterly in each region.

Provider Education Meetings (PEM)

The Provider Education Meetings (PEM) give our providers an opportunity to listen to updates and ask questions from each operational department including Provider Services, Claims, Medical Management, Quality, Compliance, and others. The participants in the meeting range from practitioners, specialists, community health centers staff, behavioral health practitioners and providers as well as office staff and billing persons. These face-to-face meetings provide excellent communication between our health plan, physicians, medical groups, and hospitals.

There are four PEM meetings held in each region per year. The attendance at the meetings vary per region.

Culturally & Linguistically Appropriate Services

Virginia Premier is committed to ensuring participating providers have training and resources needed to deliver culturally and linguistically appropriate services (CLAS) to our members. The organization strives to meet the needs of the underserved and vulnerable populations by delivering quality driven, culturally sensitive and financially viable healthcare. It is the organization's belief that all its members should receive equitable and effective treatment which is non-discriminatory. Virginia Premier follows the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*.

According to the Institute of Medicine's *Unequal Treatment Report*, social and cultural differences influence practitioner-patient communication and health care decision-making. Evidence suggests that practitioner -patient communication is directly linked to patient satisfaction, adherence, and health outcomes. NCQA also addresses cultural needs and preferences the Standards which say "The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary". Virginia Premier meets the intent of this standard through the Cultural Competency Program.

To ensure that programs and services are available to meet the cultural and linguistic needs of members, Virginia Premier will utilize sources such as census data and enrollment files to identify member language, race and ethnicity when possible to determine additional languages for written materials, compatibility with practitioner networks, cultural and linguistic needs of members and other potential healthcare needs that might be associated with cultural beliefs and healthcare behaviors.

Goals of the Program

- Provide educational opportunities for participating practitioners to on how to deliver culturally competent care in an effective and respectful manner
- Strengthen the delivery of health care to culturally diverse populations
- Facilitate meeting members' cultural, racial, ethnic, and linguistic needs and preferences by creating guides and tools to help practitioners and other providers better communicate in meaningful ways with their patients
- Promote safe and effective clinical practice by improving access for diverse populations

Virginia Premier will ensure systems and processes are in place to address the goals for serving the culturally and linguistically diverse membership, through the following objectives:

- Analyze demographic data to identify significant culturally and linguistically diverse populations with plan's membership. Revalidate data at least annually.
- Identify specific cultural and linguistic disparities found within the plan's diverse populations.
- Analyze HEDIS® results for potential cultural and linguistic disparities that prevent members from obtaining the recommended key chronic and preventive services.

- Enhance current patient-focused quality improvement activities to address specific cultural and linguistic barriers using culturally targeted materials addressing identified barriers.
- Provide a more thorough organizational understanding of the specific reasons behind identified cultural and linguistic barriers. This can be accomplished through varied forms of direct member input including focus group, member feedback forms or surveys, and complaint analyses.
- Conduct analysis of interpreter availability
- Develop educational materials to meet the cultural and linguistic needs of the population served addressing the top clinical conditions and others as requested.
- Provide staff with necessary information, training, and tools to address identified cultural barriers.

Performance Monitoring and Targeted Improvement Plans

Clinical Performance

Monitoring Quality Performance Indicators - HEDIS® Measures

The purpose of HEDIS® is to ensure that health plans collect and report quality, cost and utilization data in a consistent way so that regulators, accreditors and the plan itself can compare performance across health plans regionally and nationally. Virginia Premier uses HEDIS® measures to provide network practitioners and providers with a standardized assessment of their performance in key areas in comparison to plan-wide findings. All HEDIS® data is collected through claims and other health plan systems and analyzed by NCQA certified software. Virginia Premier selected Inovalon as our HEDIS® software vendor. They are a leading national company meeting all the requirements and are certified by NCQA. Multiple reports and analysis summaries are created within the software which enables the company to identify excellent outcomes as well as identify opportunities for improvement. Virginia Premier conducts further analysis of HEDIS® results to better understand clinical outcome patterns and focus on key priorities.

The QI Department annually collects and reports HEDIS® data according to the contract and regulatory requirements. Staff members analyze HEDIS® data to identify opportunities to improve all measures. The MAPD Quality Team places a special emphasis on HEDIS Measures that are used for scoring of Star Measures. Medicare Advantage Plans are required to submit audited HEDIS® data to CMS annually. This data is used in determining scores on 17 out of 34 Part C Star Measures.

Provider Education and HEDIS® Visits

Physician engagement is key to impacting the care and outcomes of our members. Virginia Premier considers physicians partners, recognizing the most effective way to improve outcomes is through a collaborative approach. A known strategy to engage providers is to use relevant and current data and provide tools that enable them to be successful. Care Gap Reports listing members paneled to their practices along with the identified measures that need to be met are one tool used successfully. HEDIS® High Volume and Utilization reports are generated to determine provider offices with more than 50 paneled members. Once identified, Quality staff complete

Provider Office training to provide education on HEDIS® measures including tips on how to set up medical records to capture all components of particular measures.

During the visit, **Practitioner HEDIS® Toolkit** is provided to the practice to re-enforce educational efforts by the staff. These provider toolkits have been well received. The contents of the toolkit consists of:

- Quick Reference Billing Codes for key measures
- PCP Change Request Form
- Care Management Request Form
- Information about CAHPS® and HOS surveys
- HEDIS® Hybrid Measures and Provider Measure Overview
- Annual Wellness Visit and Comprehensive Exam information
- Diabetes Patient Checklist
- Information on how to request additional toolkits
- Member Safety Program Flyer

Patient Safety Monitoring

Patient safety needs are addressed through the following activities:

- Review of grievances and determination of quality of care impact
- Notification to patients, practitioners, and providers of medications recalled by the Food and Drug Administration
- Notification to the Quality Team of any potential quality or safety cases (e.g., re-admissions within 30 days when a premature discharge is a question, significant provider errors include pharmacy, unexpected deaths, missed diagnoses or treatments, missed follow-up, or insufficient discharge planning)
- Comprehensive site surveys and medical record review, or in response to a Grievance or direction of the Quality Committee
- Targeted and general member educational outreach
- Encourage the completion, for at least 50% of the network physicians, especially primary care practitioners, to complete a cultural competency CME to aid in caring for members of diverse populations.

Chronic Care Improvement Program (CCIP)

Decreasing the Risk of Cardiovascular Complications in Members with Diabetes

Planned Implementation Date: January 1, 2018

Target Chronic Condition

The Centers for Disease Control (CDC) report that 30.3 million people in the United States have diabetes with about 23% of them undiagnosed. Of the 30.3 million, 25% are 65 years old or older. Diabetes prevalence is higher among the American Indian, Black, and Hispanic populations. Over 7 million people with hospital admissions in 2014 had a primary or secondary diagnosis of Diabetes. Many of these admissions are considered preventable with most frequent diagnosis related to major cardiovascular disease. Diabetes is the seventh leading cause of death in the United States as of 2015.

The American Diabetes Association (ADA) reports that 837,000 people in Virginia have diabetes with close to 25% of them unaware that they have the condition. An additional 2 million in Virginia have prediabetes with 37,000 newly diagnosed every year.

The CDC estimated the total cost of Diabetes to be $245 billion in 2012. The ADA estimated the cost of Diabetes for Virginia was $6.2 billion in direct medical expenses in 2012. As the incidence of Diabetes continues to grow, so does the cost of care.

Aside from the dollars spent on Diabetes across the nation; complications from extended elevated blood sugars occur over time causing micro and macro cardiovascular conditions such as retinopathy, nephropathy, heart disease, and stroke. Diabetic Retinopathy (DR), one of the microvascular complications, is the leading cause of vision loss. In a 2010 meta-analysis, 28.5% of the U.S. population diagnosed with Diabetes had some stage of DR. Controlling hyperglycemia and decreasing spikes in serum blood sugar after meals is one of the most important factor in prevention and slowing the progression of DR.

Achieving and maintaining a close to normal blood sugar is critical in preventing and slowing progression of the cardiovascular complications associated with Diabetes. Evidence based standards of care exist for medical management of Diabetes and should be followed. Research has shown that the best method for achieving normal glycemic levels is to facilitate diabetes self-management skills in those affected and will be the primary focus of this program.

Virginia Premier selected Type I and Type II Diabetes as the chronic condition on which to focus efforts for this CCIP. The following are the overall goals and outcomes for this program including

- Improved self-management skills for members with Diabetes
- Improved Hemoglobin A1c values
- Increased numbers of members receiving an annual retinal eye exam
- Decreased hospital readmissions for members with a primary diagnosis of Diabetes during an index stay

The Virginia Premier Medicare Advantage Elite plan is one of the three plans included under the Medicare Advantage and Prescription Drug (MAPD) contract. This plan is a Dual Eligible Special Needs Plan (DSNP) that requires members to be fully eligible for Medicaid (low income) and Medicare. As of January 1, 2018; this plan had 1,200 plus members enrolled comprising over half of the membership of the entire MAPD contract. Enrollment is continuing to grow. The Elite plan initially enrolled its first members in 2017. While enrollment was very small the first year, it is increasing rapidly in 2018 largely due to the closing of the Medicare and Medicaid Plan (MMP) in which Virginia Premier participated. Many of the MMP members enrolled into the DSNP plan and the Medicaid Long Term Services and Supports (MLTSS) plan also offered by Virginia Premier. Since the population will largely consist of the same members that were in the MMP plan, we are able use MMP data to estimate characteristics of the 2018 DSNP population.

The MMP population reported the HEDIS Diabetes measures for 2017. We can use that rate and compare to the CMS Stars 2018 Report Card to evaluate the effectiveness of Diabetes management across all MAPD plans for both A1c control (<9) and Retinal Eye Exams.

According to the 2017 Report Card Master Table, an average of 77% of members had blood sugars in control and 72% had received an annual eye exam or had a negative eye exam for the prior year. Diabetes is prevalent among the MMP population and Virginia Premier Medicaid population has experienced low rates of success with both of these measures. While this population may be somewhat different, we anticipate results may be similar for the DSNP population.

Measure	2017 Master Report Card for all MAPD Plans – Average rate across all plans	Virginia Premier 2017 HEDIS Submission for the MMP – reported rate
A1c <9	77%	63.33%
Diabetic Retinal Eye Exam	72%	51.40%

Planned Interventions

Virginia Premier is currently providing Disease Management for members with Diabetes including education, care coordination, and transition care management post hospitalization for a primary diagnosis of Diabetes or related complication. These efforts are aimed at positioning the organization for success in the future by delivering high quality care in a cost effective manner while enhancing the member's experiences in care.

While services are currently being offered, several enhancements to the program are planned and will include all the following:

- Monthly claims reports identifying all members who have a diagnosis of Type I or Type II Diabetes filed on an inpatient or outpatient claim
- Changing the method of outreach from a TeleVox interactive voice response (IVR) system to a live phone call
- Creating standardized evidence based teaching materials and lesson plans to be used in self-management education and coaching
- Conducting an initial assessment of member self-management knowledge and needs
- Creating an interdisciplinary care plan based on individualized assessed needs, documenting in the care plan when goals are achieved
- Provide education and support, evaluating member understanding, reinforcing education as needed
- Provide follow up at least every 90 days or more frequently based on member's needs
- Work collaboratively with the newly formed Virginia Premier transition care team to eliminate duplication of efforts and ensure members receive care coordination during the immediate post hospitalization period

Measures for Evaluation

- Percent of eligible members agreeing to participate
- Percent of participating members who demonstrated increased knowledge of their self-management skills for Diabetes
- Percent of members whose A1c was in control (HEDIS Measure and Star Measure)
- Percent of members with Diabetes who have an annual dilated eye exam or who had a negative eye exam the year prior

- Percent of members who had an index hospital stay with a primary diagnosis of Diabetes who also had a readmission within 30 days of discharge

These measures will be collected from claims and internal data and will be reviewed monthly in the form of a dashboard report.

Clinical Guidelines

The following guidelines and best practices were used in the formation of this project:

- American Diabetes Association *Standards of Medical Care* – 2017
  - The standards are evidence-based best practices and include a focus on the Diabetes self-management, medication management, monitoring for cardiovascular complications including retinal eye exams, and A1c goals of less than 8
- Planned collaborative interventions for care coordination during transitions from hospital care are built on the Care Transitions Model which is based on the work of Eric Coleman and team. It incorporates four pillars for interventional focus including:
  - Medication self-management
  - Use of a dynamic patient-centered record to facility accurate communication across the continuum
  - PCP and Specialists follow up
  - Knowledge of "Red Flags" for signs that the condition is worsening and how the member should respond

Enrollee Population

At the time this CCIP was written, there were just over 1200 members enrolled in the DSNP program with enrollment still underway. This number will be updated once enrollment is complete.

Using the MMP data as a guide to estimate our Elite population, the following are expected characteristics for this plan membership:

- All DSNP members struggle with socioeconomic barriers
- Most are frail, putting them at higher risk for adherence problems and self-management
- The majority are community dwelling (79%)
- About 20% are nursing home eligible but may be in the community with a waiver
- The leading chronic conditions for hospital care include
  - Chronic kidney disease
  - Diabetes
  - Cancer
  - Serious Mental Illness including depression
  - Cerebrovascular disease
- The leading chronic conditions in nursing facility care include:
  - Cerebrovascular disease
  - Dementia

    - Diabetes
    - Congestive Heart Failure
    - Chronic Obstructive Pulmonary Disease
- The leading conditions for care provided by the community providers include:
    - Serious Mental Illness
    - Diabetes
    - Mental retardation
    - Chronic Obstructive Pulmonary Disease
    - Cancer
- 65% are female
- Race
    - 56% are white
    - 36% black
    - 6% Asian
    - 2% other

The diagnosis of Diabetes appears in the top 5 clinical conditions across all care settings. The CDC estimates that one in every four United States Citizens have Diabetes. This leads us to expect that of the 1200 Elite members, there should be at least 300 who have Diabetes.

Primary Goals of the CCIP

The primary goals of the CCIP are to improve member ability to self-manage their disease and gain better control their A1c values in effort to prevent of cardiovascular complications like retinopathy. Additionally, the program will focus on decreasing readmissions to the hospital within 30 days of discharge from an index stay with a primary diagnosis of Diabetes.

Baseline

The Virginia Premier MMP plan did not meet the requirements for reporting data for members with Diabetes in the 2017 data collection for HEDIS so there is no adequate population to use to establish an estimated baseline. Instead, we will use the first year to establish baseline and compare results with those of the other MAPD plans across the nation.

National Standard

The national standard used to compare outcomes will be the annual Report Card for MAPD plans published by CMS along with the Star Ratings by measure for each plan contracted with CMS. The 2017 (using 2016 data) average score was 77% for blood sugar control and 72% for retinal eye exams. These benchmarks may change annually based on new data received by CMS.

Data Sources to Measure Goals

- Claims data for internal measurement of monthly readmission rates and cost
- HEDIS data for annual measurement
- CMS Star Ratings for annual measurement
- Internal data to evaluate member knowledge and monthly progress

The Quality Department will evaluate the success of the project annually and report to the appropriate Quality Committees. Quarterly meetings with Disease Management and others will be held to review current state, barriers encountered, and effectiveness of intervention strategies. As needed, the team will follow the PDSA cycle to make rapid improvements and keep the program on course.

Quality Improvement Project (QIP)

Making Care Safer by Using Enhanced Care Coordination to Reduce the Risk of Readmission within 30 days After Hospital Discharge for the MAPD Elite Population

Nearly one in five Medicare patients discharged from the hospital have an acute medical problem that arises in the subsequent 30 days requiring a readmission. Hospital readmission accounts for $15 billion in Medicare spending annually. About 70% of the readmissions are related to problems other than the original index stay diagnosis and may be due to Post-Hospital Syndrome which creates more physiologic and cognitive vulnerability in the immediate time just after discharge. Additional influences such as individual risk factors, socioeconomic status, medication reconciliation after discharge, and access to the primary care provider all impact the risk of readmission.

According to the 2015 Quality Disparities Report, healthcare quality has generally improved but care coordination measures have lagged behind in overall performance. In particular, disparities and differences persist in access to care based on race and socioeconomic status. Virginia Premier member population for Medicare Advantage includes a large number of dual eligible special needs members who are socioeconomically challenged due to low income. Research has shown that readmission rates are higher for the Medicaid population and is linked to this disparity. Effective care coordination, communication, and improved access are the primary focus in this project. Ensuring that care transition procedures are providing clear, less fragmented communication and sharing of pertinent information are all important elements in care coordination. Virginia Premier believes that better care coordination during the transition from acute care to the community provider will improve safety and decrease unplanned readmissions.

QIP Supports CMS Strategy Goals

This project will support three of the Centers for Medicare and Medicaid Quality (CMS) Strategy Goals:

- Goal 1: Make care safer by reducing harm caused in the delivery of care
- Goal 3: Promote effective communication and coordination of care
- Goal 6: Make care affordable

Anticipated Outcomes

Enhanced care coordination will improve patient safety due to improved accuracy of communication and information shared across the continuum. Care coordination will involve collaborative approaches with the entire care team across the continuum. Community providers will be able to use that information to determine the best course of treatment including safe use of medications through medication reconciliation. Accurate information and a collaborative plan of care are critical factors in appropriate management and prevention of complications in the post-hospital phase. Another key factor in making care safer is patient education in a form that is easy to understand and enables the patient and caregiver to accurately follow the discharge

instructions. Patient centered education has proven to be effective in preventing visits to the Emergency Department and/or additional hospitalization. By decreasing ED visits and hospital readmissions, cost of care becomes more affordable.

Rational for Selection

The Virginia Premier Medicare Advantage Elite plan is one of the three plans included under the Medicare Advantage and Prescription Drug (MAPD) contract. This plan is a Dual Eligible Special Needs Plan (DSNP) that requires members to be fully eligible for Medicaid (low income) and Medicare. Currently, this plan has 1,200 plus members enrolled effective January 1, 2018 comprising over half of the membership of the entire MAPD contract. Open enrollment is continuing so this number will most likely grow. The Elite plan initially enrolled its first members in 2017. While enrollment was very small the first year, it is increasing quickly in 2018 largely due to the closing of the Medicare and Medicaid Plan (MMP) in which Virginia Premier participated. Many of the MMP members are moving to the DSNP plan and the Medicaid Long Term Services and Supports (MLTSS) plan also offered by Virginia Premier. Since the population will largely consist of the same members in the MMP plan, we are able use the MMP data to estimate characteristics of the 2018 Elite population.

Readmission data for the MMP plan showed a year over year increase in the 30-Day All-Cause Unplanned Hospital Readmission rate going from 18.83% in 2015 up to 21.34% in 2017. Among the top 30 high-volume conditions seen on readmission, the average cost per readmission was $8,690. This totaled over 23 million in 2017 just for the high volume cases.

Since Virginia Premier has claims data for 84% of the 2018 enrolled Elite members, additional analyses were conducted to help create a more accurate baseline readmission rate for this population. The data used for the analyses were admissions that occurred for these members from January 1, 2017 to June 30, 2017 initially and was recalculated using additional data from July 1, 2017 to December 31, 2017.

All-Cause Readmissions in 30 days of hospital discharge for the Elite population effective January 1, 2018	Calendar Year 2017
Inpatient Admissions	562
Inpatient Cost	$ 5,477,011
Cost per Admit	$ 9,745
Index Admissions	519
30 Day Readmissions	88
Total Readmission Cost	$ 1,003,146
Cost per Readmit	$ 11,399
Readmission Rate	16.95%

Target Population

The target population of this project is all DSNP members who are admitted to an acute care facility for any reason from January 1, 2018 – December 31, 2018.

Planned interventions

Virginia Premier is currently participating in an organization wide initiative called "Vision by Design" (VBD) aimed at positioning the organization for success in the future by delivering high quality care in a cost effective manner while enhancing the member's experiences in care. One part of this effort is focused on utilization and specifically the readmission rates and cost of readmissions. A team of front line staff were selected to work on designing an improvement project to improve the transitions of care with a focus on an interdisciplinary collaborative process. The project will use **enhanced care coordination during the transition phase from acute care to community care**.

The following interventions have been designed by this team to improve care coordination and collaboration across the continuum:

- Collaborating by phone with the member, member's caregiver, physicians, and other providers
- An initial assessment while the member is still in the hospital
    - Completing a standardized risk for readmission tool and stratifying the member either in a high risk or low risk category
    - Collaborating with the hospital discharge planner
- Creating a transition care plan that is shared with the caregiver team across the continuum and the member
    - Ensuring the PCP follow up visit is scheduled, either in 7 days from discharge for high risk members or 14 days of discharge for low risk members
    - Ensuring written discharge instructions are given to the member
- On discharge or within 3 business days of the discharge, a follow up call will be made to assess success with the discharge plan, ensuring the member and caregiver understand the discharge instructions along with each of the following:
    - The member is aware of signs and symptoms or "Red Flags" for which they need to call their doctor or return to the ED
        - If education needs are identified, referral to the appropriate disease management or health education program
    - Reassessment of support in the community, make referrals to social services if needed
    - Reassessment of changes in IADLs, changes in DME requirements; assisting with obtaining needed equipment
    - Review member understanding of medication changes and assess ability to self-manage medications as a result of transition
    - For members in the high risk category, the Care Manager (CM) will:
        - Complete a full medication reconciliation
        - Review more in depth the action plan for when to call the PCP or the VPHP Nurse Advice Line versus a visit to the ED
        - CM will conduct an additional follow up call with the member or caregiver with 7 – 14 days after the last successful contact with the member
    - Depending on the needs of the member after the final transition call, the CM may:

- Close the transition case or
- Transfer the member to complex case management

Primary Goal of the QIP

The primary goal of the QIP is to decrease the all cause 30 day hospital readmission rate. This will be monitored and trended month to month using internal data with the final annual rate coming from the 2018 HEDIS and Star Rating assigned by CMS. The target for 2018 is to decrease the readmission rate to 15%.

Clinical Guidelines used to Shape the QIP

The following guidelines and best practices were used in the formation of this project:

- The risk assessment tool used to stratify the member as high risk or low risk is modified for VPHP from the LACE Scoring tool which uses these criteria:
    - Length of Stay
    - Acuity
    - Comorbidities
    - Emergency Department Visits
- The planned interventions for enhanced care coordination are built on the Care Transitions Model which is based on the work of Eric Coleman and team. It incorporates four pillars for interventional focus including:
    - Medication self-management
    - Use of a dynamic patient-centered record to facility accurate communication across the continuum
    - PCP and Specialists follow up
    - Knowledge of "Red Flags" for signs that the condition is worsening and how the member should respond

Enrollee Population

The enrollee population for this QIP are the same as described above in the CCIP. Using the MMP population as a guide, we can expect about 9% of this population to have one or more hospital admissions this year. That translates to about 108 Elite members who will have a hospitalization in 2018.

Monitoring

Virginia Premier will be monitoring select measures including:

- The percentage of members who complete the Transition of Care program
- The percentage of members who had a PCP appointment within 14 days of discharge
- The percentage of members who had Medication Reconciliation within 30 days of discharge
- Total costs of readmissions

The Quality Department will evaluate the success of the project annually and report to the Quality Committees. Quarterly meetings with Disease Management and others will be held to review current state, barriers, and effectiveness of intervention strategies. As needed, the team will follow the PDSA cycle to make rapid improvements and keep the program on course.

Stars Improvement Plan

Star Ratings are critically important to MAPD plans. They are a reflection of both the quality of care being delivered as well as the member experience with the plan and the network providers. The Stars Improvement Plan matches best practice interventions with measures that may be impacted by the intervention. The following briefly describes the known best practices for each of the measure categories. The Stars Improvement Plan is intended to be a working document and will be updated as new best practices are identified. In addition, a complete section on the Quality Annual Work Plan will be dedicated to this effort.

Gap Closing Process for Medical Record Measures

Many of the member outcome measures are linked to clinical care and are collected each year as part of HEDIS reporting. The primary intervention for these measures is to create a monthly monitoring process in which to identify gaps in care then work collaboratively with providers and members to close the gaps. Member engagement with incentives and provider engagement with incentives will be offered for selected gap closing activities. Additional interventions for some medical record measures include enhanced care coordination for transition care management and targeted education to enrich self-management skills for members with chronic conditions.

The Quality Department in collaboration with Performance Analytics is developing a strategic approach to designing interventions through use of Tableau technology. Tableau is able to identify care gaps geographically and provides visualization of where the members are geographically concentrated that have the most gaps. This allows the Quality team to focus efforts where the most need exists.

Survey Measures

CMS requires all MAPD plans to contract with approved vendors to administer both the Health Outcomes Survey (HOS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey each year the plan is eligible. Only the Elite plan was initiated in 2017 and membership was very small so Virginia Premier is not eligible for the official CAHPS survey in 2018. In its place, we will do an off season survey using the same vendor to assist the plan in gathering experience of care information.

The determining factor for eligibility for the HOS survey is the number of enrollees as of February 1 in the measure year. Enrollment has grown and both the Gold and Platinum plans accepted members for 2018. This created an adequate number of members for the HOS baseline survey which will be conducted in 2018. The HOS survey is administered to cohorts of members with a baseline survey followed two years later with a follow up survey. This allows for comparison of member perception over time.

Virginia Premier will design member and provider engagement activities in effort to improve the member experience with their healthcare. A focus on member education to help them understand how the healthcare system works will be used in addition to care coordination across the continuum, and first call resolution by member services. Timely responses to member requests, management of grievances and appeals will also be a focus.

Data to help manage the planned activities will come from mini surveys the plan administers throughout the year, CMS reports on Call Center activities, the official HOS and offseason CAHPS surveys, as well as grievance and appeals data.

CMS Monitored Activities

There are several Star Measures that are calculated from CMS administrative data gleaned from direct reporting to CMS by the plan and or member communications. The mandated reporting is defined in the CMS Part C and Part D Reporting Specifications. Best practices to be used for improved ratings in for the survey measures include:

- Monthly dashboard monitoring, using root cause analyses and developing action plans when data indicates a concern.
- Enhanced care coordination and outreach
- Empowering customer service representatives to expertly use first call resolution in problem solving are primary interventions

Medication Safety Measures

Each of the medication safety measures are scored by CMS using plan reported data, mostly PDE data except for the Medication Therapy Management (MTM) program. Best practices used for improvement of these measures include:

- Monthly monitoring of adherence and MTM reports
- Provider and member engagement and education
- Member outreach and care coordination when there are issues in obtaining medications
- Involving a pharmacist in these monitoring and outreach efforts

Upcoming Measures

CMS makes changes in the Star Measures on an annual basis. When changes are made in Star Measures or new ones developed, they are usually place on the display measure list for at least one year to allow time to evaluate the effectiveness of the measure changes. Display Measure results are gathered from the same data sources as the Star Measures but they are not used in the calculation of the Star Rating score. They are additional quality indicators used by CMS in the overall evaluation of quality provided by a health plan. Some display measures have never migrated over to the Star Measure list but continue to be important in evaluation of the quality of care outcomes for the Plan's population.

Currently, there are 18 Part C, 18 Part D, and 7 Enrollment measures on the Display Measure list. CMS publishes these results every year along with an average score across all MAPD plans for benchmarking purposes. It is expected that plans will review these scores and identify additional opportunities for improvement activities.

Some additional measures are expected to be included in the Star Measures in 2019. Those measure results will be based on 2018 data and therefore must be included in our 2018 Stars Improvement Plan. Both of the new measures involve prescribing statin therapy for certain populations. Each of these measures will be included in the Gap Closing processes and the Medication Safety processes.

Service Performance

Member Experience

Use of CAHPS®

Surveying member experience provides Virginia Premier with information on our members' experience with the plan and their practitioners. Member experience is assessed in several ways, but the primary measurement tool is Medicare CAHPS®. Results from this survey helps the Plan identify areas of member dissatisfaction and opportunities for improvement. Based on the results along with other member satisfaction feedback mechanisms, such as the Member Advisory Committee Meetings, Virginia Premier prioritizes improvement initiatives that are most meaningful to members.

Use of HOS

The Medicare Health Outcomes Survey (HOS) is designed to gather information about the member's perception about their health status. This survey is actually two surveys conducted over a two year span of time intending to evaluate changes in the member's health status over that time. There is a baseline survey and a follow-up survey and provides valuable information to the Health Plan regarding effectiveness of care and Plan programs. The survey is also designed to focus on quality of life concerns and includes questions about these conditions:

- Urinary incontinence
- Physical activity
- Fall risk
- Osteoporosis treatment
- Physical and mental health status

Practitioner Experience

Surveying practitioner satisfaction, access and availability provides Virginia Premier with information on our practitioner's experience with the plan and their members. Practitioner satisfaction is assessed in several ways, but the primary measurement tool is the Provider Satisfaction Survey and the Access and Availability Survey and the After Hours Survey. Results from these surveys help the organization identify areas of practitioner dissatisfaction and opportunities for improvement. Based on the results, along with other practitioner feedback mechanisms such as the Provider Advisory Committee Meetings, Virginia Premier prioritizes improvement initiatives that are most meaningful to practitioners and members.

Quality Satisfaction Committee

The Director of Quality or designee, is responsible for the Virginia Premier Quality Satisfaction Committee. The Committee includes representatives from operational departments that have a direct impact on accreditation, member compliance and member and practitioner/provider satisfaction. (The Committee ensures that there is a coordination of activities, reduction/elimination in duplication of efforts, and streamlined activities to ensure maximum output and outcomes. This includes sharing of information that could be beneficial to all related satisfaction activities that could adversely impact the satisfaction level of members, practitioners/providers, consumers, regulators, or accrediting organizations as well as a review and audit of Virginia Premier processes, procedures, activities and programs. This Committee also makes certain that collaboration and sharing of information occurs periodically to improve

organization, membership and network-wide satisfaction. The organization annually makes information about its Quality Program available to member and practitioners.

The Quality Satisfaction Committee has been developed in response to growing requirements and standards and the need for a more streamlined and collaborative process that encompasses organizational-wide satisfaction.

Model of Care - MAPD Elite Population

The Model of Care is a specific outline of care management processes designed and regulated to provide the best possible care and services for members participating in a designated program. The MOC consists of:

- Specific target populations
- Measurable goals
- Interdisciplinary Care Team (ICT)
- Provider network with expertise and use of clinical practice guidelines
- Health risk assessment
- Individualized care plans
- Communication of network
- Care management of the most vulnerable subpopulations

Model of Care Performance and Health Outcome Measures

Specific Target Populations

Virginia Premier Advantage Elite is a Medicare Advantage Special Needs Plan, serving members who are dually eligible for Medicare and Medicaid within Virginia Premier's Advantage Elite servicing area. Virginia Premier's Advantage Elite members have demonstrated the eligibility requirements and have been enrolled in Medicare Part A, Part B and Medicaid benefits. Members may be enrolled in the Virginia Premier Elite Plus (MLTSS) Plan as their Medicaid benefit.

To better understand the MOC, it is imperative to identify the specific target population covered under Virginia Premier. Dual Eligible Special Needs (D-SNP) members are those who have diagnoses or clinical conditions that place these individuals at high risk for poor health outcomes. These individuals have an increased risk due to a combination of risk factors such as being elderly with two or more health conditions, being socially isolated, having limited access to food or transportation, and being at increased risk for making poor health choices. Virginia Premier identifies the following groups as the most vulnerable members who will be in the DSNP:

- Individuals with cognitive or memory problems (e.g., dementia and traumatic brain injury)
- Individuals with physical or sensory disabilities
- Individuals requiring skilled nursing facilities
- Individuals with serious and persistent mental illnesses
- Individuals with complex or multiple chronic conditions
- Individuals who are frail/elderly or end of life Measurable Goals

The purpose of the MOC is to improve the care and services provided to members. The MOC works to ensure:

- Access to essential medical, behavioral, and social services
- Access to affordable care
- Coordination of care through an identified primary point of contact
- Seamless transitions of care across health care settings, providers, and health services
- Access to preventive health services
- Improvement of member health outcomes
- Appropriate utilization of services

Interdisciplinary Care Team (ICT)

The ICT is a group of individuals that participates in the development and implementation of a person-centered care plan that includes appropriate interventions that assist members with achieving their self-identified health goals. The ICT may include, but not be limited to:

- The member**
- Family member(s), caregiver, or legal representative**
- Care Manager**
- Primary Care Physician**
- Social Worker
- Disease Management
- Health Educator
- Specialist
- Targeted Case Management (for members with behavioral health needs)
- Pharmacy
- Medical Directors

**Core composition of the ICT team for all members

The frequency of these ICT meetings are contingent upon the member's health needs and preferences. The Care Manager will arrange for ICT meetings at the member's and/or their representative's availability and supply ICT participants. ICT meetings will occur telephonically and participants will have access to the Interdisciplinary Care Plan (ICP) and pertinent health information with permission from the member or his/her representative.

Clinical Practice Guidelines

Virginia Premier conducts a welcome call with each new member to initiate a health risk assessment tool (HRAT). The HRAT determines the medical, psychological and environmental needs of the member. This assessment is also used to determine the level of care management the member will require and serve as the foundation for developing the ICP.

Care Manager

A registered nurse who has demonstrated the appropriate level of education and experience to provide care management services for the D-SNP population. The Care Manager conducts a comprehensive assessment of the member's health and psychosocial needs in collaboration with the member, family, providers, social agents, and other participants of the care team. Care

Managers will:

- Conduct in-depth assessments to determine the services the member will need.
- Convene and lead the interdisciplinary care team (ICT).
- Employ a person-centered approach based on each member's strengths, needs and preferences through involvement of the member, their family, their caregiver(s), and members of the Virginia Premier care team and a network of community-based supports in the care planning and care delivery process.
- Develop an individualized care plan (ICP) with the member, their family and caregivers coordinated by the Interdisciplinary Care Team (ICT) to fully address and adhere to the member's strengths, needs and preferences.
- Utilize community-based resources as available to help support the member's needs and preferences.
- Coordinate with the member's Medicare plan to ensure appropriate utilization
- Promote the member's ability to actively exercise their rights and responsibilities.
- Provide ancillary program referrals such as disease management services for individuals with chronic conditions to obtain disease-specific education and support. Educate members regarding the importance of self-care, prevention, and health maintenance

Health Risk Assessment Tool (HRAT)

The HRAT is an assessment conducted to evaluate a member's physical condition, cognitive functioning, behavioral health, frailty and functional needs. This assessment is administered within the first ninety (90) days of enrollment to the plan. Once the initial HRAT has been completed, the assessment will then occur on an annual basis. The Member Engagement Representative (MERs) are primarily responsible for conducting the HRAT with the member and/or his/her caregiver. The HRAT identifies the potential need for specific case/disease management and potential care management needs based on medical or psychosocial issues. The HRAT assesses the following:

- Member's perception of health status
- History of hospital and ER utilization
- Substance use
- Caregiver supports
- Pain level
- Chronic medical and/or behavioral health conditions
- Number of medications taken
- Fall screening and mobility limitations
- Special care needs such as Durable Medical Equipment (DME)
- Weight gain/loss patterns.
- Behavioral health screenings

Individualized Care Plan (ICP)

The ICP is a person-centered, comprehensive plan designed to address the member's strengths, specific needs and preferences that includes but is not limited to:

- Prioritized goals based on member and/or caregiver needs and preferences
- Time frame for evaluation of the goals, interventions and resolution of problems
- Resources to be utilized

- Transition/continuity of care
- Collaborative approaches
- Medication management
- Self-management plan
- Outcome measures
- Social/community service needs
- End of Life Needs
- Advance care planning (such as advance directives)
- Condition-specific educational needs
- Integrated elements of other care plans (such as home health or targeted case management)

The initial step in developing the ICP is completion of the HRAT with the member and/or caregiver. The Care Manager then engages the member and/or their caregiver along with the ICT in developing the ICP. The ICP is a working document and may have updates as the member completes goals or wishes to add additional goals/preferences to the plan. Additionally, if a member experiences a triggering event such as a change in their health condition or hospitalization, the ICP will be updated to include these changes by the Care Manager, member, and ICT.

Communication Network

The MOC must include effective, and in some cases enhanced and technologically advanced, communication methods. Virginia Premier utilizes many different methods when communicating with members and providers. Avenues of communication include the following:

- Member Services Call Center
- Newsletters
- Brochures
- Reminder Mailings
- Website
- Member Meetings
- Focus Groups Provider Communication
- Provider Visits
- Provider Training
- Peer Review Committee letters
- Provider Meetings
- Provider Services Call Center
- Provider Newsletters
- Provider Website
- Personalized faxes
- Face-to-face meetings

Model of Care Quality Improvement

Virginia Premier has implemented a Quality Improvement process specifically for the Model of Care which includes all the mandated elements listed below.

Required Element	Description
Element A	MOC Quality Performance Improvement Plan
Factor 1	Overall Quality Performance Improvement Plan
Factor 2	Data Sources Used
Factor 3	Personnel and the Internal Quality Performance Process
Factor 4	Integrating SNP-Specific Goals and Health Outcomes with the Plan
Element B	Measurable Goals and Health Outcomes for the MOC
Factor 1	Identifying Measureable Goals
Factor 2	Identifying Health Outcome Measures
Factor 3	Tracking and Assessing Goals
Factor 4	Processes and Procedures Regarding Goals and Outcomes
Factor 5	Steps Taken with Unmet Goals
Element C	Measuring Patient Experience of Care (SNP Member Satisfaction)
Factor 1	Surveys Used
Factor 2	Rational for Surveys Used
Factor 3	Integrating Survey Results
Factor 4	Steps taken to Address Issues in the Surveys
Element D	Ongoing Performance Improvement Evaluation of the MOC
Factor 1	Ongoing Improvement of the MOC
Factor 2	Continually Assessing Quality of the MOC
Factor 3	Interpreting and Responding to Lessons Learned
Factor 4	Sharing Information with Key Stakeholders
Element E	Dissemination of SNP Quality Performance related to the MOC
Factor 1	Communicating Results
Factor 2	Scheduled Frequency
Factor 3	Ad-Hoc Communications
Factor 4	Responsible Staff

Quality Reporting System (QRS)

The Quality Program provides a formal structure and process designed to monitor and evaluate the quality and safety of care and service through defined performance metrics. Managing data is an essential part of performance improvement. It involves collecting, tracking, analyzing, interpreting, and acting on an organization's data for specific measures, such as the clinical quality measures. Measuring a health system's inputs, processes, and outcomes is a proactive, systematic approach to practice-level decisions for patient care and the delivery systems that support it. Data management also includes ongoing measurement and monitoring. It enables an organization to identify and implement opportunities for improvements to its current care delivery systems and monitor progress as changes are applied. Managing data also helps a the team understand how outcomes are achieved, such as, improved patient satisfaction with care, staff satisfaction with working in the organization, or an organization's costs and revenues associated with patient care.

Clearly defined performance metrics will allow the organization to collect the data necessary to improve the appropriateness, efficiency, effectiveness, availability, timeliness, and continuity of care delivered to our members. This approach also provides focus on opportunities for improving operational processes, increasing member and practitioner satisfaction, and effectively providing and managing health outcomes.

The Quality Program employs multiple evaluation and improvement methods including, but not limited to, data-driven monitoring, medical record audits, performance measures, and provider and member satisfaction surveys. We analyze the appropriateness of care provided by comparing practice against evidence-based practices and professional practice standards. We collect, analyze, report, and act on diverse program data points in the QM/QI Work Plan and Annual Evaluation to drive targeted, continuous quality improvement strategies.

Managing Data for Performance Improvement encompasses four primary steps of data management:

- Collecting data
- Tracking data
- Analyzing and interpreting data
- Acting on data

Virginia Premier participates in validation audits through external review organizations to ensure data is accurate and complete.

Reporting Data

The Virginia Premier Quality Management Department is responsible for implementation and management of all quality activities through an interdisciplinary team that includes internal quality specialists, quality nurses, and medical economic analysts. Quality specialists ensure ongoing compliance for accreditation and regulatory standards through auditing, assessment, data collection, tracking, monitoring, and analysis and provide feedback/recommendations. Quality nurses monitor for clinical outcomes through medical record reviews and investigations of clinical care. Medical economic analysts design and create reports to track data completeness and accuracy and create databases to collect and report metrics in support of clinical outcome measures. Data collected is organized by the analysts and transformed into easy to understand tables, graphs, and diagrams for reporting to various committees and groups.

Key mechanisms for sharing data are used such as:

- Performance Measure Dashboards
- Consumer Decision Support tools
- Tableau (heat maps)
- Statistical Analysis tools such as control charts, graphs and data tables
- Predictive Analytics

The Quality Management team is responsible for creating a reporting schedule as well as ensuring that data is ready on time and in a format that is clear, concise, and effective.

Quality Program Work Plan

The annual Work Plan (Attachment 1) focuses on the Quality Program goals, objectives, and planned projects for the upcoming year. The Work Plan includes specific tasks, responsible owners of activities and anticipated time frames for completion. It serves as the road map to reflect a coordinated strategy to implement the Quality Program including planning, decision-making, interventions, assessment of results and achievement of the desired improvements. The Board of Directors and the appropriate Quality Committees approve the Work Plan based on the Quality Management Program Description. The annual Work Plan is a living document with periodic updates expected as a result of interim project findings and reports.

Updates to the Work Plan are reviewed and approved by the appropriate Quality Committees, and are submitted to the State or Federal agencies as required. The annual QI Work Plan specifically addresses the following elements:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Program scope
- Yearly objectives
- Yearly planned activities
- Member experience
- Time frame within which each activity is to be achieved
- The staff member responsible for each activity
- Monitoring previously identified issues
- Evaluation of the QI program

The annual Work Plan incorporates activities related to quality improvement goals as well as to NCQA-accreditation standards. Virginia Premier monitors the work plan throughout the program year and evaluates the work plan on an annual basis. Virginia Premier uses evaluation results to plan improvement activities for the next program year. Virginia Premier carries over improvement opportunities that do not meet established goals in the current program year into the next program year for continued monitoring and improvement efforts.

Evaluation of the Quality Program

The Quality Management Program Description and Work Plan govern the program structure and activities for a period of one calendar year. At least annually, the Quality Department will facilitate a formal evaluation of the Quality Program. Evaluation of all activities will include a description of limitations and barriers to improvements.

The annual evaluation identifies the program outcomes and includes the following areas:

- Evaluates the results of each activity implemented during the year and identifies quantifiable improvements in care and service
- Where available, includes a trended indicator report and brief analysis of changes in trends and improvement actions taken as a result of the trends
- Identifies opportunities to strengthen member safety activities

- Identifies opportunities to strengthen evidence-based care initiatives and clinical outcomes
- Evaluates resources, training, scope, and content of the program and practitioner participation
- Evaluation of the overall effectiveness of the QIP and CCIP
- Identifies limitations and barriers and makes recommendations for the upcoming year, including the identification of activities that will carry over into next year

The evaluation includes an assessment of the overall effectiveness of the Quality Program, including progress toward influencing safe clinical practices throughout the delivery system, as well as monitoring other aspects of the program, such as practitioner availability, over and underutilization, and complaints and appeals.

The evaluation includes an assessment of the overall effectiveness of the QIP and CCIP, including progress toward influencing network-wide safe clinical practices throughout the delivery system as well as monitoring other aspects of the program, such as practitioner availability, over and underutilization, and complaints and appeals. At a minimum, the evaluation will include:

- Adequacy of resources for the QIP and CCIP
- Practitioner participation in the programs and review process
- Leadership involvement in the programs and review process
- Identify needs to restructure or revise the programs for the subsequent year

Practitioners and members are advised of the availability of the program evaluation that will be posted on the Plan's web site. The evaluation is also available in print form upon request.

Communication of Quality Program

Virginia Premier staff will provide members and providers with information, both orally and in writing that is pertinent and necessary for our members/providers to effectively use our services. Oral interpretation is available for any language and written information is available in prevalent languages. The types of information provided will include, but is not limited to; Member Rights and Responsibilities, and instructing members/providers on how to file a Grievances and/or Appeal and the Quality Program. Virginia Premier uses a comprehensive approach to involve both internal and external stakeholders in the communication and quality processes.

In an effort to fulfill this commitment, Virginia Premier will use all available mediums to disseminate information to our members and providers. Information available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

Virginia Premier makes materials and other information available to individuals who contact the company requesting information about the MAPD plans. Information regarding procedures, benefits, services, etc. are also publicly offered on the company's website. Furthermore, the company will mail adequate written descriptions of plans to anyone who contacts the company

and requests information about the plans. In order to address special needs, these materials are available by request in other languages and alternative formats, such as braille and large print.

Virginia Premier connects with members, providers, the community, State and Federal agencies through both targeted and general communication methods. The company utilizes the following channels to communicate with Medallion members:

- Virginia Premier's Website (Member Portal)
- Social Media
- Health Awareness/Community Events
- Marketing Campaigns
- Member Newsletters
- Mailings of material such as Member Handbook

Virginia Premier communicates with its providers through face-to-face meetings, including HQUM meetings, HEDIS® education classes, provider training, Peer Review committee meetings and visits to providers by Network Development staff, as well as the Provider Services Call Center. The company utilizes the following communication channels for our provider community:

- Virginia Premier's Website (Provider Portal)
- Provider Education Meetings
- Provider Education Visits
- Blast Faxes on pertinent regulatory changes
- Provider Newsletter

Confidentiality

The Health Plan maintains confidentiality policies, and no voluntary disclosure of peer review information is made except to persons authorized to receive such information to conduct QI activities. Information is strictly confidential and is not considered discoverable under state and federal peer review laws.

FEEDBACK/COMMENTS:

Feedback related to VIRGINIA PREMIER's Quality Program, quality assurance and improvement activities, and clinical or service studies should be mailed to:

Medical Management Department - Quality
600 E. Broad Street – Suite 400
P.O. Box 5307
Richmond, VA 23220-0307
Toll-Free #: (800) 819-5151, ext. 55429
Fax #: (804) 819-5176

Comments and suggestions will be reviewed and assessed for quality improvement opportunities.

XII. 2018 Quality Program Description Signature Page

APPROVED BY:

_____ _____
VIRGINIA PREMIER Quality Improvement Committee Chair Date

_____ _____
VIRGINIA PREMIER HQUM Committee Chair Date

Original Date:
Revised Date(s): February 28, 2018

Effective Date: **January 1, 2018**