

**Magellan Complete Care of Virginia  
#H7559  
Special Needs Program for Dual Eligible Individuals  
(D-SNP)  
Quality Improvement Program Description  
2020**

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## **Introduction**

Magellan Health, Inc. (“Magellan”), is headquartered in Phoenix, Arizona, is a privately-held, multi-state organization with broad expertise in physical health, behavioral health, pharmacy benefits management, diagnostics and specialty services. Magellan Complete Care of Virginia (“MCC of VA”) are fully-integrated health plan subsidiaries of Magellan that combine the best of the parent company with local commitment and knowledge. MCC of VA leads individuals to healthy, vibrant lives by improving access to quality and affordable care. MCC of VA is person-centered, community-focused, evidence-based health plan that provide complete care coordination to people who receive healthcare benefits through government-sponsored programs such as Medicare and Medicaid, and other government sponsored programs that include individuals who need help with long-term care or other specialized services. MCC of VA specializes in the provision of integrated services designed to meet the needs of Special Needs Program for Dual Eligible Individuals (D-SNP). Magellan conducts business through licensed health plans located in Arizona, Florida, Massachusetts, and New York.

Magellan Complete Care of Virginia (MCC of VA) began providing services to DSNP members on January 1, 2020. MCC of VA membership breakdown is as follows (as of February 1, 2020):

<b>DSNP Total</b>
<b>21</b>

For all plan members, MCC of VA emphasizes personalized care that places the physician in the pivotal role of managing healthcare. MCC of VA is responsible for overseeing the provision of accessible, appropriate, cost-effective, high quality health care services for its members throughout the continuum of care. The health plan assists members as they move through the managed care system, reducing barriers to care, and supporting members in reaching optimal health. MCC of VA monitors the services provided assessing the appropriateness and quality of care while always stressing improvement in health outcomes.

MCC of VA offers a full range of coordinated medical and behavioral health services, including acute and chronic care, and preventive care. Services are designed specifically to meet the needs of a diverse population that may include:

1. Dual eligible members presenting with multiple behavioral and physical chronic conditions and long-term services and support needs.
2. These members present with complex chronic conditions and are eligible for full Medicaid standard benefits, as well as Medicare Parts A, B and D.
3. The member population comprises among the most vulnerable individuals served by publicly-sponsored programs.
4. Dual eligible members are among the poorest and highest risk Medicare beneficiaries, and have significant catastrophic illness or injury, developmental, or intellectual disability, mental illness and or substance use disorder than non-dual beneficiaries.
5. These members are ethnically diverse, poor, frail, disabled, and chronically ill or near end of life.
6. MCC of VA dual members present with additional unique health needs, including serious mental illness and high risk pregnancy.

MCC of VA pursues excellence in the care of low-income families while improving efficiencies and effectiveness. The Quality Improvement Program (QIP) is designed to achieve these goals and is

established to provide the structure and key processes that enables MCC of VA to carry out its commitment to ongoing improvement of care and service and the improvement of the health of its members. It is an evolving program that is responsive to the changing needs of the health plan's customers and the standards established by the medical community, regulatory and accrediting bodies. The QIP establishes guidelines for Medicaid and Medicare/Medicare SNP plans, outlines the program requirements, processes, and/or conduct of quality program operations and ensures that there is a step-by-step outline of activities. The following QI Program Description includes discussion of program philosophy, scope, structure, and methodology. The term *quality improvement* is used in place of the terms *quality assurance* and *quality management*.

The QIP Program supports the monitoring and auditing of physical and behavioral health services delivered and includes, but is not limited to:

- Credentialing and licensure,
- Referral and intake process,
- Adoption of assessment and screening tools,
- Appropriate referrals to other agencies,
- Service plan adherence,
- Training and education,
- Medical record review
- Timely access.

The auditing and monitoring of processes ensure that members' needs are met within regulatory timeframes. The care plans are also monitored to ensure services are provided in the time and frequency outlined by the assessment and that members are informed of their rights. MCC of VA/ SWH recognizes the importance of honoring the members' culture and heritage in provisioning services to them.

The QIP defines, incorporates and addresses the unique health and health outcome needs of MCC of VA's members. These include additional factors in the stratification and identification to manage catastrophic or high risk conditions, coordination of services during healthcare setting transitions to address social determinants of health, facilitate communication between providers and facilities, educating and supporting members and their care-givers on the management of complex medical, pharmaceutical and behavioral health issues, and incorporating the complex issues of these members into chronic care improvement programs (CCIP) and population health management (PHM) programs.

MCC of VA recognizes the providers' role in delivering services to its members and the coordination required to effectively improve integrated care and quality outcomes (clinical and non-clinical) while ensuring appropriate utilization. MCC of VA integrated network includes, but is not limited to, primary care providers, specialists, ADHS licensed providers, behavioral health providers, community-based providers, field clinics, virtual clinics, multi-specialty interdisciplinary clinics, targeted investment providers, and Centers of Excellence.

The QIP is designed to assure the health plan credentials and contracts with individual practitioners, provider organizations, facilities and institutions to deliver health care and service to members, including the provision of care to address complex needs. Magellan has established specific functions that are performed centrally and in conjunction with the health plan. MCC of VA delegates the authority

to perform specified plan functions and services while maintaining oversight responsibility for delegated and non-delegated activities.

The QIP includes detailed goals and objectives that are developed annually through the QI work plan with timelines for the implementation and accomplishment of these objectives. Problems or concerns identified by the QIP activities are evaluated in accordance with the QI work plan's methodology and causal analysis performed. Action plans are developed and implemented to correct identified problems and include the following:

- the type of corrective action to be taken,
- the goals of the corrective action plan,
- the timelines and work plan for the corrective action,
- the identified changes in processes, structure, internal/external education,
- proposed and existing performance measures and targets, and
- the type of monitoring, evaluation and improvement including any enhancements to existing programs and outreach activities.

This process includes ongoing monitoring to evaluate the effectiveness of the action plans as well as implementation of processes to prevent recurrence of these problems.

#### **I. Purpose**

MCC of VA's QIP establishes the structure and standards for quality management and integrated improvement activities within the plan and is an integral component of measuring its effectiveness as an organization. The QI Program Description is the primary document that establishes the health plan's commitment to continuous quality improvement, and it serves the purpose of enabling all MCC of VA leaders and staff to have a clear definition of the quality program structure, goals, and objectives within the organization.

The goal of MCC of VA's QIP is to ensure the provision of consistently excellent healthcare, health information, and service to its members. The goal will be met by:

- Defining and addressing the health care and health outcome needs of members that experience a higher burden of multiple chronic illnesses (medical and behavioral), aspects of care and coordination for frail/disabled populations, culturally diverse, and those undergoing multiple care transitions with complex or unresolved needs.
- Ensuring the provision of high quality and cost-effective integrated healthcare in compliance with state, federal and/or accreditation requirements.
- Ensuring that improvements are based on "best practices" or on standards set by state, federal and/or accrediting organizations.
- Providing the organization with an annual Work Plan Program Evaluation in accordance with state, federal and/or accreditation requirements.

- Implementing quality standards, guidelines, processes, and tracking indicators to monitor the safety and quality of clinical care, the quality of the service and member experience.
- Promoting a culture and structure for continuous quality improvement that identifies opportunities and addresses them through changes to existing processes and programs, or by developing new approaches to improve care and service.
- Focusing on the measurement of effectiveness for quality interventions by tracking and monitoring the implementation and outcomes of quality interventions and scientifically evaluating the effectiveness of improving care and services.
- Establishing policies and procedures that describe the implementation of comprehensive and coordinated delivery of integrated physical and behavioral health services including administrative and clinical integration of health care service delivery.
- Coordinating 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.
- Communicating results of quality improvement activities to internal and external stakeholders.

## II. Scope

The scope of the QIP encompasses clinical and non-clinical services provided for MCC VA members. The program is designed to monitor, evaluate and continually improve the care and services delivered by MCC of VA practitioners and affiliated providers across the full spectrum of services and sites of care. The program encompasses services rendered in inpatient, outpatient, and transitional settings and is designed to resolve identified areas of concern on an individual and system wide basis.

The QIP reflects the population served in terms of age groups, disease categories, special risk status, and diversity. While many of the QIP initiatives address the needs of the entire population, there are specific programs focused on MCC of VA's most vulnerable members, e.g., frail, disabled, near end of life, multiple chronic conditions and homeless. The major program focusing on the vulnerable members is the Complex Case Management Program, which uses assessments to identify members' unique needs and develops customized care plans to address those needs. Complex Case Management is one component of a broader Population Health Management approach that includes care coordination programs, chronic disease programs, and other population health management initiatives.

Through the QIP, MCC of VA, is committed to providing behavioral health (BH) programs and services, including comprehensive behavioral health care management, in partnership with the member and the practitioner. The BH programs and services include coordinating and monitoring the delivery of BH services to all members as designated in their assigned benefits. Full consideration of general medical issues in the management of BH care delivery is provided to enhance the quality of care through improved treatment delivery and outcomes as well as strengthen member and provider satisfaction.

The QIP embraces the plan, do, study, act (PDSA) methodology for conducting all quality activities including:

- Problem identification;
- Establishing performance goals and benchmarks;
- Conducting performance measurement;
- Performing barrier and root causes analyses;
- Analyzing performance data;
- Developing and implementing interventions to address identified barriers/remedial action as appropriate issues; and
- Perform re-measurement and evaluation of program activities.

To provide for overall quality functioning as a health plan, MCC of VA continuously monitors important aspects of care, safety and service. These aspects or activities include, but are not limited to:

- A. Appropriateness of care measured by
  - a. comparison of performance against established benchmarks,
  - b. under/over-utilization,
  - c. use of and compliance with clinical/preventive guidelines,
  - d. grievance resolution, tracking and trending,
  - e. case review processes, and
  - f. monitoring and distributing member's rights and responsibilities;
- B. Medical records and communication of clinical information for each member that reflect all aspects of member care, including ancillary and behavioral health services;
- C. Access/Availability, to include health risk assessments, appointment scheduling, network composition through assessment by volumes and type of providers, and geographical analysis;
- D. Population Health Management programs and behavioral health care services as measured by the use of and compliance with evidence-based guidelines and processes for structured assessment and follow-up;
- E. Preventive care and wellness services as measured by the use of and compliance with clinical practice guidelines (activities are also designed to focus on wellness and health promotion);
- F. Members with complex health needs who may need case management and/or care coordination;
- G. Member outreach to ensure effective coordination of services (i.e., clinical, transportation, support to access care, etc.);
- H. HEDIS® Measurement/Reporting and activities to address performance gaps;

- I. Pharmacy Services and Medication Management;
- J. Member and Practitioner Satisfaction with medical and behavioral health services, including CAHPS®;
- K. Quality of Care/Critical Incident Clinical Case Review and Serious Reportable Adverse Events and Hospital Acquired Conditions (activities are also designed to improve health outcomes, improve member safety and/or reduce/avoid medical errors and/or prevent hospital readmissions);
- L. Cultural, Ethnic, Racial and Linguistic Needs and Services for members including a focus on cultural and linguistic competency and enrollees within diverse communities;
- M. Plan-determined quality improvement projects, internal and collaborative projects with other health plans and external quality review organizations (EQRO), including but not limited to, Quality Improvement Projects, Model of Care activities, Performance Improvement Projects, and Chronic Care Improvement Projects designed to meet state and federal regulatory requirements and internal health plan needs;
- N. Co-morbid conditions and complexities associated with concurrent/ongoing or unresolved medical and behavioral health issues;
- O. Temporary/provisional, initial and re-credentialing processes for individual and organizational providers;
- P. Communication and collaboration between the QIP and other functional areas of the organization;
- Q. Input from members, stakeholders, advocates, and contracted providers in matters related to the QIP activities;
- R. Quality and coordination between behavioral and physical health services;
- S. Timely engagement and appropriate service levels for members;
- T. Training and monitoring for related QIP activities, including use of tools;
- U. Health Information System that collects, integrates, analyzes, validates and reports data necessary to implement its QM/PI Program (42 CFR 438.242);
- V. Delivery of services are delivered in conformance to with state and federal regulations and accreditation requirements.

All QIP components are supported through the development, implementation, and maintenance of policies and procedures, which are reviewed annually to ensure compliance.

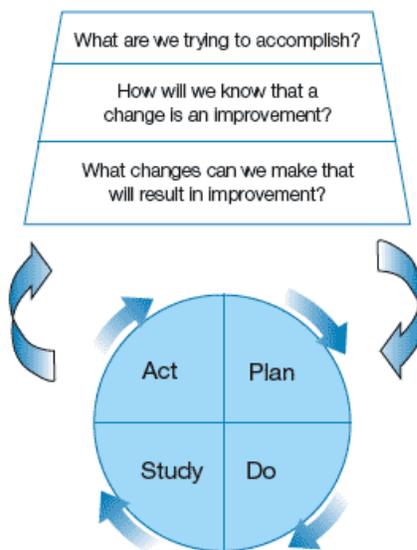
**III. Quality Program Documentation**

The QIP trilogy documents provide the foundation for the quality committee structure, oversight, and activities. MCC of VA annually reviews, updates and approves the QI Program Description with annual quality goals and the QIP Work Plan. The QIP Work Plan consists of scheduled activities and key performance indicators that is tracked through the appropriate quality committee for ongoing monitoring and oversight. The QI Program Description is created and maintained to reflect the unique needs of each population.

At the end of the year, MCC of VA’s Quality Director coordinates the development of the health plan’s Program Evaluation, which is a scheduled activity on the QIP Work Plan assigned to the appropriate quality committee. Please refer to Section XIV for further details about the annual program evaluation.

**IV. Quality Improvement Process**

MCC of VA/ SWH processes are built on the use of continuous quality improvement principles and methodologies. Utilization of the Plan, Do, Study, Act (PDSA) model is built into analytical and evaluative processes. As data are collected and analyzed, it is done within the context of continuous identification of possible deficiencies and opportunities for improvements. Use of the PDSA model shown in the figure below propels continuous improvement while supporting and enhancing the integration of quality and accountability into the QIP. MCC of VA quality improvement activities incorporate this approach to solving complex or multifaceted problems in a logical and systematic manner, leading to continuous quality improvement. This approach ensures that MCC of VA/ SWH services and operations meet or exceed identified measures, goals and benchmarks.



The quality improvement process begins with a review and an assessment of the overall health plan priorities for the year followed by a review of key metrics and available data. The data is compared to regional or national benchmarks to determine where the plan is performing well and in what areas it has an opportunity to improve.

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Potential projects are evaluated according to their alignment to state, federal and accreditation requirements as well as health plan priorities, importance and relationship to the goals of the QIP and resource needs. The Vice President, Medical Director (VP-MD) and the President and Chief Executive Officer (CEO) have the ability to direct, implement and prioritize interventions resulting from quality management and performance improvement activities and investigations. Prioritization activities can be conducted through conversations with executive leadership, the Board of Managers, and/or the Quality Improvement Committee. The Quality Teams may use a prioritization matrix based on an agreed-upon criteria to prioritize projects.

Once quality projects have been prioritized, supporting documentation is developed using the PDSA framework. The foundation of the PDSA focuses on setting aim, establishing measures, selecting changes and testing changes. The PDSA framework promotes the following process:

- Problem identification
- Establishing desired goals and benchmarks
- Conducting performance measurement
- Performing barrier and root causes analyses
- Developing and implementing measurable interventions to address identified barriers
- Performing re-measurement and evaluation of program activities
- Communication through internal feedback loops

The PDSA model is used with all quality projects to resolve complex or multifaceted issues in a logical and systemic manner as well as to engage and communicate with stakeholders throughout the process. If the project has significantly improved and sustained performance over time, MCC of VA decides whether to continue the project as is or end the it. New goals could also be developed for a well-performing project. Consistent application of the PDSA model insures continuous quality improvement throughout MCC of VA.

In the event problems are not resolved or goals and objectives are not met, MCC of VA will take appropriate steps to improve care, which includes developing and implementing evidence-based corrective action plans (CAPs) and developing a work plan. MCC of VA maintains policies and procedures for implementing CAPs that are in alignment with state, federal and/or accreditation requirements. The development of a CAP follows the PDSA model and includes the root cause(s) of the deficiency, steps to be taken for expedient return to compliance and submission to the applicable regulatory agency. CAPs are monitored for effectiveness through the Quality Improvement Committee, the QIP Work Plan and Program Evaluation and are disseminated as appropriate.

This methodology is applied annually to the entire QIP as part of the annual program evaluation and is further described in Section XIV.

## **V. Health Information Data System and Analytics**

Quality Improvement is a data driven process. MCC of VA collects and utilizes multiple data sources to monitor, analyze and evaluate the QIP and planned activities to address all target populations. Sound approaches and methods are used to develop indicators that are objective, clearly defined, accurate and complete. MCC of VA uses systematic collection processes to assure

valid, reliable and population appropriate data are reported. Data that measures health outcomes and indices of quality are developed specific to MCC of VA's targeted activities and goals.

MCC of VA utilizes multiple data sources to monitor, analyze and evaluate its QIP and planned activities. These sources include, but are not limited to the following:

- Encounter data
- Claims data
- Pharmacy data
- Medical record review
- Utilization reports and case review data
- Provider and member feedback through complaints and grievances
- Feedback collected from internal departments and external sources
- Provider and member satisfaction survey results
- Credentialing data
- Appeal information (internal and external review)
- Statistical, epidemiological, and demographic member information
- Authorization and denial reporting
- Diagnostic information (laboratory, pathology, and radiography results)
- Enrollment and disenrollment data
- HEDIS® data
- Behavioral Health data
- GeoAccess provider availability data and analysis
- Appointment accessibility data
- CAHPS® and ECHO® survey data
- Health Outcomes Survey (HOS) data
- Population health management program data
- Health Risk Assessment information
- Contact center data (member services and nurse advice line)

Data for all activities are collected and processed through a number of mechanisms such as electronic software and applications, manual collection processes, and available external resources. MCC of VA maintains health information systems that collect physical and behavioral health data and stores pharmacy claims, medical claims, lab data and results, enrollment files, provider data and characteristics, appeal and grievance data and other supplemental data received such as social determinants of health codes and member outcomes. MCC of VA also integrates supplemental data in the analysis/stratification process to ensure a comprehensive view of the member in an effort to improve the quality of health and member outcomes.

MCC of VA's care management system, Casetracker provides access to relevant disease and care management data with a focus on:

- Advanced Directives
- Health/Risk Assessments
- Care Plans
- Clinical Surveillance
- Mental Health

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- Outcome Analysis
- Population Health Management
- Screening and Wellness Prompts
- EPSDT Forms

MCC of VA uses certified HEDIS software to produce analytics to support some or all of the following:

- HEDIS® reporting
- State reporting
- CMS Core measurements
- Clinical outcomes assessment
- Provider profiling

MCC of VA's systems also meet the requirements to submit performance reports and adherence to written policies, procedures as requested by CMS. Systems also include processes to submit data appropriate and required for public review that informs stakeholders about the health plan's performance. Public data and reports include some or all of the following:

- HEDIS® measures
- CAHPS® data
- HOS® data
- Medicare/Medicare SNP Model of Care (MOC) Measures
- Part C and Part D Reporting Elements
- Part D Medication Therapy Management

MCC of VA employs key data and analytical personnel who produce needed reports and statistical analyses pertinent to development, monitoring and evaluation of the QIP. These include IT hardware personnel, data import experts, data management experts and several staff with expertise in HEDIS® specifications and data management. The IT Department reviews data inputs and conducts data integrity checks to ensure the data supporting the QIP is accurate, timely and complete. Reported data is reviewed for accuracy, completeness, logic, and consistency. The data review and evaluation processes are clearly documented. Information such as encounters and eligibility that are rejected or contain errors are tracked to ensure errors are corrected and the data is resubmitted and accepted.

The IT leadership is responsible for developing, implementing and overseeing assessments to verify that the health information system meets all HIPAA standards, privacy laws and professional standards for health information management. The data in the system and the management approaches will be available to regulators for review as requested. The system supports the identification, management and measurement of quality improvement projects and is a key enabler of producing the annual QIP work plan and evaluation.

## VI. **Staff Resources**

MCC of VA maintains QI staff dedicated to the collection, integration, analysis of data, and implementation of quality improvement activities. The resources dedicated to QI activities may include all or some of the following:

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- Vice President, Medical Director
- Medical Director, Behavioral Health
- Director, Quality
- Manager, Quality
- Manager, HEDIS Outreach
- Specialists, Quality
- Coordinators, Quality
- Clinical Reviewers
- Specialists, HEDIS Outreach
- Specialists, Provider Services
- Health Care Analysts

MCC of VA staff are provided with an overview of the QIP activities, requirements, policies and procedures at the time of hire and ongoing through staff forums and internal communication. External providers are informed of these activities and requirements through the onboarding process, website, one-and-one meeting during office visits and provider newsletters.

## VII. Organizational/Administrative Structure

### A. Committee Structure

MCC of VA maintains a strong organizational structure that is committed to ensuring quality services to its members. The MCC of VA Board of Managers has designated the MCC of VA Quality Improvement Committee (QIC) to govern and be the policy-making body for the program with specific responsibility assigned to the VP-MD. The QIC evaluates and documents the effectiveness of its QIP strategy and activities.

#### 1. The Board of Managers (BOM)

The MCC of VA BOM has ultimate authority and responsibility for the quality of care and service delivered by MCC of VA. The BOM is responsible for the direction and oversight of the QIP and delegates authority to the Quality Improvement Committee (QIC) under the leadership of the VP-MD and Quality Director. The BOM reviews regular plan reports and the recommendations made by the QIC as well as any significant actions taken by the QIC or any other sub-committee. The MCC of VA BOM reports to the Magellan Board of Directors. The MCC of VA CEO serves as a member of the Magellan Board of Directors.

#### 2. Quality Improvement Committee (QIC)

The QIC is responsible for the implementation and ongoing monitoring of the QIP. The QIC recommends policy decisions, analyzes and evaluates the progress and outcomes of all quality improvement activities, institutes needed action and ensures follow-up. The QIC sets the strategic direction for all quality activities at MCC of VA.

The QIC reports to the BOD and the National Medicare/DSNP Quality Improvement Committee (MQIC) and assures that plan activities comply with all state, federal, regulatory and accreditation requirements. The MCC of VA CEO delegates oversight and implementation of the QIP and QIC leadership to the VP-MD. The QIC is co-chaired by the VP-MD and the Quality Director and is comprised of executive representatives of key

health plan functional areas, which includes representatives responsible for the operations of the Medicaid and Medicare lines of business, and by contracted or affiliated providers. Each QIC member is selected based on his/her responsibility over key health plan quality functions or his/her clinical expertise. His/her participation is vital in the provision of general direction and oversight for the status of work plan activities and core monitoring metrics, the identification of barriers, challenges, and the support for areas needing resources and coordination. In addition, a designated behavioral health practitioner plays a key advisory role in MCC of VA's QIP development and activities. The chairs of the sub-committees serve as members of the QIC and are the quality owners of sub-committee communications and deliverables. A quorum for decision making is considered to be fifty percent plus one among voting members. Please refer to Section B below for a brief description of the responsibilities of each QIC member.

The QIC meets at least quarterly, or more frequently as needed, to ensure ongoing monitoring and oversight of all activities. Meeting activities and discussions are documented in contemporaneous minutes using a standard format. The minutes are privileged and confidential and reflect, at a minimum, the following:

- Date and time of the meeting,
- Location, including conference call information,
- Chairperson's name and title
- Members present and absent,
- Names and titles of guests
- Detailed summary of the discussion
- Conclusions drawn by the committee,
- Responsible party for interventions or activities,
- Timelines (start and end dates),
- Recommendations and actions
- Follow-up items

Additional documentation including quantitative and qualitative analyses from review of the core monitoring metrics can be found in the QIP Work Plan. Applicable reports and data are appended to the minutes. When deficiencies are noted, the minutes clearly document discussions of identified issues, responsible party for interventions or activities, proposed actions, evaluation of the actions taken, timeliness including start and end dates and additional recommendations or acceptance of results as applicable. All minutes are signed and dated by the committee chairperson following approval by the committee.

The QIC provides direction and coordination of QIP activities within and between its functional sub-committees and workgroups. The QIC receives reports from its sub-committees and/or workgroups, advises and directs the sub-committees and/or workgroups on the focus and implementation of the QIP and work plan. The QIC reviews data from QI activities to ensure that performance meets standard and makes recommendations for improvements to be carried out by sub-committees, workgroups or by specific departments. QIC sub-committees and/or workgroups provide direct oversight of quality functions assigned to them and facilitate rapid process change when opportunities for improvement are identified. The sub-committees/workgroups listed

below provide direct oversight of quality functions assigned to them and facilitate rapid process change when opportunities for improvement are identified:

- Grievance and Appeals (G&A)
- Drug Utilization Review Committee (DUR)
- Medical Management Committee (MMC) / Utilization Management Committee (UMC)
- Member Advisory Committee (MAC)
- Network Strategy Oversight Committee (NSC / NSOC)
- Peer Review and Credentialing Committee (PRCC)
- Service Operations Committee (SOC)
- Vendor/Subcontractor Delegation Oversight Committee (VDOC / SDOC)

The responsibilities of the QIC include, but are not limited to, the following:

- Oversee the development and monitoring of the QI and Utilization Management program descriptions, work plans and annual evaluations;
- Endorse of the QI and UM Program Description, Work Plan and Evaluation;
- Review, approval or recommendations of further action on subcommittees and workplan actions;
- Direct policy and procedures for each QIP function and activity and modify policies as needed;
- Provide necessary resources;
- Review of recommendations for provider corrective actions submitted by the PRCC and authorization of proposed actions;
- Address deficiencies and CAP to ensure expedient remediation;
- Select of QI studies to be performed based on identified high volume, high risk, high cost, and potential/actual problems;
- Develop performance indicators/process improvement tools for selected studies;
- Oversee data collection and analysis of selected studies;
- Identify opportunities for improvement and develop plans of action;
- Assign responsibilities to sub-committees, workgroups and/or ad hoc committees;
- Follow up on global quality issues received from other committees and implement action plans to drive improvements;

- Ensure staff and providers are informed of the most current QIP requirements, policies and procedures, quality initiatives and plans of action;
- Ensure providers are informed of information related to their performance such as results of studies, performance measures, profiling data, medical record review results, utilization data such as performance improvement, prescribing practices, emergency room utilization, etc.;
- Develop provider profiling policy and procedures;
- Review and approve evidence-based community standards of care for all prior authorization, concurrent review and preventive health guidelines;
- Develop and monitor improvement strategies, such as maternal/child health, EPSDT/Dental, and Immunization programs and processes;
- Review member complaint, grievance, and appeal data to identify trends and improvement opportunities;

Please refer to Appendix A for detail description of each committee, Appendix B for the quality committee structure and Appendix C for a schedule of reports.

3. National Medicare/DSNP Quality Improvement Committee (MQIC)

The MQIC oversees, coordinates and provides recommendations for quality improvement program activities. The MQIC serves as the central advisory body for the national QIP. It works collaboratively with the health plans in the development and implementation of QI activities. The MQIC provides direction related to QI projects for Medicaid, Medicare and dual eligible populations.

The MQIC responsibilities include, but are not limited to, the following activities:

- Developing, maintaining and approving the Trilogy documents (program description, work plan and program evaluation) templates.
- Developing, maintaining and approving the Model of Care for dual eligible population.
- Performing oversight and coordinating national quality improvement activities.
- Recommending policy decisions and resource allocation related facilitating opportunities for improvement and action plans.
- Providing a forum for reporting and communicating the status of centralized QI functions.
- Initiating needed actions and ensuring follow-up from the responsible person/department.
- Delivering summary reports of quality improvement activities to the state health plans for review and action.

- Developing, approving, and revising as needed centralized operational policies and template tools and resources.
- Assuring policies are reviewed, updated annually, and distributed to state health plan for quality improvement and/or other committee review and adoption.
- Ensuring all reports, documents and evaluations developed or reviewed by the CQIC are reviewed and adopted by appropriate the QIC or appropriate sub-committee/workgroup.
- Assuring that the QIC and/or appropriate sub-committee/workgroup continues to be responsible for adapting materials to meet state regulatory requirements.

**B. Quality Improvement Leadership****1. President and Chief Executive Officer (CEO)**

The CEO is responsible of overseeing the QI Program implementation, maintaining the consistency and effectiveness of the QIP and confirming the QIP's compliance with regulatory, contractual and accreditation standards. The CEO has the overall responsibility for promoting the success of the MCC of VA QIP by establishing a culture of quality. The CEO ensures the QIP has the resources, equipment and personnel required to maintain and support QIP initiatives. The CEO reports to the President of Magellan Complete Care.

**2. Vice-President, Medical Director (VP-MD)**

The VP-MD is a board-certified and licensed physician who reports to the health plan's CEO. The VP-MD is responsible to plan, design, implement, and coordinate QI activities. The responsibilities include, but are not limited to, the following:

- Provide direction, management, supervision, evaluation and planning of quality improvement activities.
- Oversee and monitor improvement initiatives assuring they are clinically valid and best practices.
- Promote activities to improve clinical and service quality
- Develop and coordinate medical integration activities and prevention/wellness activities
- Oversee assigned physician advisors, primarily through day-to-day support of and consultation with clinical staff.
- Demonstrate and promote QIP through communication, practice and resource allocation.

- Direct involvement in QI activities to include analysis of QI and utilization management (UM) data.
- Supervise healthcare activities including operational oversight responsibility for the Quality Improvement, Utilization Management, Credentialing, Behavioral Health and Pharmacy departments.
- Oversee the development, dissemination, implementation and evaluation of clinical practice guidelines, preventive health guidelines and benefit interpretation guidelines.
- Communicate information and decisions to network practitioners and providers, and follow-up on corrective action plans implemented for issues regarding quality of care, safety, or service.
- Chair the QIC, PRCC, and UMC or delegate the responsibility to a designated medical director.

3. Medical Director, Behavioral Health (MD-BH)

The MD-BH is a doctoral-level practitioner or a licensed, board-certified psychiatrist who participates in developing clinical and service activities for behavioral health. The MD-BH reports to the VP-MD and works closely with the clinical staff and network providers to enhance coordination of medical and behavioral care and treatment. The MD-BH is responsible for the clinical validity of behavioral health care and the behavioral health quality program. The MD-BH accountabilities include:

- Participation in the QIC and appropriate sub-committees/workgroups.
- Participation in the adoption of BH best practice guidelines.
- Consultation and recommendation on behavioral health projects/initiatives.
- Providing a BH perspective on identified issues, assessment of potential and confirmed BH quality of care concerns and member safety issues, providing recommendations for further action as it relates to BH.
- Screening member/provider material for identification and communication of behavioral health needs.

4. Medical Directors:

The Medical Directors report to the VP-MD and assist with strategic leadership and oversight of the care management, quality, utilization management and pharmacy programs and are responsible for administering clinical, quality and pharmacy operations including setting policies and procedures. Medical Directors serve as liaisons with physician specialty reviewers used in providing expert consultation for needed services

and procedures and collaborate with medical leadership across the network in establishing clinical policies and guidelines and quality improvement initiatives to ensure that members receive the highest quality of services in the most efficient and cost-effective manner. The Medical Directors are responsible for the oversight of the resource management activities by reviewing appropriateness of services, issuing review determinations related to the approval, denial or termination, reduction, suspension or delay in services, whether prospectively, concurrently, or retrospectively. Medical Directors also review clinical quality complaints.

#### 5. Quality Director

The Quality Director reports to the National MCC VP of Quality with local leadership from the CEO and the VP-MD. The Quality Director has overall accountability and responsibility for the following:

- Promote and maintain quality as a priority and guiding principle throughout the organization.
- Implement and manage quality processes.
- Serve as a resource for planning, implementation, and evaluation of the QIP.
- Provide operational oversight of the QIP and annual work plan, including, performance measures, quality of care concerns, seclusion and restraint and critical incidents monitoring and reporting to all contractually required entities.
- Coordinate health service activities to provide for measurement and analysis, obtaining additional expertise as needed.
- Coordinate the organization's NCQA accreditation readiness.
- Assist with the planning, implementation and evaluation of the risk management program.
- Manage a staff dedicated to quality activities that include, but is not limited to, the following:
  - ✓ Manager, Quality
  - ✓ Manager, HEDIS Outreach
  - ✓ Provider Services Specialists
  - ✓ Quality Specialist(s)/Coordinator(s)
  - ✓ Complaint and Grievances Coordinators

#### 6. Vice President Health Services

The Vice President Health Services reports to the CEO and has responsibility for day-to-day management of clinical operations, including utilization management, development and coordination of the utilization management/health services program, which includes medical care management, complex case management, care coordination, disease management, and behavioral health recovery and resiliency efforts. The Director of

Clinical Services, Director of Population Health, and the Director of Care Coordination report to the Vice President Health Services and are key leaders in the QIP.

7. Compliance Officer

The Compliance Officer reports to the national Magellan Chief Compliance Officer and also has direct reporting access to the MCC of VA BOD. The Compliance Officer directs and coordinates all Medicaid and HIPAA compliance activities for the MCC of VA. The Compliance Officer is responsible for the development and annual update of the formal MCC of VA Compliance Program, ensures annual compliance training of MCC of VA staff, and serves as the central contact for internal and external customers regarding compliance, security, HIPAA, and the Special Investigations Unit relating to anti-fraud efforts within the unit. In addition, the Compliance Officer supports internal and external audits and reporting.

Appendix E includes MCC of VA organizational chart, which demonstrates the current reporting structures, including the number of full time and part time positions, staff names and responsibilities, and shows direct oversight of QIP activities by the local Medical Director and the implemented process for reporting to Executive Management.

MCC of VA maintains policies and procedures that outline the QI staff qualifications including education, certifications, experience and training for each position and mandatory attendance to mandated meetings. MCC of VA may participate in community collaborative initiatives related to quality management and quality improvement, maternal child health, EPSDT, disease management, behavioral health and other state and/or EQRO meetings.

## **VIII. Goals and Objectives**

The goal of MCC of VA QIP is to ensure the provision of consistently excellent healthcare, health information, and service to Magellan members. The QIP is built upon a values framework that promotes high quality, patient-centered, community-focused, safe, innovative, integrated, and evidence-based services.

Specific objectives of the MCC of VA QIP include, but are not limited to, the following:

- Ensure the delivery of high-quality, appropriate, efficient, timely, and cost-effective health care and services that are in compliance with state, federal and accreditation requirements;
- Improve the overall quality of life of members through the continuous enhancement of MCC of VA comprehensive health management programs;
- Promote collaboration to improve continuity and coordination of care across the network including behavioral health;
- Ensure a safe continuum of care and care transitions through the application of MCC of VA member safety initiatives;

- Consistently deliver exceptional customer service to members, practitioners, providers by assessing member and provider experience and the access and availability to services;
- Implement quality standards, guidelines, processes, and track indicators to monitor clinical quality, member safety, compliance, and identify opportunities for improvement;
- Review provider level performance against clinical practice guidelines;
- Develop and monitor a statewide network of providers and health systems that are accessible and available to our members;
- Promote community wellness program and partnering with community services and agencies, include the state's EQRO;
- Participate in collaborative partnerships with community organizations focused on aligning quality, member and health outcomes, including the state's EQRO;
- Deploy Provider Support Specialists (licensed clinicians) to work side-by-side with contracted providers to improve outcomes by adopting evidence-based practices, facilitating relationships between medical and behavioral providers, transforming data into actionable information, and supporting value-based payment initiatives;
- Identify and provide innovative population-based approaches to achieving demonstrable health improvement through implementation of effective and innovative clinical programs, services, and processes;
- Identify and address the needs of members with complex health issues including those with physical and developmental disabilities, multiple chronic conditions, and severe mental illness;
- Demonstrate accountability through the use of member-care goal achievement, utilization, member experience, and clinical outcomes measures;
- Ensure culturally, competent care delivery through the collection of member and practitioner cultural education and through the provision of information, training and tools to staff and practitioners to support culturally competent communication;
- Assess member needs by region and tailor programs to address the needs of vulnerable sub-populations and regional health disparities; and
- Implement sub-population and regional analytics that yield customized, culturally competent, and holistic approaches to members' lives;

To support these objectives, MCC of VA develops and monitors its QIP Work Plan with specific activities, dates for completion, and responsible parties to meet these objectives. The QIP Work Plan is a living document that is actively monitored and adjusted throughout the year by the quality team through the oversight of its multiple quality committees. The Work Plan aligns to

MCC of VA's mission, values, and quality goals as well as those from the DMAS Quality Strategy. Key performance metrics, encompassing clinical, operational, population health, and satisfaction indicators are also an integral component of the Work Plan. MCC of VA sets benchmark goals for each metric and assigns a specific individual, department or quality committee for its ongoing monitoring. Please refer to Appendix E for the Annual QIP Work Plan.

## **IX. Quality Program Activities**

QIP program activities include a variety of mechanisms and procedures to measure, evaluate and improve the total scope of services provided to members and providers. MCC of VA employs comprehensive monitoring and evaluation activities to demonstrate compliance with requirements and improve the service delivery system and provider network. The Quality Team conducts reviews or seeks improvement in areas that reflect important aspects of high-quality care and service. These monitoring and evaluation activities include, but are not limited to:

- reporting, tracking and trending potential quality of care (QOC) concerns and incidents;
- evaluating activities and conducting onsite reviews within specific service or site;
- monitoring coordination between PCP and Behavioral Health Provider;
- selecting improvement projects, and
- performing medical record review monitoring.

The following activities and processes are used to either conduct reviews or support improvement in areas that reflect important aspects of high quality care and service. Utilization management, care management and disease management written program descriptions and evaluations are reviewed and approved by the QIC and the VP-MD. In addition, MCC of VA contracts with the state's EQRO and collaborates with the EQRO and the state in the development of studies, interventions, and methodology to support and evaluate QI activities. Collaboration with the state's EQRO includes, but is not limited to, the provision of appropriation information to support the completion of QI activities.

### **A. Adequacy of Appointment Access and Provider Availability – Provider Network**

MCC of VA assesses appointment accessibility and provider availability to primary care, specialty care and behavioral care services. The monitoring is conducted on an ongoing basis to ensure that established standards for reasonable geographical location, number of practitioners, hours of operation, appointment availability, provision for emergency care and after-hours services are measured. Software is made available to assess adequacy of and access to network practitioner/providers as well as insight as to "out of network" use so the cadre of practitioners available to patients meets the need. Monitoring activities may include:

- Provider surveys
- On-site visits
- Evaluation of member satisfaction surveys
- Evaluation of service complaints, grievances and appeals reports
- Geo-access surveys
- Monitoring of closed primary care physician panels
- Review of regional access surveys by external organizations
- Monitoring provider designations for cognitive and physical disabilities

- Monitoring availability to specialty providers to meet the special health care needs of the population.

Specific deficiencies are addressed with a corrective action plan, and a follow up activity is conducted to reassess compliance. Data are reviewed within various quality sub-committees on an ongoing basis with barriers and challenges escalated to QIC as needed for support and recommendations.

**B. Appeals**

The appeals process includes the evaluation of decisions previously denied requests related to complaints, grievances, denied claims and/or other services. Assessment of appeals allows the health plan identify trends and areas that need improvement.

**C. Assessing Member Experience – CAHPS® and Other Member Surveys**

Member satisfaction and experience is assessed through administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and other surveys and the evaluation of member inquiry/grievance and appeal information. MCC of VA contracts with an NCQA-certified vendor to administer the CAHPS® survey annually. Member satisfaction surveys and routine monitoring indicators are designed to measure plan performance and to assess member satisfaction with the plan services. Member survey data are used for continuous quality improvement in several key areas:

- To establish benchmarks and monitor plan performance;
- To assess overall levels of satisfaction as an indication of whether the plan is meeting customer expectations;
- To assess service performance in comparison to competitors.

Members and providers are informed of survey results and may be consulted for input. Member complaints, grievances and appeals data is trended to identify potential opportunities for improvement. The results of this trending and analysis may be correlated with member survey data or other indicators in the assessment and development of action plans. Results are summarized and reviewed by the health plan, including review against national thresholds and benchmarks, to identify areas of improvement and prioritize interventions. Action plans for addressing opportunities for improvement are developed as appropriate.

In addition to CAHPS®, MCC of VA uses other member surveys such as satisfaction with behavioral health services, care management and population health management. Surveys similar to CAHPS® may also be conducted to assess results at the provider-group level. MCC of VA's may present the results to the Member Advisory Committee to request feedback from members on how to improve the areas of identified opportunities.

MCC of VA member surveys follow state, federal and accreditation requirements for notification and approval. The request includes a project scope statement, project timeline and a copy of the survey. Survey results are reported to the state according to the state's policies and requirements.

Proprietary & Confidential - Trade Secret

Note: This Quality Program Description may be modified to include any and all state or federal government program requirements and any such modification shall be submitted to the applicable regulatory agency prior to implementation.

**D. Behavioral Health Delivery System**

MCC of VA is an integrated health plan, providing and managing behavioral health services through a credentialed and contracted behavioral health (BH) network. The MD-BH with the BH specialized clinical and utilization review staff at MCC of VA coordinates all BH services for its members. The MD-BH ensures access to appropriate care and encourage collaboration and coordination between medical and BH providers. Behavioral health services are assessed and provisioned in collaboration with the member, the member’s family and all others involved in the member’s care including agencies or system.

**E. Care Management/Care Coordination**

The Care Management/Care Coordination (CM/CC) Program, which is part of the Population Health Management Program/Strategy, is designed to ensure appropriate access to high quality, safe and cost-effective medical and behavioral health care through collaboration with the member/family, physician and other healthcare providers. The CM/CC Program implements an individual care plan (ICP), a person-centered plan, that meets the individual member’s needs and goals based on risk stratification. MCC of VA provisions care management to assist members who may or may not have a chronic disease but have physical or behavioral health needs or risks that need immediate attention. Please refer to the Population Health Management (PHM) Program Description and the Care Coordination Program Description for details about this program.

**F. Clinical Practice Guidelines**

Clinical practice guidelines are developed or adopted with practice parameters and other criteria that consider the needs of the population and provide guidance in the provision of acute and chronic physical and behavioral healthcare services to the MCC of VA’s membership. The guidelines adopted are based on professionally accepted standards of practice and national guidelines and are approved by the QIC. Practice guidelines are reviewed and updated at least every two years and are distributed to appropriate network practitioners via provider newsletters and the provider website.

**G. Communication – Member and Provider Newsletters, Websites**

MCC of VA is committed to communicating the approach, activities and results of its QIP to regulators and to its members and the providers who care for them. A major communication mechanism are the member and provider newsletters, which are published quarterly. In the newsletters, MCC of VA publishes high-level summary articles about quality improvement topics. Other topics communicated at least annually are the member rights and responsibilities, quality goals and results of quality improvement activities related to HEDIS® and CAHPS®. In many cases, the newsletter article pushes the member to the MCC of VA website for supplemental information. Any document available through the website is also available through member and provider services.

Other communication activities include various member advisory forums managed by the Member Advisory Committee and direct-to-provider presentations conducted by the Provider Services and Supports Team.

**H. Complex Case Management (CCM):**

The complex case management (CCM) program specifically addresses members with complex health care needs. Care management teams address the physical and behavioral health care needs of members who have been identified with key conditions or co-morbidities that warrant intervention at the individual level. Overall objectives of the CCM program are:

- Access to the program through a variety of avenues
- Thorough initial assessment to identify the member’s needs
- Development of a care plan that addresses the member’s needs
- Ongoing management of members to assist them in meeting the goals of their care plan
- Ongoing re-evaluation of the program to assess for opportunities to improve the program.

The process starts with an individual assessment of the member conducted by a nurse care manager. Completion of the assessment provides identified health improvement opportunities for the nurse to address in subsequent interactions with the member. These opportunities are included and prioritized in a care plan developed specifically for the member. The effectiveness of the CCM program is evaluated on an ongoing basis as part of the PHM program through the Population Health Committee, and on an annual basis, with particular focus on the members’ overall health status at different stages in the care management process. Opportunities for improvement are identified on an ongoing basis, and interventions are implemented to improve the effectiveness of care management activities. CCM is part of the Population Health Management Program. Details about the program are contained in the Population Health Management Program Description and the Care Coordination Program Description.

**I. Continuity and Coordination of Care**

Special attention is given to improving coordination of care and facilitating the delivery of the most appropriate and effective healthcare for the member. To enhance continuous and appropriate care for members across the physical and behavioral health delivery system and to strengthen continuity, MCC of VA monitors continuity and coordination of care among primary, specialty and behavioral healthcare practitioners.

MCC of VA ensures continuity of care and integration of services by:

- Utilizing transition of care processes and the effectiveness of inter-provider communications and documentation, including member’s approved care representative to facilitate care or treatment decisions for members with mental or physical incapacity, targeted toward members with complex needs;
- Facilitating arrangements with community and social service programs;
- Identifying chronically ill or complex new patients through assessments, member/provider/caregiver referrals and during care/case/disease management process who would benefit from program activities;

- Identifying opportunities related to continuity and coordination of care through medical record review, practitioner surveys, or any valid methodology;
- Using programs for care coordination that include coordination of covered services with community and social services which are generally available through contracted or non-contracted providers within the service area;
- Monitoring of referral activities for both the PCP and the behavioral health provider during referral to, coordination of care with, and transfer of care between the PCP and the behavioral health provider;
- Coordinating medical and behavioral healthcare including information exchange, appropriate diagnosis, treatment and referral to primary care, management of treatment access, appropriate use of medications, primary/secondary preventive BH program implementation, and special needs of members with severe and persistent mental illness;
- Assessing continuity and coordination of care collaboration may include, but is not limited to, measurement of the following, as demonstrated through the use of surveys, team meetings/clinical rounds reflected in minutes, medical record review, and data analysis:
  - Exchanging information in an effective, timely and confidential manner
  - Reviewing and evaluating the referral process
  - Evaluating the use of psychopharmacological medication or other high-risk medications
  - Coordinating the timely access for appropriate treatment and follow-up for individuals with coexisting medical and behavioral health disorders
  - Preventing admission's and/or reducing 30-day readmissions
  - Improving the care transition process.

**J. Credentialing and Recredentialing**

MCC of VA credentials all network practitioners to ensure they comply with relevant internal, state, federal and accreditation requirements and are appropriately trained to provide care to members. Magellan, which is an NCQA-certified credentialing verification organization (CVO), conducts primary source verification (PSV) for MCC of VA. Upon receipt of completed PSV, MCC of VA, reviews all applications for completeness and conducts additional research/outreach for applications that do not meet the established credentialing criteria. Practitioners who meet MCC of VA “clean” criteria may receive sign-off by the VP-MD or designee in his/her capacity as the PRCC committee chair. Those who do not meet the “clean” criteria are referred for a full PRCC review. Details about the credentialing/recredentialing program are found in the Credentialing Program Description.

**K. Crisis Intervention and Coordination**

MCC of VA receives daily crisis notifications when a member contacts the crisis lines. This could be for any type of crisis, telephonic, mobile, inpatient and observation admissions. MCC of VA has a dedicated care manager who conducts outreach to any member who contacts the crisis lines. The care worker ensures the member is no longer in a crisis and has all needed outpatient services. If the member needs services, the care manager will assist the member in securing outpatient services and follow up to ensure the member attends the appointment. Crisis notes are forwarded to the member’s behavioral health team if they are currently engaged in behavioral health services by the crisis line/provider. As outlined in the MCC of VA’s Provider Manual and through ongoing training, this notification should also be sent to the PCP by the member’s behavioral health provider for care coordination purposes.

Members who are hospitalized due to a suicide attempt or ideation will be sent to care management for follow-up post discharge. Members who had a suicide attempt will be followed in care management at a minimum for thirty (30) days. The care manager will ensure the member is in outpatient services and is following their outpatient care plan. The care manager will ensure there is coordination between the all health care providers including behavioral health professionals and PCP. All involved health care professionals should have the member’s crisis plan in their medical record and know the members signs and symptoms when they are experiencing suicidal ideations. The assigned care manager will ensure all involved health care professionals have information pertaining to the member’s physical and behavioral health care.

The chart audit review process ensures providers are performing care coordination functions with all involved health care providers. The audit is conducted at a minimum annually and all results are presented to the QIC or appropriate sub-committee/workgroup.

**L. Cultural Competency/Health Disparities**

MCC of VA is dedicated to ensuring that all members, providers and staff are treated with dignity and respect concerning their values, race, color, age, gender, ethnicity, sexual orientation, gender identity, or expression of religion, creed, ancestry, national origin, disability, veteran’s status, or background culture.

MCC of VA recognizes and values the cultural diversity of its membership and supports interventions that promote an effective healthcare encounter between a member and provider where language or cultural values regarding health and healing may vary. The following are MCC of VA’s objectives to meeting its members’ cultural and linguistical needs:

- Providing culturally appropriate linguistic services to members;
- Hiring staff (including Nurse Care Managers and Member Service Representatives) of similar cultural background and language preferences,
- Promoting cultural sensitivity training throughout the provider network.

Activities to meet these objectives may include, but are not limited to, the following:

- Annual collection and analysis of race, ethnicity and language data from eligible individuals to identify significant culturally and linguistically diverse populations with plan’s membership;
- Annual collection and analysis of race, ethnicity and language data from contracted practitioners to assess gaps in care;
- Collection of data and reporting for the Diversity of Membership HEDIS® measure;
- Annual identification of threshold languages and have processes in place to provide members with vital information in threshold languages;
- Identification of specific cultural and linguistic disparities found within the plan’s diverse populations;
- Analysis of HEDIS® and CAHPS® results for potential cultural and linguistic disparities that prevent members from obtaining the recommended key chronic and preventive services;
- Enhancement of current patient-focused quality improvement activities, such as prenatal and well-child exam incentive program, to address specific cultural and linguistic barriers using culturally targeted materials addressing identified critical barriers;
- Identification of cultural and linguistic barriers and priorities through direct member input including focus group, member feedback forms or surveys, and complaint analyses;
- Analysis of interpreter availability;
- Development of educational materials to meet the cultural and linguistic needs of the population served as well as those with complex conditions;
- Provision of staff with necessary information, training, and tools to address identified cultural barriers;
- Identification, implementation and monitoring planned activities related to the American with Disabilities Act (ADA) requirements, such as provider, staff and member training, communication, and assessment of provider compliance;
- Evaluation of the CLAS Program to include assessment of completion of planned activities, identification of barriers, opportunities and interventions to overcome barriers, and overall effectiveness.

**M. Data Collection**

1. Data Collection Methodology

The department or functional area conducting the related QI activity is responsible to data collection. Qualified staff (i.e., data extraction from medical records is completed by, or under the direction of licensed personnel) completes the manual medical data collection. Data collection follows protocols established in collection procedures.

Standardized data collection tools ensure consistent and accurate abstraction of data per indicator/written specifications. Inter-rater reliability is evaluated for all manual data abstraction processes, data entry and data review.

2. Sampling Methodology

The sample selected is based on the indicator or measure being evaluated and identified in the written documentation of monitoring activities. Statistically valid sampling is used for data collection when appropriate. HEDIS® specifications are used as applicable.

3. Frequency of Data Collection

Data is collected systematically at specified intervals, i.e., semi-annual, once per day, week, month, quarter, or year and an ad hoc basis as necessary. The collection/reporting frequency is included in the Work Plan for each measure. Data results are reported on a metric grid and presented to the relevant quality committee.

4. Data Analysis and Evaluation

Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving the Plan’s clinical and service performance goals. These analyses consider potential barriers for achieving desired outcomes and interventions or recommended strategies. Data is aggregated to track and trend over time for identification of optimal and suboptimal plan performance. Revisions to the QIP Work Plan may be initiated as a result of findings or reprioritization of projects and new events.

Results of these analyses are presented to the relevant quality committee for review and approval. Summary reports are presented to the BOD.

**N. Disease Management**

The objectives of disease management activities are to monitor the care received by members with chronic conditions such as asthma, diabetes, cardiac disease, chronic obstructive pulmonary disease, and congestive heart failure, and to improve the care process, the members’ health status and reduce serious health problems. MCC of VA collects relevant data about the health status of its members, including disease prevalence, and develops disease management programs to assist members and their practitioners in managing the most prominent chronic conditions.

MCC of VA implements structured disease management programs that are designed to:

- Identify and stratify (low-high) chronic disease members depending on the severity of the disease. Members are identified using medical and pharmacy claims data, UM data, and referral by provider or member;
- Provide educational outreach to members to help self-manage their condition;
- Reduce avoidable inpatient and Emergency Department utilization for members;
- Promote appropriate services and programs to assist members in managing their conditions;

- Inform and educate practitioners about available health and disease management programs;
- Evaluate the clinical outcomes of members with chronic conditions using operation, clinical, and utilization metrics.

The disease management program is part of the PHM Program. For more information, please refer to the PHM Program Description and the Disease Management Program Descriptions.

**O. Engaging Members through Technology**

Engaging members through technology occurs through the MCC of VA member portal and web-based applications which may also include mobile device technologies. Care Management and member facing staff refer members to the available tools and encourage adoption and use.

MCC of VA identifies populations who can benefit from web/mobile based applications used to assist members with self-management of health care needs such as, chronic conditions, pregnancy, social determinants of health resources, or other health related topics that may be most beneficial to members. Monitoring of member engagement occurs regularly at the QIC.

**P. Evaluation of New Medical Technologies**

Evaluation of new technology occurs in the national Magellan Clinical Guidelines and Technology Assessment Committee. This committee includes medical directors from Magellan health plans with expertise in a wide variety of medical specialties and behavioral health. MCC of VA benefits from policies created by this committee and can initiate the review of new medical technologies through the request process. The MCC of VA's VP-MD is a voting member on this committee.

The Magellan Clinical Guidelines and Technology Assessment Committee assesses, evaluates and reviews new clinical procedures, drugs or medical equipment identified through utilization and care management activities or through review of literature that is relevant to MCC of VA's population. The review process includes consideration of data from varied sources including:

- Published peer-reviewed medical literature
- New or imminent treatment regimens on a case-by-case basis
- Position Statements from professional societies such as the American College of Physicians or federal agencies such as the National Institute of Health
- Independent medical experts or companies who have expertise in technology
- Review of information from appropriate government regulatory bodies.

Proposed additions to benefits are reviewed at the Magellan Clinical Guidelines and Technology Assessment committee.

**Q. Grievances**

The member grievance process follows state, federal and accreditation requirements and includes the intake of member concerns and complaints and their resolution in a satisfactory and timely manner. MCC of VA has policies and procedures describing the process in detail to include review, investigation, documentation and notification of the decision to members and the appropriate provider.

**R. HEDIS®:**

HEDIS® is a comprehensive measurement tool used by MCC of VA to evaluate the performance and effectiveness of its quality program. HEDIS® contains multiple measures representing a variety of health care service metrics, including effectiveness of care, access to care, use of health care services, member satisfaction, health plan stability, and health plan descriptive information. HEDIS® results are compared to regional and national benchmarks to help Senior Whole Health identify quality improvement opportunities. Annually, these data are collected and submitted to NCQA as required for accreditation and compliance purposes. MCC of VA uses an NCQA-certified vendor and software to produce its HEDIS® results. As each year's results are produced, a variety of analytic and statistical tests are performed on the results to confirm their accuracy. Many of the results use the hybrid approach with medical record abstraction supporting the administrative data. The medical record review vendor is trained in the abstraction process and conducts inter-rater reliability testing and over-reads of the work done by the abstraction team. MCC of VA also over-reads a sample of these records to verify their accuracy. Finally, MCC of VA HEDIS® process is audited by an independent, certified HEDIS® Review Auditor who must sign off on the processes used to produce the data and the accuracy of the results. Final HEDIS® results are submitted to NCQA, CMS and state Medicaid departments, as required.

**S. Health Outcome Survey (HOS)**

MCC of VA uses a certified vendor to administer the HOS per CMS' guidelines with the goal of gathering valid, reliable, and clinically meaningful health status data from the dual eligible population to use in quality improvement activities, pay for performance, program oversight, public reporting, and to improve health.

**T. Medical Record Review**

MCC of VA/ SWH develops and implements an annual strategy for medical/case record reviews that is data informed and focused on assessing the quality and appropriateness of care provided to members. The QIC has oversight of the end-to-end process. Provider audits are conducted using standardized tools, defined sampling and scoring methodologies, and clearly stated policies and procedures. MCC of VA utilizes objective, transparent, and collaborative processes that provide timely feedback and technical assistance to providers as needed. MCC of VA conducts both routine and ad-hoc audits in response to an identified or suspected trend in complaints, incidents, or poor quality outcomes. Providers who do not have a passing score after a review are assisted through development and implementation of a performance improvement plan and are re-evaluated after a specific timeframe. The expectations of record documentation are outlined in the MCC of VA provider manual, on the

website and in provider contracts. Information collected through medical record review may also be used for quality improvement activities such as assessment of continuity and coordination of care. Medical record review policies and procedures provide further details about the process.

**U. Member Rights and Responsibilities**

MCC of VA ensures that members are treated in a manner that respects their rights and dignity. Through the distribution of the MCC of VA Member Handbook, members are informed of their rights and responsibilities. The member handbooks are distributed at enrollment and made available to members annually thereafter (unless a significant change requires dissemination).

Each MCC of VA employee is expected to adhere to member rights and responsibilities policies and receives orientation and ongoing training with respect to member rights. Employees and subcontractors are informed to take member rights into account when furnishing services to members. MCC of VA ensure that each member is free to exercise their rights and that the exercising of those rights does not adversely affect the way the Contractor or its subcontractors treat the member.

**V. Model of Care Description and Documentation:**

MCC of VA produces Model of Care (MOC) descriptions and documents to support regulatory requirements. The MOC is an overview of the basic care management services, delivery network, and quality measurement of the MCC of VA programs. Evaluation of the MOC is completed throughout the year through ongoing reporting to the QIC. Reports include, but are not limited to, population assessment, care management/complex case management reports, the provider reports on network access, adequacy and training, and the evaluation of the QIP.

**W. Peer Review**

The Peer review process is used to improve the quality of medical care provided to members by practitioners and providers. It is the mechanism utilized to conduct review of suspected inappropriate care or inappropriate professional behavior by a physical or behavioral health care provider (individual and organizational) while providing care to an MCC of VA member. The peer review process includes an evaluation from a provider or consultant of the same or similar specialty. If the findings of the independent investigation indicate that a practitioner or provider who is subject to investigation has provided substandard or inappropriate patient care, or has exhibited inappropriate professional conduct, MCC of VA exercises its discretion and takes appropriate action against such practitioner. The process and the scope of actions that may be taken are identified in the plan policies defining the quality of care process. The actions that may be taken if a quality issue is identified may include, but are not limited to:

- Development of a corrective action plan with time frame for improvement
- Education
- Counseling
- Monitoring and trending of practitioner/provider data
- Sanctions on the practitioner’s practice
- Notification to appropriate state and federal bodies

- Limitation or contract termination.

All peer review information is considered privileged and confidential under applicable state and federal laws. Quality of care reviews are tracked and trended by the quality team with annual reporting to the PRCC for review and discussion. The PRCC may make policy recommendations to enhance the quality of care delivered by network providers.

**X. Performance Measures**

The QIP uses the Institute for Health Improvement (IHI)'s Triple Aim for Populations as the foundation for optimizing the performance of the delivery system. The three components to the Triple Aim are to 1) improve the experience and outcomes of care, 2) improve the health of populations, and 3) reduce the per capita costs of healthcare. The QIC actively assesses data collected through the health plans health information systems and other supplemental data to recommend integrated interventions and strategies. The QIC analyzes data to explore opportunities over time to reduce the cost of health care. The trending of data such as utilization, costs and access to care is evaluated to determine opportunities for structuring value-based purchasing agreements, pay-for-performance arrangements and payments based on quality.

MCC of VA monitors HEDIS®, state-specific metrics, CMS and NCQA metrics through the QIP Work Plan and reports at least quarterly to the QIC. The QIC assesses opportunities to continually improve clinical integration and achieve the Triple Aim goals, which in turn will support meeting and exceeding all performance goals and targets.

The QIC addresses deficiencies and ensures evidence based corrective action plans (CAP) are submitted when the performance measures fall below the minimum performance. CAPs follow the PDSA cycle process until sustained improvement has been demonstrated by statistically significant improvement. The QIC monitors performance and activities monthly and may seek stakeholder (provider, member, community) engagement and feedback to improve performance. The quality team may participate in community initiatives aimed to improve these measures and adopt practices that demonstrate improvement within the community. National best practices and interventions may be adopted based on demonstrated improvement using CMS methodologies.

**Y. Performance Improvement Projects (PIPs)**

MCC of VA participates in state-mandated PIPs as well as CMS quality projects such as CCIP and QIP. MCC of VA may select and design additional PIPs based on internal surveillance of trends. Quality studies are designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided to members using standardized methodology. Topics for special studies are chosen based on relevant demographic and epidemiological characteristics of the plan membership where there is an identified opportunity to make significant improvements or are topics mandated by the state and/or CMS. Members are identified for these quality studies using either claims, or medical management data. In some cases, members are stratified for different interventions based on the seriousness of their condition or their need for support. Data is collected, reviewed, and analyzed at baseline and then re-assessed annually after initiating interventions to look for trends, opportunities for improvement toward goals or sustained improvement. The

project must be submitted to the state and/or to CMS for review and approval. The data is presented to the designated quality committee for review and discussion on a quarterly basis.

PIPs may include a clinical and/or non-clinical topic that are designed to correct significant system problems and/or achieve significant improvement in health outcomes and enrollee satisfaction, that is sustained over time. Please refer to Appendix F for a list of current PIPs, CCIPs, and QIPs.

**Z. Pharmacy Management Program**

The goal of the pharmacy management program is to provide programs to help ensure that members have timely access to medications they need in the proper dosage and quantity. Pharmacy program staff, in collaboration with the Pharmacy Benefit Manager when appropriate, evaluates the clinical use of drugs and devices, develop policies for managing drug use, and manage the formulary system. Staff functions also include monitoring quality activities related to pharmaceutical management. The reviews conducted include:

- Assessing utilization and appropriateness of therapeutic agents;
- Ensuring pharmaceutical safety measures are in place, e.g., potential drug-drug interactions, potential disease-drug interactions, notice of drug recall activity
- Analyzing and aggregating data on drug usage;
- Assessing evidence of cost shifting activities;
- Reviewing and providing recommendations on formulary status of drugs;
- Participating in drug or population health management initiatives and studies;
- Developing educational materials and strategies for providers and members;

The Pharmacy Program is also responsible for managing the Medication Therapy Management (MTM) program. The data supporting MTM reporting is produced using internal and vendor sources and is reported to regulators based on the defined specifications. The results of the MTM are reviewed for accuracy before they are submitted, including data validation reviews and trend analysis to make sure unexpected results aren't derived from the data. As the Pharmacy Department compares the MTM results to goals, thresholds and benchmarks, it will identify whether there are opportunities to improve MTM utilization and performance.

**AA. Population Health Management**

The objectives of population health management activities are to monitor the care received by members with chronic conditions such as diabetes, cardiac disease, chronic obstructive pulmonary disease, and congestive heart failure, and to improve the care process, the members' health status and reduce serious health problems. MCC of VA collects relevant data about the health status of its members, including disease prevalence, and develops population health management programs to assist members and their practitioners in managing the most prominent chronic conditions.

MCC of VA implements structured population health management programs that are designed to:

- Identify and stratify (low-high) chronic disease members depending on the severity of the disease. Members are identified using medical and pharmacy claims data, UM data, and referral by provider or member
- Provide educational outreach to members to help self-manage their condition
- Reduce avoidable inpatient and Emergency Department utilization for members
- Promote appropriate services and programs to assist members in managing their conditions
- Inform and educate practitioners about available health and population health management programs
- Evaluate the clinical outcomes of members with chronic conditions through the use of operation, clinical, and utilization metrics.

**BB. Preventive Health Guidelines**

Preventive Health Guidelines are provided to practitioners, providers, and members to promote preventive health practices that are consistent with scientifically based and nationally recognized preventive healthcare guidelines on areas such as immunization and cancer screenings. Making these guidelines available to our members assures that members are kept informed and to support our members to seek services compliant with these guidelines. MCC of VA regularly reviews updates to adult and pediatric guidelines with input from practicing practitioners, including behavioral health care components. These are reviewed and approved by the appropriate quality committee.

**CC. Potential Quality of Care Concerns**

MCC of VA maintains policies and procedures for reviewing, evaluating and resolving potential quality of care concerns reported by enrolled members and contracted providers. The issues may be received from anywhere within the organization or externally from anywhere in the community. All issues, regardless if they are a potential quality of care concern, are addressed regardless of source (internal or external). The Quality Team assesses each issue to ensure they are handled and resolved through the correct process.

**DD. Provider Monitoring**

The QIP is designed to ensure the delivery of quality of services. Provider Monitoring is designed to assess provider performance and includes, at a minimum, the following quality management functions:

1. Peer Review processes,
2. Incident, Accident, Death (IAD) report timely completion and submission,
3. Quality of Care (QOC) Concerns and investigations,
4. DMAS required Performance Measures,

5. Access to Care
6. Performance Improvement Project, and
7. Temporary, provisional, initial and re-credentialing processes and requirements.

MCC of VA conducts an annual audit of subcontracted provider services and service sites and assess each provider's performance on satisfying established quality management and performance measures standards. A Corrective Action Plan is developed and implemented when provider monitoring activities reveal poor performance as follows:

1. When performance falls below the minimum performance level, or
2. Shows a statistically significant decline from previous period performance.

#### **EE. Provider Profiles**

The Quality Team is designing provider profiles that will be available in real time and located on the provider secured portal. Profiles will be available to physicians and hospitals. MCC of VA maintains a data lake where the data from the health information system and claims system resides. This data will be compiled to report on key performance metrics such as readmission rate, utilization percentages, appeals and grievances volumes, results from medical record review, performance measure rates, gaps in care, panel size, etc. The provider profile is reviewed during the re-credentialing process. MCC of VA will adjust and modify the provider profile metrics as the program matures and from feedback from providers and the QIC.

#### **FF. Provider Satisfaction**

Provider Satisfaction Surveys are designed to assess what services are important to plan providers, and to determine provider satisfaction with MCC of VA/ SWH. Results are summarized and reviewed by provider relations staff such as the Provider Support Specialist team, and Network team, to identify and prioritize areas for improvement and to develop action plans. Communications to practitioners through the provider portal, the handbook, practitioner/provider profiling and individual communications based on incident review, all contribute to a robust network with both service quality and clinical rigor.

#### **GG. Reporting:**

The QIP is responsible for reporting certain quality measures, including HEDIS<sup>®</sup>, CAHPS<sup>®</sup>, and HOS results, among others, to its state and federal regulators. This process is supported by the Compliance Team for reporting Part C and Part D elements to CMS through HPMS.

The data elements are collected from internal and external (vendor) sources, including claims data, prior authorization data, pharmacy data, lab data, and assessment data, among other sources. Before data is reported, it goes through internal review to make sure that the data was produced according to CMS specifications. The data results are also trended over time (when measure definitions haven't changed) to make sure the trends are as expected. Any unexplained changes in the rates will be investigated to make sure that data is accurate.

#### **HH. Risk Management and Patient Safety:**

Risk management is a collaborative effort managed under the QIP in conjunction with other departments including compliance and legal. The goal of the program is to accomplish early identification of potential or existing risks to eliminate or mitigate risks to members and the health plan. To support this goal, the Risk Management Program supports the review,

analyses, and follow-up on all adverse events and “near miss” events. A “root cause analysis”, which helps to sort out system as well as individual deficiencies points the way to programmatic change as key learning emerges from investigation of each of these incidents.

To encourage patient safety MCC of VA strives to provide an environment that fosters safe clinical practice. The QIP functions as a key component in the promotion of patient safety and incorporates multiple mechanisms to monitor patient safety, including:

- Assessment of members upon enrollment and periodically thereafter to improve their knowledge about clinical safety including home care or medication related issues;
- Promoting patient centered decision-making in the development of the individual care plan; and
- Directing the focus of existing quality improvement activities on patient safety, including, but not limited to:
  - Adverse incident reporting, tracking, and trending (practitioner, health services and customer service staff interactions);
  - Accessibility of services for emergent and urgent care needs (member complaints/grievances and practitioner self-report);
  - Consistency of application of medical necessity criteria (interrater reliability testing);
  - Adherence to clinical practice and preventive health guidelines (HEDIS measures);
  - Appeals review and analysis (internal audit process);
  - Continuity and coordination of care initiatives;
  - Requests to change providers (telephone and web requests);
  - Abuse and neglect identification and reporting;
  - Provider compliance with administrative and treatment standards (site visits and record reviews);
  - Complaint and satisfaction data analysis related to patient safety with corrective actions taken as needed;
  - Pharmaceutical practice safeguards to enhance patient safety;
  - Sentinel events reporting as required by regulation; and
  - Emergency preparedness.

**II. Services/Service Site Monitoring**

MCC of VA monitors and evaluates the service of delivery system and provider network which includes services and service sites. The Quality Team monitors the services and services sites annually and every three years per state, federal and accreditation requirements. The process for monitoring these areas is through the examination of data obtained by MCC of VA in comparison to benchmarks and pre-established goals, along with collaboration with network providers ensuring oversight and continued progress. The Quality Team conducts on-site reviews if there is a health and/or safety concern. MCC of VA leverages and incorporates information from the medical record review process and from quality of care concern issues to ensure the health and safety of the members. The monitoring results are presented to the QQC Committee.

**JJ. Special Health Care Needs**

MCC of VA recognizes that members with Special Health Care Need have unique and complex health conditions that require distinct processes to ensure members' physical and behavioral health care needs are met. The coordination of services and activities between providers, MCC of VA, and other agencies are monitored to ensure members with special health care needs are provisioned the services needed to meet their specific needs and that coordination occurs in a timely and appropriate manner. Members with special health care needs that are determined to need specialized course of treatment or regular care monitoring may directly access a specialist as appropriate for the member's condition and identified needs. This may be accomplished through standing referrals and approved number of visits. MCC of VA monitors and ensure members have individualized physical and behavioral treatment or service plans that are aligned to their assessment that are performed by an appropriate health care professional.

**KK. Utilization Management (UM)**

The MCC of VA's UM program activities cover clinical aspects of behavioral, dental and physical health care, and diagnostic and treatment services in both the inpatient and outpatient settings. These services, which are designed to promote independence and enhance the member's ability to live in the community, include physical and behavioral health and pharmacy management. The UM program meets its objectives, in part, by conducting prospective, concurrent, retrospective and discharge planning review of services rendered to our members. The UM department monitors quality, continuity, and coordination of care as well as over-utilization and under-utilization of services. High risk/high cost cases are followed closely by the UM staff to ensure that the most cost-effective services are identified, coordinated, implemented, and evaluated on a continual basis. Please refer to the Utilization Management Program description for further details.

**X. Compliance Program**

MCC of VA provides a robust compliance program that:

- Covers all applicable Federal and state laws, rulings, regulations and standards;
- Meets all contractual requirements pertaining to operations and business activities conducted by MCC of VA; and

- Applies to all health plan employees, trainees or interns, to all MCC of VA associates working in other departments supporting MCC of VA services, and to all persons and companies providing contractual and delegated services to MCC of VA.

In all cases, MCC of VA takes proactive steps to ensure compliance and defines the steps to be taken when non-compliance is detected. MCC of VA cooperates with other Magellan functional areas, including Magellan Compliance, Legal and Security Departments, and the Special Investigations Unit, as needed.

The Compliance Program fosters an atmosphere that promotes knowledge of regulations and expected conduct by associates and managers so that they routinely monitor themselves and their programs accordingly. Within the MCC of VA Compliance Program, *monitoring* refers to an ongoing, generally continuous, process conducted to verify that appropriate policies are followed, and compliance requirements are met, including review of reports collected routinely or automatically. Through this process, the Compliance Program or other functional areas may identify areas of compliance risk for the Plan. In these cases, the Compliance Program monitors steps taken to mitigate those risks.

In contrast to *monitoring*, *auditing* refers to a more formal review of a sample of cases or activities under review. Although some internal auditing is completed by supervisory staff within the area being audited, most is completed by auditors external to the area (including audits by the Quality Department or Compliance staff members). These audits generally follow a pre-defined, specific process and result in formal reports that include recommendations for improvement and, as appropriate, Corrective Action Plans. An external independent review of the quality, timeliness and access to services may be performed under the state contracted EQRO.

A range of appropriate responses is available when noncompliance with regulatory requirements and Standards of Conduct and ethical responsibilities is identified including the following:

- Clarification of the requirements or standards;
- In-depth review of program procedures, as well as education and training for affected staff;
- Review and involvement of the Human Resources Department, for serious or repeated associate performance in conflict with the Magellan Standards of Conduct and ethical responsibilities, with possible disciplinary action.

In general, a method for measuring future compliance is incorporated into any plan developed to resolve a significant compliance problem. The MCC of VA Chief Compliance Officer and the Compliance Committee are available to consult with managers regarding development and implementation of appropriate compliance plans.

MCC of VA has implemented corrective action guidelines related to noncompliance with regulatory requirements, Standards of Conduct and ethical responsibilities, and these are documented in the Magellan Employee Handbook. These guidelines are designed to encourage fair and impartial treatment of all associates and are administered without discrimination and in full compliance with the MH Equal Employment Opportunity philosophy. Compliance Program outlines the details and requirements under this program.

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Note: This Quality Program Description may be modified to include any and all state or federal government program requirements and any such modification shall be submitted to the applicable regulatory agency prior to implementation.

**XI. Confidentiality and Privacy with Communication and Medical Records**

MCC of VA recognizes the increased complexity of protecting patient privacy while managing access to, and the release of, protected health information (PHI) about members. The MCC of VA Chief Compliance Officer is responsible for the creation, implementation and maintenance of privacy-compliance related activities. The MCC of VA Quality team maintains copies of all committee minutes, reports, or other data in a confidential manner that provides anonymity to practitioners, services recipients and family members. Access to these documents is available only to committee members, specific individuals as designated by the committee chair, members of the Magellan corporate committee structure, and to auditors authorized to review MCC of VA activities for the purpose of accreditation oversight due diligence. The minutes and reports may be open to review by the applicable state per contractual arrangement and when required by law.

**XII. Program Integrity: Fraud, Waste and Abuse (FWA)**

The Compliance department with cooperation and support from legal and finance, oversees a proactive anti-fraud program. The program integrity and Special Investigations Unit (SIU) is responsible for coordinating prevention, detection, education, investigations, and reporting activities.

The FWA program at MCC of VA is tasked with:

- Creating an organizational culture of awareness related to recognition of potential FWA scenarios through comprehensive education of staff, providers, vendors, and other stakeholders.
- Providing a process to prevent, identify, detect and report potential fraudulent occurrences.

The FWA plan, including the training plan, is reviewed annually and revised as needed. The SIU investigates all allegations of FWA if suspicious activity is surfaced regarding practices by a practitioner, member, employer or insurance agent/broker. Periodic re-audits of aberrant practitioners may be conducted to determine if the billing, prescribing pattern, or inconsistencies have been corrected. We realize that members of our health plan are living with conditions that may make them more vulnerable to less-than-honest individuals

The Program Integrity (SIU) director is a National Health Care Anti-Fraud Association (NHCAA) accredited health care fraud investigator (AHFI). The director is responsible for coordinating with Magellan legal, state and federal law enforcement agencies and regulators as required by law.

**XIII. Delegation Oversight**

MCC of VA maintains policies and procedures that govern the process and oversight for delegated functions to ensure compliance with state, federal and accreditation standards. MCC of VA works to collaborate with delegated entities to continuously improve health service quality, including but not limited to service quality to members, appropriate access to benefits, and care coordination.

The Delegation Oversight Committee oversees the compliance of delegated activities with the signed delegation agreements for vendors. The PRCC oversees the compliance of delegated

activities of providers that are delegated initial credentialing and recredentialing. MCC of VA conducts pre-delegation and annual audits with ongoing monitoring of delegates' performance in compliance with NCQA delegation standards.

Delegation oversight is conducted by auditing delegates' files, policies and procedures or program descriptions. Delegates not meeting the intent of the delegation agreement will respond to the opportunities identified with a corrective action plan. The action plan will be reviewed until the matter is brought into compliance. Please refer to Appendix G for delegated activities and entities.

#### **XIV. Program Evaluation**

The QI Program Description and Work Plan govern the program structure and activities for a period of one calendar year. At least annually, the QI Department will facilitate a formal evaluation of the QIP. The evaluation of all quality activities will include, at a minimum, the following areas:

- A summary of quality improvement activities;
- Evaluation of the results of each QI activity implemented during the year and identification of quantifiable improvements in care and service;
- When applicable, includes a trended indicator report and brief analysis of changes in trends, barriers that impact the rates and improvement actions taken as a result of the trends and to mitigate barriers;
- Identification of opportunities to strengthen member safety activities;
- Evaluation of resources, training, scope, and content of the program;
- Evaluation of practitioner participation and health plan leadership involvement;
- The impact the quality improvement process had on improving health care and service to members, including beneficiary health outcomes;
- Identification of limitations and barriers and makes recommendations for the upcoming year, including the identification of activities that will carry over into next year;
- Evaluation of the overall effectiveness of the QI Program;
- Recommendations for quality improvement program revisions and modifications resulting from the evaluation which would result in subsequent actions to enhance the program and its projects; and
- Evaluation of the MOC Program to include:
  - Administrative (demographics, call data and information);
  - Authorizations and referral patterns;

- Utilization data analysis (medical, pharmaceutical and behavioral health);
- Measures of satisfaction related to program enrollment (disease/case management);
- Claims/Encounter data and information for pattern identification
- National performance metrics, such as HEDIS®, CAHPS® and HOS
- Access, availability and adequacy of provider network
- Timeliness, adequacy and completeness of care plans
- Provider satisfaction survey
- Risk assessments, member health status and other indices of health, such as HOS
- Staff structure and operational measures and performance thresholds

The results of the annual QIP evaluation are used to develop and prioritize the QIP Work Plan for the upcoming year. MCC of VA evaluates the effectiveness of its quality program at least annually. The annual evaluation is reviewed and approved by the QIC, National Medicare/DSNP QIC and the BOD. QIC review and approval is documented in meeting minutes and are available to state and federal regulators. A summary of the quality program and evaluation is provided annually to members and providers. The quality program evaluation is made available to members and providers upon request.

**XV. Amendments and Revisions**

The MCC of VA QI Program Description can be amended or revised at any time by the MCC of VA QIC and the National Medicare/DSNP QIC. Documentation for amendments or revisions can be found in the signed and dated QIC and National Medicare/DSNP QIC minutes.

**XVI. Committee Approval**

This MCC of VA QI Program Description was approved by the Quality Improvement Committee and the National Medicare/DSNP Quality Improvement Committee during its meeting on as indicated by the signatures below:

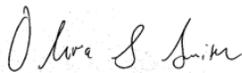


Menahem Dimant MD

2/27/2020

\_\_\_\_\_  
Date

Vice President, Medical Director  
Chairperson, Quality Improvement Committee



Olivia S. Smith

2/28/2020

\_\_\_\_\_  
Date

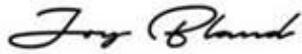
Quality Director, MCC of VA (Interim)  
Co-Chair, Quality Improvement Committee



\_\_\_\_\_  
Dr. Edith Calamia  
Chief Medical Officer, MCC  
Chairperson, National Medicare/DSNP Quality Improvement Committee

2/28/2020

\_\_\_\_\_  
Date



\_\_\_\_\_  
Joy Bland  
VP of Quality Health Plan, MCC  
Chairperson, National Medicare/DSNP Quality Improvement Committee

2/28/2020

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Date

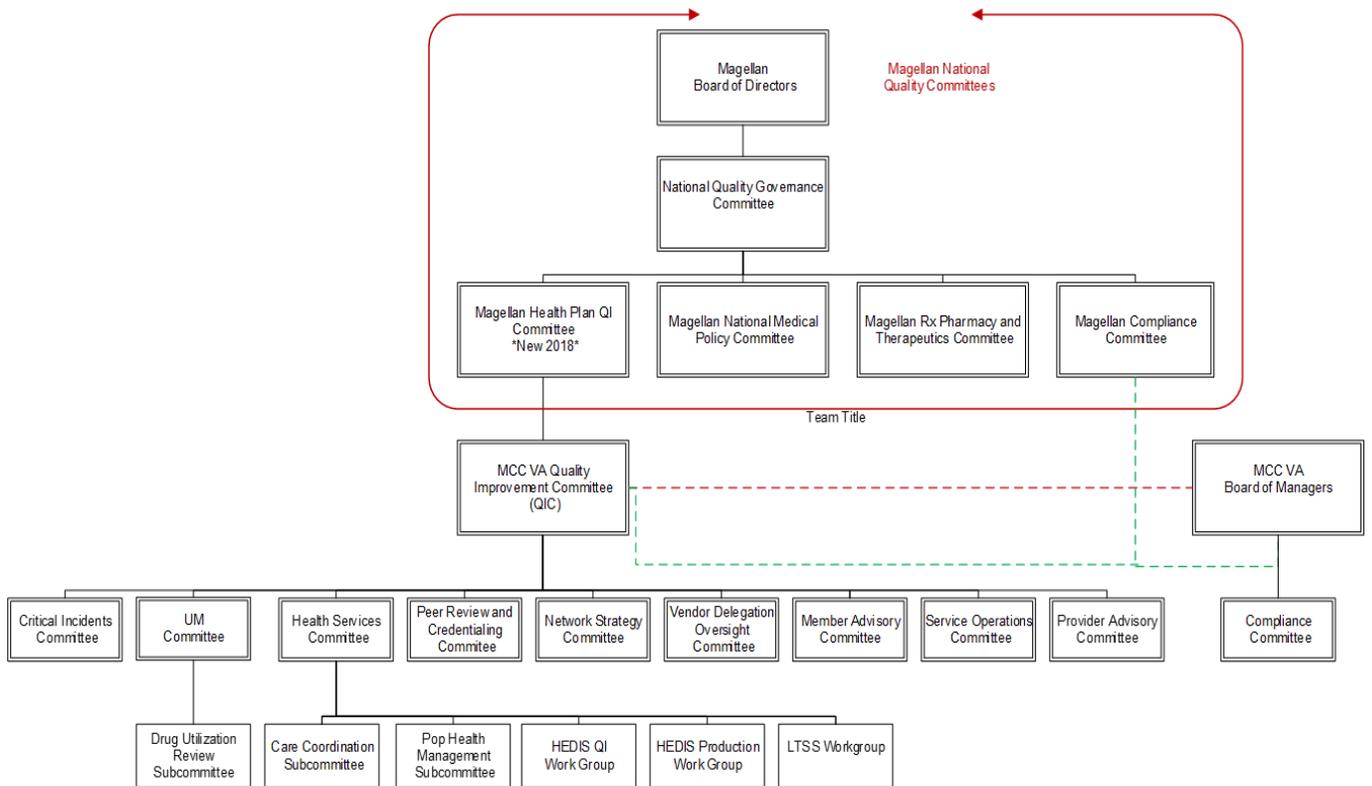
## Appendix A: 2020 Quality Improvement Committees

Committee Name	Frequency	Responsibilities	Chair	Members
Board of Managers (BOM)	Quarterly	See Charter	MCC VA CEO	See Charter
Quality Improvement Committee (QIC)	Quarterly	See Charter	VP Medical Director Director, Quality	See Charter
National Medicare/DSNP Quality Improvement Committee	Quarterly	See Charter	Chief Medical Officer and VP Quality	See Charter
Compliance Committee (CC)	Quarterly	See Charter	Compliance Officer	See Charter
Utilization Management Committee (UMC)	Quarterly	See Charter	VP Medical Director VP Health Services	See Charter
Health Services Committee (HSC)	Quarterly	See Charter	VP Health Services	See Charter
Care Coordination Subcommittee	Quarterly	See Charter	VP Health Services	See Charter
Population Health Management Committee	Bi-Monthly	See Charter	Sr. Director, Clinical Care Services Director, Quality	See Charter
Drug Utilization Management Subcommittee	Quarterly	See Charter	Director, Pharmacy	See Charter
Critical Incidents Committee	Quarterly	See Charter	VP Medical Director	See Charter
Service Operations Committee	Quarterly	See Charter	VP Chief Operation Officer	See Charter
Peer Review and Credentialing Committee	Monthly	See Charter	VP Medical Director	See Charter
Provider Advisory Committee	Quarterly	See Charter	VP Medical Director	See Charter
Network Strategy Committee	Bi-Monthly	See Charter	Sr. Director, Network	See Charter
Vendor Delegation Oversight Committee	Quarterly	See Charter	Director, Vender Management	See Charter
Member Advisory Committee	Quarterly	See Charter	Member and Family Advocate	See Charter

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Note: This Quality Program Description may be modified to include any and all state or federal government program requirements and any such modification shall be submitted to the applicable regulatory agency prior to implementation.

## Appendix B: 2020 Quality Improvement Committee Structure



Additional Notes: Show dotted line reporting from Local QIC to BOD or BOM. Show dotted line from Local Compliance Committee to the National Quality Governance Committee and QIC.

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**Appendix C: 2020 Quality Improvement Committee Meeting Report Schedule**

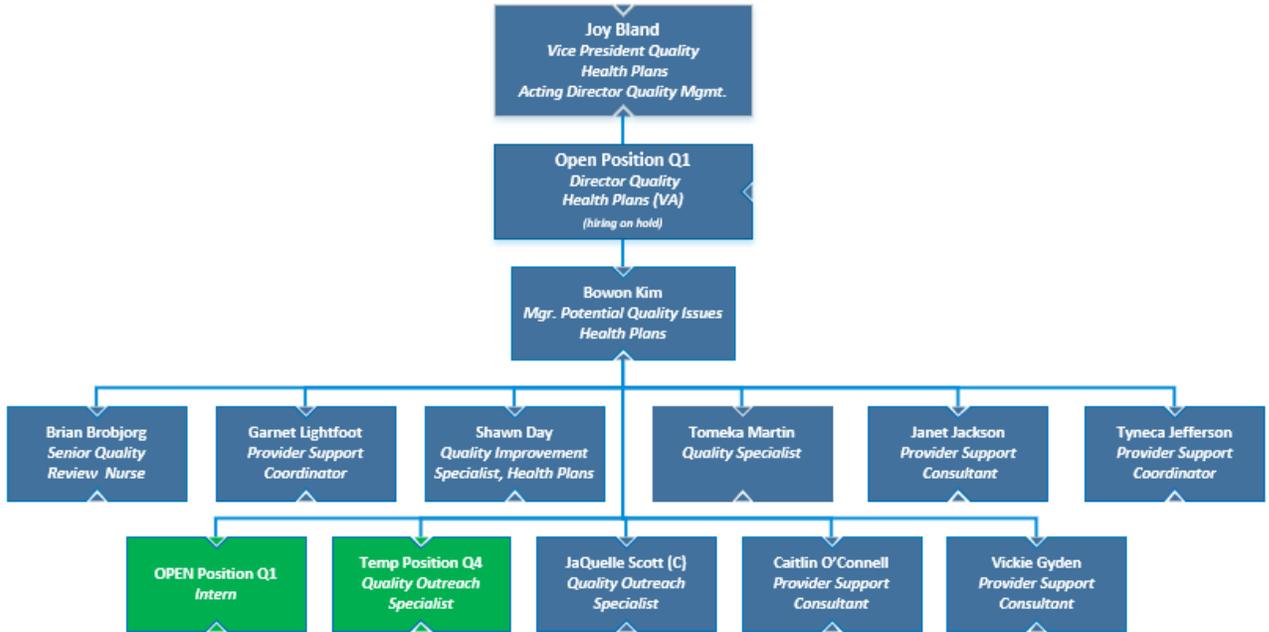
Date of Meeting	Committee	Reports	Responsible Person	Regulatory Requirements
3/18/2020	QIC	All subcommittees Quarterly Report to QIC	Medical Director, Director of Quality	TBD
6/17/2020	QIC	All subcommittees Quarterly Report to QIC	Medical Director, Director of Quality	TBD
9/16/2020	QIC	All subcommittees Quarterly Report to QIC	Medical Director, Director of Quality	TBD
12/16/2020	QIC	All subcommittees Quarterly Report to QIC	Medical Director, Director of Quality	TBD

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Appendix D: 2020 Quality Improvement Organizational Chart

# MCC Virginia



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## **Appendix E: 2020 Quality Improvement Program Work Plan**

\*Separate document in progress

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Note: This Quality Program Description may be modified to include any and all state or federal government program requirements and any such modification shall be submitted to the applicable regulatory agency prior to implementation.

**Appendix F: Current PIPs, CCIPs, and QIPs**

Name	Indicators	Responsible Person(s)	Regulatory Agency
TBD- first year of DSNP (started 1/1/20)			

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## Appendix G: Delegated Entities/Activities

Delegated Entity	Delegated Activity(ies)
TBD	

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