POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Quality Assessment and Performance Improvement Program
PAGE: 1 of 51	**REPLACES DOCUMENT:**
APPROVED DATE: 09/11	**RETIRED:**
EFFECTIVE DATE: 01/12, 02/15, 12/15	**REVIEWED/REVISED:** 09/11, 11/11, 09/12, 10/12, 2/13, 10/13, 11/13, 1/14, 12/14, 3/15, 4/15, 9/15, 1/16, 7/16, 9/16, 1/17, 7/17, 2/18, 1/19, 9/19, **1/20**
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA. QI. 01

SCOPE:
Louisiana Healthcare Connections Quality Improvement and Medical Management Departments

PURPOSE:
To describe the Quality Assessment and Performance Improvement Program (QAPI).

PROCEDURE:
See attached Program Description

REFERENCES: Managed Care Organization (MCO) RFP Section 14 Current NCQA Health Plan Standards and Guidelines
ATTACHMENTS:

DEFINITIONS:

REVISIONS to PROGRAM DESCRIPTION:	**DATE**
Added that the QAPIC will be co-chaired by the CMD.	09/11
Added that a member advocate representative will be on the QAPIC	09/11
Added that a delegate of the QAPIC will attend the DHH Quality Committee meetings	09/11
Clarified in Performance Measures section reporting requirements to DHH for both clinical and administrative performance measures	09/11
NCQA section updated to clarify on submission of NCQA accreditation application at "earliest point possible"	09/11
Added bullet under Scope on pg. 4: "Care furnished to enrollees with special health care needs"	11/11
Added bullet under QAPI Program Evaluation: Measurement of the quality and appropriateness of care furnished to enrollees with special health care needs	11/11
Added Evaluation of "areas of concern in the provision of healthcare services to members" under 5th bullet point under QAPIC Pg. 10	11/11
Added: Minutes will be submitted to DHH within 10 (ten) business days following each meeting. Pg 11 under QAPIC description.	11/11
Added: The full annual evaluation is submitted to DHH following approval by the BOD. Under QAPI Program Evaluation on Pg. 20	11/11

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Under QAPI Program Evaluation on Pg 20 updated bullet point 1 to include: all care management activities	11/11
Under **Scope:** Removed Corporate and	10/12
Under **Program Resources**-changed CCMS to TruCare	10/12
Under **Documentation Cycle-**added DHH reserves the right to request additional reports as deemed necessary. DHH will notify the plan of additional required reports no less than sixty (60) days prior to due date of those reports.	10/12
Under **Performance Measures**-added All Administrative, Level I and Level ii PMs are reporting measures and reporting is required semi-annually and upon DHH request. DHH may add or remove PM reporting requirements with a sixty (60) day advance notice. Prevention Quality Indicator measures within Level I shall be reported quarterly and upon DHH request beginning in 2013 utilizing CY 2012 data for Contracts that began January 1, 2012. Reporting begins in 2014 quarterly and upon DHH request utilizing CY 2013 data for Contracts that began after January 1, 2012. Level I and Level II measure reporting is required annually, and upon DHH request, beginning in 2013 utilizing CY 2012 data for Contracts that began January 1, 2012. Level I and Level II PM reporting is required annually, and upon DHH request, beginning in 2014 utilizing CY 2013 data for Contracts that began January 1, 2012.	10/12
Under **Member and Provider Satisfaction-**included "…and a description of the survey process" to the sentence, "Member Satisfaction Survey Reports and a description of the survey process will be submitted to DHH 120 days after the end of the plan year as part of the QI Program Evaluation."	10/12
Under **Performance Improvement Activities** added: The detailed PIP description submitted to DHH will include: An overview explaining how and why the project was selected, as well as its relevance to the plan members and providers. The study question and population. Goals, benchmark, baseline methodology, data sources, data collection methodology, and plan, data collection cycle, analysis cycle and plan, results with quantifiable measures, analysis with time period and the measures covered, analysis and identification of opportunities for improvement with explanation of all interventions to be taken.	10/12
Under **Regulatory Compliance Reporting** added dates to DHH CAP requirement: If DHH determines that Louisiana Healthcare Connections quality performance is not acceptable, DHH will require LOUISIANA HEALTHCARE CONNECTIONS to submit a corrective action plan (CAP) within thirty (30) calendar days of the date of notification or as specified by DHH for each unacceptable performance measure. Within thirty (30) days of receiving the CAP, DHH will either approve or disapprove	10/12

the CAP. If disapproved, the plan shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by DHH. Upon approval of the CAP, whether the initial CAP or the revised CAP, the plan shall implement the DAP within the time frames specified by DHH. DHH may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.	
Under **NCQA Accreditation** added clarification of 30 calendar days to: If at any point a provisional accreditation is achieved, a Corrective Action Plan will be implemented within 30 calendar days of receipt of the Final Report from NCQA. Also added: *Failure to obtain full NCQA or URAC accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.*	10/12
No changes	10/13
Updated reference to 2013 NCQA Health Plan Standards and Guidelines	11/13
No changes	1/14
Under QAPI Goals added RFP requirement: Incorporate improvement strategies that include, but are not limited to: • - performance improvement projects; • - medical record audits; • - performance measures; • - Plan-Do-Study-Act cycles or continuous quality improvement activities; • - member and/or provider surveys; and • - activities that address health disparities identified through data collection.	12/14
Changed date to 2015 Changed CCN to MCO Changed NCQA status to accredited	3/15
Updated reference of NCQA guidelines to Current NCQA Health Plan guidelines and standards.	4/15

• Added BH language under scopes: Behavioral health fidelity plans and criteria
• Added BH language: Compliance with all applicable behavioral health reporting requirements including:
  • The percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or member/family ratings on standardized tools, and/or measurable functional outcomes) to measure positive outcomes of service delivered
  • The number and percentage of members who show improved functioning with treatment, as well as the amount of improvement as a result of the assessment
	12/15

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Added that Sr. Director of Quality reports to the COO and removed that the Sr. Director of Quality reports to the VPMM	
• Changed 2015 to 2016 on front page	1/16

• Removed
  • The percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or member/family ratings on standardized tools, and/or measurable functional outcomes) to measure positive outcomes of service delivered
  • The number and percentage of members who show improved functioning with treatment, as well as the amount of improvement as a result of the assessment
	1/16

• Removed "three frameworks: individual State definitions of cultural competency, the federal CLAS standard guidelines, and the Georgetown University National Center for Cultural Competence model framework." and added "The Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) Standards."	1/16
• Updated Committee structure to reflect committees vs sub-committees. Removed the following Committees as directly reporting to the QAPIC: • Joint Operations Committees • Member Advisory Council • Provider Advisory Committee • Community Advisory Committee Added subcommittees and descriptions that were not present on current committee structure. Changed Utilization Management Committee (UMC) to Medical Management Committee (MMC)	1/16
Removed Credentialing Program Description as there is no longer a formal program description.	1/16
Removed "Although the pharmacy benefit is carved out of the MCO contracted benefits,	1/16
Removed "and a representative of LPC&A" under CLAS Taskforce	1/16
Added: ***Pharmacy and Therapeutics Committee*** The purpose of the Plan's Pharmacy & Therapeutics Committee (LPTC) is to review and make decisions for changes to the drugs listed for coverage, the edits related to controls or limitations of drug coverage, and the policies and procedures governing provision of drug coverage under the Medicaid Preferred Drug List (PDL). The P&T Committee reports directly to the QAPIC and meets at least semi-annually and upon DHH request to consider products in categories recommended for consideration for inclusion/exclusion on the Plan's PDL.	1/16

Provider Engagement Committee The Provider Engagement Committee is the Plan's leadership committee responsible for identifying and solving provider issues, as they pertain to quality and cost. The Committee reports directly to the QAPIC. The purpose of the Provider Engagement Committee is to review and make recommendations on provider profiling, provider payment innovations, claims issues, gaps in care and pharmacy trends. The Provider Engagement Committee meets monthly with additional meetings scheduled as needed. ***Other Subcommittees of the QAPIC include:*** ***HEDIS Steering Committee*** The HEDIS Steering Committee is Plan's senior leadership committee responsible for monitoring and improving HEDIS scores. The purpose of the HEDIS Steering Committee is to oversee the HEDIS process at the Plan level. The Committee will review monthly rate trending, identify data concerns and communicate Corporate initiatives to the Plan Senior Leadership. The Committee will direct member and provider initiatives, both clinical and non-clinical, to improve HEDIS scores. The HEDIS Steering Committee meets monthly with additional meetings scheduled as needed. ***Physician Advisory Committee*** The Physician Advisory Committee is the Plan's advisory committee responsible for soliciting feedback from contracted physicians and seeking their advice as to ongoing operations and opportunities for improvement. The Committee reports to the Provider Advisory Committee. The purpose of the Physician Advisory Committee is to engage network physicians to provide input, feedback and advice to the Plan. The Physician Advisory Committee meets Quarterly with additional meetings scheduled as needed. ***Practice Management Committee*** The Practice Management Advisory Committee is the Plan's senior leadership committee responsible for soliciting feedback on a number of issues related to the day-to- day managing of the practice. The purpose of the Practice Management Committee is to engage Practice Managers from in network provider's offices. The Committee will touch on issues related to payment and claims submissions, network adequacy, member needs and benefits, provider credentialing, provider load and the provider manual. The Committee will also help to expand HEDIS/ EPSDT and Care Gap knowledge. Practice Management Committee meets monthly with additional meetings scheduled as needed.	
NCQA/HEDIS Project Manager/…ADDED "Coordinator" Removed One of the QI Coordinators will be designated as the 'Medical Records Review Coordinator' who will ensure compliance with the medical records requirements. The medical records review coordinator will maintain medical record standards and direct medical record reviews.	1/16
Added for the initial three-year term of the contract. and	1/16

Louisiana Healthcare Connections may select and DHH may require an additional project each year to reach a maximum of four (4) projects. Louisiana Healthcare Connections will perform a minimum of (1) additional DHH-approved behavioral-health PIP each contract year.	
Removed The Member Services Department is responsible for coordinating the CAHPS surveys through an NCQA certified survey vendor for administering the Adult, Child and Child with Chronic Conditions surveys, aggregating and analyzing the findings and reporting the results. Added "The Quality Department" instead.	1/16
Within three (3) months of execution of the MCO Provider Agreement and at the beginning of each Provider Agreement year thereafter, Louisiana Healthcare Connections will submit in writing, a general and a detailed description of each required PIP to DHH for approval….ADDED "or as otherwise specified by DHH." (due to the collaborative PIP effort by Bayou Health Plans with DHH)	1/16
Removed "separately for each MCO regional area" from Member and Provider Satisfaction Survey paragraph.	1/16
Added new continuity of coordination of care measures 1) The total number of emergency department visits resulting in a follow-up visit with an outpatient provider within 30 days. 2) The total number of inpatient discharges resulting in a follow-up visit with an outpatient provider within 30 days. 3) The total number of members discharged from an inpatient setting following a live birth that had a postpartum visit with a primary care provider (PCP) or OB-GYN within 21-56 days. Removed old ones Added wording before COC and BH: "Louisiana Managed Care Organizations (MCO) have been designated by State authorities to ensure that the behavioral health (BH) population be integrated into traditional Medicaid offered services. Continuity of Coordination of Care activities will identified and assessed. The following are examples of potential activities that will be monitored:"	1/16
Changed frequency of medical record reviews from every 3 to 2 years.	1/16
Removed COC measures, inserting examples of types of COC measurements that are monitored for both Medical and BH. Changed DHH to LDH.	7/16
• Clarified BH participation in the program • Adjusted QI description for QI Director role to QI Director/VP • Added wording "The P&T Committee is a multidisciplinary team that includes representation from a range of network Providers (including a behavioral health practitioner), participating network pharmacist(s) and clinical pharmacist(s). Plan executive leadership and Pharmacy/QI staff may also attend the P&T as appropriate. The Committee is chaired by the Medical Director, although as committee member	9/16

leadership develops, the Committee may be chaired by a network Provider at the discretion of the P&T Committee."	
• Replaced 2016 references with 2017. • Removed the word "representative" and replaced with "The QAPIC chair" will attend LDH Quality Committee meetings on a regular basis and report back to the QAPIC. • Updated department staffing to reflect job titles and current 2017 quality structure.	1/20/2017
• Provider Advisory Committee removed from the QI Program Description due to being retired.	
• Removed language referring to the delegated Behavioral Health Organization assessing Member Satisfaction • Changed date to 2018	2/2018
• Adopted Centene template for Quality Program Description (CC.QI.01) • Added Louisiana-specific requirements per the RFP • Replaced Quality Improvement Committee (QIC) with Quality Assessment and Performance Improvement Committee (QAPIC) throughout document • Updated Committee Structure diagram • Incorporated committee charters in lieu of committee descriptions	2/2019
• Incorporated committee descriptions in lieu of committee charters. • Revised Committee Structure diagram. • Replaced Grievance and Appeals Manager and job description with Director of Quality and job description to reflect organization's structural changes • Added wording, "~~At~~"At least annually, the Plan will assess the entire member population and any relevant subpopulations (e.g. Foster Care, Chisholm) to identify potential areas of need. Data utilized for assessment of the entire member population includes information provided by CMS and/or the state agency and includes information such as age, gender, ethnicity, race, primary language, benefit category, location, and disability indicators. Results of the Population Assessment are analyzed and subsequent enhancements are made to the QAPI Program if opportunities for improvement or gaps in services are identified."	09/2019
• **Change date to 2020** • **Rearranged/alphabetized Medical management under Scope ,** • **Added Monitoring for compliance with all regulatory and accreditation requirements, Social determinants of health and Encouraging providers to participate in quality initiatives and giving support to providers, including a provider analytics system that delivers frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care, and adoption and distribution of evidence-based practice guidelines, under Scope**	**1/2020**

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• Added "Louisiana Healthcare Connections and all network providers and subcontractors comply with the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), and all applicable federal and state privacy laws." under Confidentiality. • Added "Health" to Plan legal executives (pg. 4) • Replaced Chief Medical Director with Chief Medical Officer (pg. 5,6) • Added under Authority, "The Behavioral Health Medical Director, or other appropriate behavioral health practitioner (i.e. a medical doctor or a clinical PhD or PsyD who may be a medical director, clinical director, or a participating practitioner from the organization or behavioral healthcare delegate), is the designated practitioner responsible for the behavioral health aspects of the Quality Program and is responsible for:" and their responsibilities (pg. 7) • Removed "Quality Committee Name" and abbreviated to "QAPI" • Added LHCC Committee Structure 2020 (pg.8) • Removed Sr. VP of Medical Affairs and added Chief Medical Officer throughout the document • Added Accreditation Steering Committee to report to the Performance Improvement Team (pg. 10) • Added "of" Medical Director Review "of" health plan operational policies (pg. 11) • Added Chief Medical Officer's team and removed Affairs from Medical Affairs team (pg.13) • Removed, "monthly" added quarterly; removed "no less than ten times per year" added "with monthly ad hoc meetings if needed", and added "analysis of performance improvement initiatives and identify barriers to the quality improvement process, removed "timely review of providers and to expedite network development." (pg. 14) • Removed Direct from Chief Medical Director and added "Officer" under Committee composition for the PRC includes: (pg. 16) • Added "Assessment and Performance" to Quality Improvement Committee (pg. 16) • Added the word "the" to the first sentence. (pg. 17), removed, "Sr. Director of Quality" and added "HEDIS Manager", removed "other" from other designee. (pg. 17) • Added a hyphen between "community-wide" (pg. 18) • Revised the Senior Director and Director of Quality Improvement description and responsibilities. (pg. 19-20) • Revised Centelligence under "Additional Program Resources" (pg. 21-22),	

Louisiana Healthcare Connections in proper places for [Health Plan Name] • Added resources, Certified HEDIS Engine, Scorecards, Predictive Analytics, Clinical Decision Support, Customer Relationship Management (CRM) Platform; removed Quality Spectrum Insight-WL (QSIXL) and INDICES, as well as, Impact Pro (pg.24-25) • Revised QAPI Program Description under "Documentation Cycle" (pg. 25-26) • Added (s) to facilitate/prepare; added Louisiana Healthcare Connections provides general information about the Quality Program to members and providers on the website or member/provider materials such as the member handbook or provider manual. If required, communication includes how to request specific information about Quality Program goals, processes, and outcomes as they relate to member care and services and may include results of performance measurement and improvement projects. Infor5mation available to members and providers may include full copies of the Quality Program Description and/or Quality Program Evaluation, or summary documents. (pg. 28) • Added to section "Promoting Member Safety and Quality of Care", "After Hours Access" and "Out of Network Services and Second Opinions" descriptions. (pg.30) • Removed "120 days after the end of the plan year as" and added "as required as" under "Member and Provider Experience" (pg. 31)	

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Centene's P&P management software, is considered equivalent to a physical signature.

Quality Assessment and Performance Improvement Program Description 202019

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PURPOSE

Louisiana Healthcare Connections is committed to the provision of a well-designed and well-implemented Quality Assessment and Performance Improvement Program (QAPI Program). The health plan's culture, systems, and processes are structured around its mission to improve the health of all enrolled members. The QAPI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, population health management, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative, member, and network services.

Louisiana Healthcare Connections recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate setting. Louisiana Healthcare Connections provides for the delivery of quality care with the primary goal of improving the health status of the members. When a member's condition is not amenable to improvement, the health plan implements measures to prevent any further decline in condition or deterioration of health status or provides for comfort measures as appropriate and requested by the member. The QAPI Program includes identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, Louisiana Healthcare Connections' QAPI Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members.

In order to fulfill its responsibility to members, the community and other key stakeholders, and regulatory and accreditation agencies, the health plan's Board of Directors has adopted the following QAPI Program Description. The program description is reviewed and approved at least annually by the Quality Assessment and Performance Improvement Committee (QAPIC) and Louisiana Healthcare Connections' Board of Directors.

SCOPE

The scope of the QAPI Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to Louisiana Healthcare Connections members including medical, behavioral health, dental, and vision care as included in the health plan's benefits. Louisiana Healthcare Connections incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality improvement activities, including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long-term care (as applicable per the health plan's products), and ancillary services. Louisiana Healthcare Connections' QAPI Program monitors the following:

- Acute, complex, and chronic care management
- Behavioral health care
- Behavioral health fidelity plans and criteria
- Care furnished to enrollees with special health care needs
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health and clinical practice guidelines
- Continuity and coordination of care

- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Marketing practices
- **Medical management**
- Member enrollment and disenrollment
- Member grievance and appeals system
- Member experience
- Member safety
- **Monitoring for compliance with all regulatory and accreditation requirements;**
- Primary care provider changes
- Pharmacy
- Primary care provider after-hours telephone accessibility Louisiana Healthcare Connections' Member Services after-hours telephone accessibility
- Provider appointment availability
- Provider complaints
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and recredentialing)
- **Social determinants of health**
- ~~Medical management~~
- Population health management
- Utilization management, including over- and under-utilization
- **Encouraging providers to participate in quality initiatives and giving support to providers, including a provider analytics system that delivers frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care, and adoption and distribution of evidence-based practice guidelines;**

GOALS

Louisiana Healthcare Connections' primary quality goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the quality of care and services delivered.

QAPI Program **goals** include but are not limited to the following:

- A high level of health status and quality of life will be experienced by the members;
- Network quality of care and service will meet industry-accepted standards of performance;
- The health plan's services will meet industry-accepted standards of performance;
- Fragmentation and/or duplication of services will be minimized through integration of quality improvement activities across functional areas;
- Member satisfaction will meet Louisiana Healthcare Connections' established performance targets;
- Preventive health and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with guidelines for

immunizations, prenatal care, diabetes, asthma, Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT),etc.;

- Louisiana Healthcare Connections will measure specialized behavioral health providers' compliance with clinical practice guidelines until 90% or more of relevant network providers are consistently in compliance.

Compliance with all applicable behavioral health reporting requirements Compliance with all applicable regulatory requirements and accreditation standards is maintained.

Louisiana Healthcare Connections' QAPI Program objectives include, but are not limited to, the following:

- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
- To select areas of study based on demonstration of need and relevance to the population served;
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time;
- To utilize management information systems in data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes;
- To allocate personnel and resources necessary to:
    - support the QAPI Program, including data analysis and reporting;
    - meet the educational needs of members, providers, and staff relevant to quality improvement efforts;
    - meet all regulatory and accreditation requirements;
- To seek input and work with members, providers, and community resources to improve quality of care;
- To oversee peer review procedures that address deviations in medical management and health care practices and devise action plans to improve services;
- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care;
- To recommend and institute focused quality studies in clinical and non-clinical areas, where appropriate;
- To incorporate improvement strategies that include, but are not limited to:
    - performance improvement projects;
    - medical record audits;
    - performance measures;
    - Plan-Do-Study-Act cycles or continuous quality improvement activities;
    - member and/or provider surveys; and
    - activities that address health disparities identified through data collection.
- Increase the use of outcome measurements for all members receiving specialized behavioral health care services through means of developed strategies and annually report as per state requirements
- To serve members with complex health needs;

- Conduct and report annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and certified Healthcare Effectiveness Data and Information Set (HEDIS®) results for members *(CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ); HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)*;
- Achieve and maintain NCQA accreditation and/or other applicable accreditations for appropriate products;
- Monitor for compliance with regulatory and accreditation requirements.

CONFIDENTIALITY

Confidential information is defined as any data or information that can directly or indirectly identify a member or provider. **Louisiana Healthcare Connections and all network providers and subcontractors comply with the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), and all applicable federal and state privacy laws.** The Quality Improvement Committee (QAPIC) and its subcommittees have the responsibility to review quality of care and resource utilization, as well as conduct peer review activities as appropriate. The QAPIC and related peer review committees conduct such proceedings in accordance with Louisiana Healthcare Connections' bylaws and applicable federal and state statutes and regulations.

The proceedings of the QAPIC, its subcommittees, work groups, and/or any ad hoc peer review committees are considered "Privileged and Confidential" and are treated as such. In this regard, all correspondence, worksheets, quality documents, minutes of meetings, findings, and recommendations for the programs are considered strictly confidential and therefore not legally discoverable.

Confidential quality findings are accessible only to the following individuals/groups:

- Board of Directors
- President and Chief Executive Officer (CEO)
- Chief Medical Director, Vice President of Medical Management (VPMM), Vice President/Director of Quality, Behavioral Health Director and designated Quality Department staff;
- Peer Review Committee
- External regulatory agencies, as mandated by applicable state/federal laws
- **Health** Plan legal executives
- Compliance leadership

QAPIC correspondence and documents may be made available to another health care entity's peer review committee, and/or any regulatory body as governed by law, for the purpose of carrying out or coordinating quality improvement/peer review activities; this may include a Quality and/or Credentialing Committee of a health plan-affiliated entity or that of a contracted medical group/independent physician association.

Louisiana Healthcare Connections has adopted the following confidentiality standards to ensure quality proceedings remain privileged:

- All peer review and quality related correspondence documents are appropriately labeled "Privileged and Confidential, Peer Review" and maintained in locked files/secure electronic files;
- Confidentiality policies and procedures comply with applicable state statutes that address protection of peer review documents and information;
- Committee members and employees responsible for Quality, Medical Management, Credentialing, and Pharmacy program activities are educated about maintaining the confidentiality of peer review documents;
- The Quality Vice President (VP)/Director designates Quality Department staff responsible for taking minutes and maintaining confidentiality;
- For quality studies coordinated with, or provided to outside peer review committees, references to members are coded by identification number rather than a protected health information (PHI) identifier such as medical record number or ID number, with references to individual providers by provider code number;
- Records of review findings are maintained in secured files, which are made available only as required by law or specifically authorized in writing by the CEO, Chief Medical **Officer**~~Director~~, Legal Counsel, VPMM, VP Quality, or the Board of Directors Chairman; and
- All participating providers and employees involved in peer review activities or who participate in quality activities or committees are required to sign confidentiality agreements.

CONFLICT OF INTEREST

Louisiana Healthcare Connections defines conflict of interest as participation in any review of cases when objectivity may not be maintained. No individual may participate in a quality of care or medical necessity decision regarding any case in which he or she has been professionally involved in the delivery of care. Peer reviewers may not participate in decisions on cases where the reviewer is the consulting practitioner or where the reviewer's partner, associate, or relative is involved in the care of the member, or cases in which the practitioner or other consultant has previously reviewed the case. When a practitioner member of any committee perceives a conflict of interest related to voting on any provider-related or peer review issue, the individual in question is required to abstain from voting on that issue.

CULTURAL COMPETENCY

Louisiana Healthcare Connections endeavors to meet the needs of all members with sensitivity to cultural needs and the impact of cultural differences on health services and outcomes. Louisiana Healthcare Connections is guided by requirements set by each respective state/federal contract and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) developed by the Office of Minority Health. Specifically, the QAPI Program identifies and addresses clinical areas of health disparities. Louisiana Healthcare Connections assures communications are culturally sensitive, appropriate, and meet federal and state requirements. Population health management initiatives are reviewed to assure cultural issues and social determinants of health are identified, considered, and addressed. As part of the annual program evaluation, Louisiana Healthcare Connections also reviews member needs from a cultural competency standpoint, analyzes data for cultural, ethnic, race, and linguistic issues, and addresses identified barriers.

At least annually, the Plan will assess the entire member population and any relevant subpopulations (e.g. Foster Care, Chisholm) to identify potential areas of need. Data utilized for assessment of the entire member population includes information provided by CMS and/or the state agency and includes information such as age, gender, ethnicity, race, primary language, benefit category, location, and disability indicators. Results of the Population Assessment are analyzed and subsequent enhancements are made to the QAPI Program if opportunities for improvement or gaps in services are identified.

AUTHORITY

Louisiana Healthcare Connections Board of Directors has authority and oversight of the development, implementation, and evaluation of the QAPI Program and is accountable for oversight of the quality of care and services provided to members. The Board of Directors supports the QAPI Program by:

- Adopting the initial and annual QAPI Program which requires regular reporting (at least annually) to the Board of Directors, and establishes mechanisms for monitoring and evaluating quality, utilization, and risk;
- Supporting QAPIC recommendations for proposed quality studies and other quality initiatives and actions taken;
- Providing the resources, support, and systems necessary for optimum performance of quality functions;
- Designating a senior staff member as the health plan's senior quality executive, defining the role of a physician in the QAPI Program, and defining the role a behavioral health practitioner in the QAPI Program; and
- Evaluating the QAPI Program Description and Quality Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary.

The Board of Directors delegates the operating authority of the QAPI Program to the QAPIC. Louisiana Healthcare Connections senior management staff, clinical staff, and network practitioners, who may include but are not limited to, primary, specialty, behavioral, dental, and vision health care practitioners, are involved in the implementation, monitoring, and directing of the relative aspects of the quality improvement program through the QAPIC, which is directly accountable to the Board of Directors.

The Chief Medical **Officer**~~Director~~, as appointed by the Board of Directors, serves as the senior quality executive and is responsible for:

- Compliance with state, federal, and accreditation requirements and regulations;
- Chairing the QAPIC, or designating an appropriate alternate chair, and participating as appropriate;
- Monitoring and directing quality activities among personnel and among the various subcommittees reporting to the QAPIC;
- Coordinating the resolution of outstanding issues with the appropriate leadership staff, pertaining to QAPIC recommendations, subcommittee recommendations, and/or other stakeholder recommendations;
- Being actively involved in the Louisiana Healthcare Connections' QAPI Program including: recommending quality study methodology, formulating topics for quality

studies as they relate to accreditation and regulatory requirements and state and federal law, promoting participating practitioner compliance with medical necessity criteria and clinical practice guidelines, assisting in on-going patient care monitoring as it relates to preventive health/sponsored wellness programs, pharmacy, diagnostic-specific case reviews, and other focused studies, and directing credentialing and recredentialing activities in accordance with Louisiana Healthcare Connections' policies and procedures;

- Reporting the QAPI Program activities and outcomes to the Board of Directors at least annually.

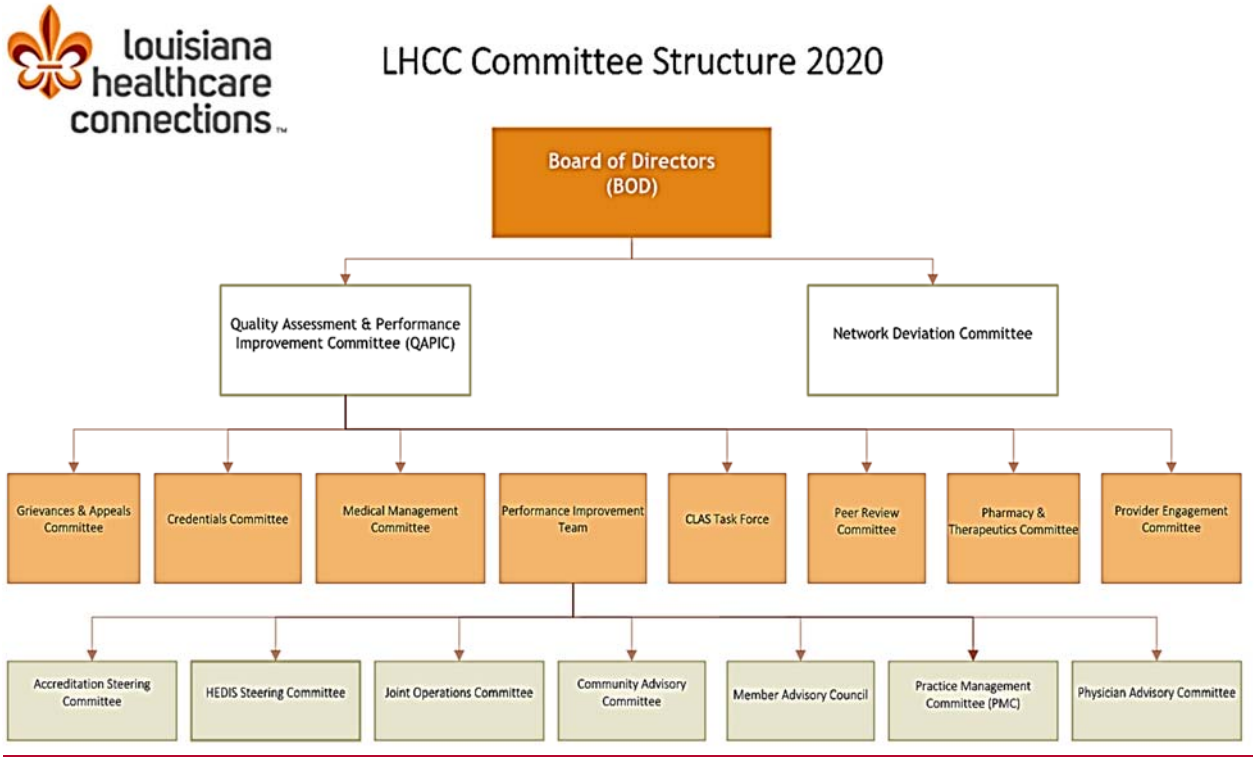
The Behavioral Health Medical Director, or other appropriate behavioral health practitioner (i.e. a medical doctor or a clinical PhD or PsyD who may be a medical director, clinical director, or a participating practitioner from the organization or behavioral healthcare delegate), is the designated practitioner responsible for the behavioral health aspects of the Quality Program and is responsible for:

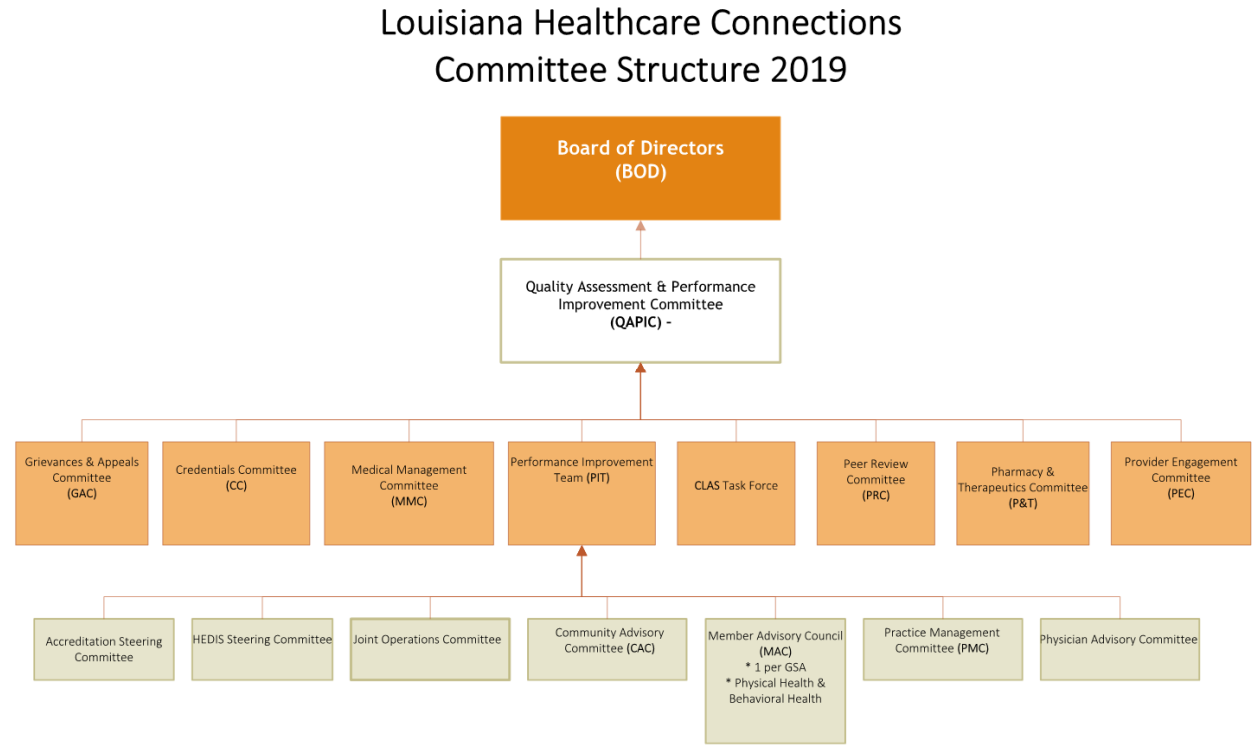
- **Compliance with state, federal, and accreditation requirements and regulations related to behavioral health;**
- **Participating in the ~~[Quality Committee Name]~~QAPI and various subcommittees reporting to the ~~[Quality Committee Name~~QAPI~~]~~, as applicable to behavioral health;**
- **Monitoring and directing behavioral health quality activities among personnel and among the various subcommittees reporting to the QAPI~~[Quality Committee Name]~~;**
- **Providing oversight of the behavioral health aspects of care to ensure appropriateness of care delivery and improve quality of service.**

QAPI PROGRAM STRUCTURE

Quality is integrated throughout Louisiana Healthcare Connections, and represents the strong commitment to the quality of care and services for members. The Board of Directors is the governing body designated for oversight of the QAPI Program and has delegated the authority and responsibility for the development and implementation of the QAPI Program to the QAPIC.

The QAPIC is the senior management lead committee reporting to the Board of Directors. Louisiana Healthcare Connections has established subcommittees and work groups based on Louisiana Healthcare Connections needs as well as regulatory and accreditation requirements. Additional committees may also be included per health plan need, including regional level committees as needed based on distribution of membership. These committees assist with monitoring and supporting the QAPI Program. The Louisiana Healthcare Connections committee structure is outlined below.





All committee activities are documented in the health plan-approved meeting minute format. Minutes are taken during the meeting and reflect attendance and participant discussion. Minutes document all committee findings and follows-up by designating "Old" and "New "Business and will be used for planning subsequent agendas and meetings. Each item for discussion includes the

person responsible and a timeline for completion. The minutes are completed, dated, and distributed to the attendees and the Louisiana department of Health (LDH) within the appropriate timeframe as indicated in the state contract. Minutes are approved and signed by the Committee Chair at the subsequent committee meeting and maintained in a secure area.

Quality Assessment and Performance Improvement Committee (QAPIC)

The QAPIC is Louisiana Healthcare Connections (Plan) senior leadership committee, accountable to the Board of Directors (BOD), that reviews and monitors all clinical quality and service functions of the Plan and provides oversight of all sub-Committees except for the Compliance Committee which reports directly to the BOD.

The purpose of the QAPIC is to perform oversight of all the Plan quality activities, to assess the appropriateness of care delivered and to continuously enhance and improve the quality of services provided to members. The QAPIC will review and direct clinical and service operational activities provided to the Plan members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring, identification, evaluation and resolution of process problems, identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the Quality Improvement (QI), Medical Management (MM), Credentialing and Pharmacy programs. This is a multi-disciplinary committee of the Plan senior leadership staff and actively involves participating network practitioners in its quality activities as available and to the extent that there is not a conflict of interest. The Committee acts as an oversight committee and receives regular reports from all the Plan sub-committees that are accountable to and/or advise the Committee. QAPIC activities include, but are not limited to, review of clinical and non-clinical issues affecting the Plan, coordination of actions of other sub-committees and making decisions regarding quality improvement functions.

The QAPIC will meet no less than quarterly and is chaired by the ~~Sr. VP of Medical Affairs~~**Chief Medical Officer**.

Objectives of the Committee and relationship to Strategic Objectives:

1. Review clinical quality recommendations submitted by the quality sub-committees.
2. Collect and report data reflecting the Plans' performance on standardized measures of health outcomes.
3. Establish an effective management information system to provide the framework for monitoring quality of care/service provided.
4. Identify opportunities for improving health outcomes.
5. Recommend resources necessary to support the on-going educational needs of participating providers and Plan staff relative to current managed care technologies, including updates to provider manuals and other relevant clinical content on a periodic basis as determined by the committee chair person.
6. Annually evaluate the effectiveness of the Quality Improvement, Medical Management, Credentialing and Pharmacy Programs.
7. Annually review and approve the QAPI, MM, and Credentialing Programs.

8. Make recommendations to the Plan sub-committees regarding monitoring, follow-up, barrier analysis and interventions required in order to improve the quality of care or service to the Plan members.
9. Review/establish benchmarks or performance goals for each quality improvement initiative and service indicator.
10. Facilitate the identification of system-wide trends and implement corrective action in order to improve performance.
11. Review due diligence information for any potential delegated entity and provide oversight to those entities already delegated.
12. Oversee the implementation of disease management programs, health education activities, cultural competency programs, and patient safety initiatives.
13. Prioritize quality improvement efforts and assure the appropriation of resources required to carry out QI activities.

Committee composition for QAPIC includes:

- Chief Medical Director or Medical Director
- Behavioral Health Director
- Plan Network Physicians
- Medical Management and Quality Improvement Directors
- Member/Provider Services Director
- Compliance Officer
- Finance Officer/CFO
- Member Advocate
- LDH Representative

The following sub-committees report directly to the QAPIC:

- Grievances and Appeals Committee
- Credentialing Committee
- Medical Management Committee
- Performance Improvement Team
- CLAS Task Force
- Peer Review Committee (Ad Hoc Committee)
- Pharmacy & Therapeutics Committee
- Provider Engagement Committee (PEC)

The Plan may, dependent on Plan needs and state requirements, also have the following subcommittees reporting to the Performance Improvement Team:

- **Accreditation Steering Committee**
- HEDIS Steering Committee
- Joint Operations Committee (JOC)
- Community Advisory Committee (CAC)
- Member Advisory Committee (MAC)
- Practice Management Committee (PMC)

- Physician Advisory Committee (PAC)

Grievances & Appeals Committee (GAC)

The GAC is a subcommittee of the QAPIC and is responsible for maintaining compliance with contractual, federal and state, and accrediting body requirements such as NCQA as relates to processing of grievance and appeals. The scope of the GAC includes tracking and analysis of Member Grievances and Appeals including type and timeliness of resolution, performing barrier and root cause analysis and making recommendations regarding corrective actions as indicated. G&A information is incorporated into recredentialing and other Quality Improvement processes as indicated. The QAPIC authorizes the GAC to make decisions and recommendations regarding corrective actions. The GAC reports to the QAPIC.

The purpose of this committee is to maintain compliance with contractual, federal and state, and accrediting body requirements such as NCQA as relates to processing of grievance and appeals. The GAC will meet no less than quarterly and is chaired by the VP of Quality or other designee.

Objectives of the Committee and relationship to Strategic Objectives:

1. Review, categorize, track, and trend member grievances and appeals.
2. Perform barrier and root cause analysis and make recommendations regarding corrective action as appropriate
3. Provide ongoing reports to the QAPIC and CC (Credentialing Committee), as appropriate
4. Medical Director Review **of** health plan operational policies and procedures at least annually and recommend modifications as necessary.

Committee composition for GAC includes:

- Clinical Appeals Coordinator Representative
- Member Services Representative
- Provider Services Representative
- Compliance Officer or designee
- Additional staff may participate as requested by the Chair

Detailed records are maintained of all GAC meetings, activities, statistics and recommendations for improvement activities. The GAC will report summary reports to the QAPIC at regular intervals, but no less than quarterly. Grievance and appeal information may be incorporated into re-credentialing and other Quality Improvement processes as indicated.

Credentialing Committee (CC)

The Credentialing Committee (CC) is a standing subcommittee of the QIC and is responsible for administering the oversight and operating authority of the Credentialing Program. The QAPIC is the vehicle through which credentialing activities will be communicated to the Board of Directors (BOD). The CC has the responsibility for credentialing and recredentialing physicians, non-physician practitioners, facilities, long-term care providers, and other practitioners in the Plan

network and to oversee the credentialing process to ensure its compliance with regulatory and accreditation requirements.

The CC shall ensure network providers, facilities and practitioners are qualified, properly credentialed and available for access by the Plans members.

The CC will meet monthly, no less than ten times per year, to facilitate timely review of providers and to expedite network development. The committee chair is the Plan Medical Director.

Objectives of the Committee and relationship to Strategic Objectives:

1. Providing guidance to organization staff on the overall direction of the Credentialing Program.
2. Reviewing and approving credentialing and recredentialing policies and procedures.
3. Reviewing and recommending credentialing and recredentialing criteria.
4. Final authority to approve or disapprove applications by providers for network participation status and recredentialing.
5. Providing access to clinical peer input when discussing standards of care for a particular type of provider.
6. Reviewing the oversight audits of delegated networks' Credentialing Program performance.
7. Evaluating and reporting to LHCC management on the effectiveness of the Credentialing Program.

Committee composition for CC includes:

- Plan Medical Director
- Plan Credentialing designee
- Plan Network Physicians from the following Specialties:
- Family Practice/Internal Medicine
- OB/GYN
- High-Volume Specialists
- Mid-Level Practitioners
- Plan Associate Medical Directors

Detailed records are maintained of all CC meetings, activities, program statistics and recommendations made by the Committee. The CC routinely submits meeting minutes as well as written reports regarding analysis of the above tracking and monitoring processes and status of corrective action plans (as applicable) to the QAPIC.

Medical Management Committee (MMC)

The MMC is accountable to the Quality Assessment and Performance Improvement Committee (QAPIC). The primary function is to monitor the appropriateness of care and guarding against over and underutilization of health care services provided to our members. The MMC reports to the Board of Directors (BOD) through the QAPIC. The QAPIC authorizes MMC to make all decisions regarding the utilization of clinical care and services provided on behalf of the Plan to the Plan members.

The MMC will meet no less than quarterly and a member of the Plan **Chief** Medical **Officer's** ~~Affairs~~ team will serve as Chair.

Objectives of the Committee and relationship to Strategic Objectives: Oversee the Medical Management activities of the Plan to ensure compliance with State and accrediting body regulations

1. Annually review and approve the Utilization Management (UM) and Case Management (CM) program descriptions, guidelines, and procedures
2. Annually review and approve the criteria for determination of medical appropriateness to be used for nurse review
3. Adapt criteria for determination of medical appropriateness to work within the delivery system
4. Review provider specific reports for trends or patterns in utilization
5. Review reports specific to facility or geographic areas for trends or patterns
6. Formulate recommendations for specific providers for further study
7. Monitor the adequacy of the network to meet the needs of the patient population
8. Examine reports of the appropriateness of care for trends or patterns of under or over utilization and refer them to the proper provider group for performance improvement or corrective action
9. Examine results of annual surveys of members and providers regarding satisfaction with the UM and CM programs
10. Include a feedback mechanism for communicating findings and recommendations, and contain a plan for implementing corrective actions
11. Report findings to the QAPIC
12. Liaison with the QAPIC for ongoing review of indicators of clinical quality

Committee composition for MMC includes:

- Representation from each service region in which the Plan operates
- Plan Medical Director(s),
- Vice President/Director Medical Management
- Plan Network Physicians
- Other Plan operational staff as requested

Performance Improvement Team (PIT)

The PIT is an internal, management level, cross-functional quality improvement team. The PIT is responsible for gathering and analyzing data, identifying barriers to quality improvement, resolving problems, and/or makes recommendations for performance improvements. The QAPIC authorizes the PIT to make decisions and recommendations regarding performance improvement processes.

The PIT will meet ~~monthly~~**quarterly**, ~~no less than ten times per year~~**with monthly ad hoc meetings if needed,** to facilitate **analysis of performance improvement initiatives and identify**

barriers to the quality improvement process~~timely review of providers and to expedite network development~~. The committee chair is the Plan Director of Quality Improvement or other Designee as assigned by the Plan President.

Objectives of the Committee and relationship to Strategic Objectives:

1. Review and evaluation of key clinical quality and service performance indicators.
2. Prompt initiation of ad hoc performance improvement initiatives (including corrective action plans) to address any negative trends.
3. Review, categorize, track, and trend grievances, administrative reviews, and requests for external reviews. Determines appropriate disposition and follow-up.
4. Monitor resource allocation to ensure appropriate support for the QAPI Program.
5. Track progress of tasks in the annual QAPI Work Plan, make recommendations to improve quality activities noted in the Work Plan as needed, in response to issues raised by the QAPIC.
6. Provide ongoing reports to the QAPIC, as appropriate, on the progress of clinical and performance improvement initiatives.
7. Review the Plan operational policies and procedures at least annually and recommend modifications as necessary.

Committee composition for PIT includes:

- Medical Director(s) as needed
- Management Staff from functional areas:
    - Medical Management
    - Quality Improvement
    - Grievance & Appeals
    - Pharmacy
    - Operations
    - Provider Network/Contracting
    - Compliance
    - Member/Provider Services
    - Human Resources
    - Additional staff may participate as requested by the Chair

~~o~~

Culturally and Linguistically Appropriate Services (CLAS) Task Force

The CLAS Task Force is responsible for the oversight and maintenance of Louisiana Connection's Cultural Competency Plan. The Cultural Competency Plan is the health plan's framework and commitment that enrollees receive care and services that are delivered in a culturally and linguistically sensitive manner.

The CLAS Task Force will meet no less than quarterly and the VP of Compliance and Regulatory Affairs will serve as Committee Chair.

Objectives of the Committee and relationship to Strategic Objectives:

1. To relay to providers their responsibility to provide competent health care that is culturally and linguistically sensitive

2. To provide members access to quality health care services that are culturally and linguistically sensitive
3. To educate and facilitate communication to develop partnerships among providers and LHC in an effort to enhance cultural awareness
4. To identify members with cultural and/or linguistic needs through demographic information and develop mechanisms to utilize this information in service delivery
5. To provide competent translation/interpreter services to our members who require these services in their preferred language
6. To provide our members with Limited English Proficiency (LEP) the assistance they need to understand the care being provided and to accomplish effective interactions with their health care Providers.

Committee composition for the CLAS Task Force includes:

- VP of Compliance and Regulatory Affairs
- Medical Director
- Director Member Services
- Director Provider Services
- Director Contracting and Network Development
- Director Quality Improvement
- Additional staff may participate as requested by the Chair

Peer Review Committee (PRC)

The PRC is an internal ad hoc subcommittee of the QAPIC. The PRC is responsible for investigating alleged adverse outcomes or events regarding members of Louisiana Healthcare Connections. The PRC collects information and other available documents needed to evaluate alleged cases and develops recommendations for corrective action. All correspondence, worksheets, QI documents, minutes of meeting and findings or recommendations of the PRC are considered confidential and therefore not legally discoverable.

Strategic Objectives of the Committee:

1. Review and evaluate the key quality of care indicators presented.
2. The Peer Review Committee discusses the case and comes to a consensus on the recommended final severity level and corrective action.
3. If the assessment results in the recommendation for termination of the practitioner this will be presented to the Credentialing Committee and/or Louisiana Healthcare Connections Board of Directors for final determination.
4. Decisions resulting in the reduction, suspension, or termination of a provider's participation will be reported to the National Practitioner Database (NPDB) as outlined in Practitioner Disciplinary Action and Reporting Policy and Procedure.
5. Track and trend quality of care events and severity leveling to determine the appropriate disposition and follow-up.
6. The Peer Review Committee evaluations and decisions are reported to QAPIC quarterly.

7. A complete documentation is maintained in Quality Improvement Department files and will be reviewed at least quarterly for trends and repeat occurrences. This information is incorporated into recredentialing and other Quality Improvement processes.
8. Monitor resource allocation to ensure appropriate support for the QAPI Program.
9. The QI operational policies and procedures (processes) will be reviewed at a minimum of yearly and recommend modifications forwarded to QAPIC.

Committee composition for the PRC includes:

- Chief Medical ~~Director~~**Officer**
- Medical Director(s)
- Three (3) or more Network Physicians who are peers of the provider being reviewed and/or who represents a range of specialties must include at least one (1) physician with same or similar specialty as case under review.

Pharmacy and Therapeutics Committee (P&T)

The Pharmacy & Therapeutics Committee is a standing subcommittee of the Quality **Assessment and Performance** Improvement Committee with oversight and operating authority of the Pharmacy Program. The P&T Committee is responsible for development and annual review of the pharmacy policies and procedures, review of pharmacy utilization data, decisions regarding inclusion of drugs on the Preferred Drug List (PDL), and recommendations for formulary management activities. The committee meets at least quarterly and is chaired by the ~~Sr. Vice President of~~**Chief** Medical **Officer** Affairs, or his/her designee.

Strategic Objectives of the Committee:

1. Develop and annually review the pharmacy policy and procedures;
2. Conduct practitioner and member profiling for appropriate drug utilization (DUR) and recommendations for DUR activities such as targeted prescriber and/or member education initiatives;
3. Evaluate and recommend drugs for inclusion in or removal from the PDL for appropriateness as a tool for providing high quality and cost-effective care;
4. Evaluation of drug costs by therapeutic class for pharmaceutical containment and projection of pharmaceutical costs;
5. Assure compliance with all contractual, regulatory, and accreditation pharmacy requirements;
6. Review of complaints/grievances regarding pharmacy issues;
7. Recommendations for formulary management activities such as prior authorization, step therapy, age restrictions, quantity limitations, mandatory generics, and other activities that promote access and patient safety
8. Review of requests from practitioners for additions or changes to formulary.

Committee composition for P&T includes:

- ~~Sr. Vice President of Medical Affairs~~**Chief Medical Officer**/Medical Director
- Behavior Health Medical Director

- Senior Director of Pharmacy
- Participating network pharmacists and internal clinical pharmacists
- Practitioners representing various clinical specialties that adequately represent the needs of the Plan's members.
- The Secretary of the Committee will be the Plan's Director of Pharmacy, or his/her designee.
- Other health plan executive and operational staff as requested

Provider Engagement Committee (PEC)

The Provider Engagement Committee is the Plan's leadership committee responsible for identifying and solving provider issues, as they pertain to quality and cost. The Committee reports directly to the QAPIC. The purpose of the Provider Engagement Committee is to review and make recommendations on provider profiling, provider payment innovations, claims issues, gaps in care, pharmacy trends, provider communication, etc. This committee meets no less than quarterly and is chaired by the health plan Chief Medical Officer.

Committee composition for PEC includes:

- COO
- **Chief Medical Officer** ~~VP Medical Affairs~~
- Behavioral Health Medical Director
- VP Operations
- VP Quality
- VP, Network Contracting
- VP, Medical Management
- Director, Finance

Other Subcommittees of the QAPIC include:

HEDIS Steering Committee

The HEDIS Steering Committee is **the** Plan's senior leadership committee responsible for monitoring and improving HEDIS scores. The purpose of the HEDIS Steering Committee is to oversee the HEDIS process at the Plan level. The Committee will review monthly rate trending, identify data concerns and communicate Corporate initiatives to the Plan Senior Leadership. The Committee will direct member and provider initiatives, both clinical and non-clinical, to improve HEDIS scores. This committee meets monthly and is chaired by the ~~Sr. Director of Quality~~**HEDIS Manager** or ~~other~~ designee. This committee reports to PIT.

Accreditation Steering Committee

The Accreditation Steering Committee is the health plan's committee responsible for monitoring the interventions and successes of the NCQA Project. The purpose of the NCQA Steering Committee is to oversee the NCQA process at the Plan level. The Committee will review and evaluate NCQA Accreditation status and risks, identifying barriers and opportunities to assist with

the improvement of same. The Committee will direct departmental initiatives, both clinical and non-clinical, to improve NCQA ratings. This committee reports to PIT.

Joint Operations Committee (JOC)
The Joint Operations Committees are vendor oversight meetings between Louisiana Healthcare Connections and delegated vendor partners. Every delegated vendor has reoccurring meetings, and Louisiana Healthcare Connections is responsible for monitoring compliance with required metrics and performance standards, collaborating and problem-solving for operational issues, and ensuring compliance with all contractual obligations and responsibilities. This committee reports to PIT.

Community Advisory Committee (CAC)
The CAC is a community-wide advisory committee that is responsible to provide the Plan with feedback and to make recommendations regarding health plan performance from a community-based perspective. This committee reports to PIT.

Member Advisory Committee (MAC)
The Member Advisory Council (MAC) is an effort to help identify and discuss member issues and concerns to enhance our healthcare services in local communities while maintaining member focus and allowing input on policy and programs. Louisiana Healthcare Connections has established the committee to solicit input on our policies, procedures and programs and to promote a collaborative effort for enhancing the services our members receive. This committee reports to PIT.

Practice Management Advisory Committee (PMC)
The PMC is the Plan's senior leadership committee responsible for soliciting feedback on a number of issues related to the day-to- day managing of the practice. This committee reports to PIT.

Physician Advisory Committee (PAC)
The PAC is the Plan's advisory committee responsible for soliciting feedback from contracted physicians and seeking their advice as to ongoing operations and opportunities for improvement. The Committee reports to PIT.

QUALITY DEPARTMENT STAFFING

The Quality Department staffing model is outlined below. Department staffing is determined by membership, products offered, and (when applicable) state and/or federal contract requirements and include at a minimum the following positions:

Louisiana Healthcare Connections Staffing

Chief Medical ~~Director~~Officer/Medical Director(s)	The health plan's Chief Medical ~~Director~~ Officer and supporting Medical Directors (including a behavioral health Medical Director) have an active unencumbered license in accordance with the health plan's state laws and regulations to serve as Medical Director to oversee and be responsible for the proper provision of core benefits and services to members, the QAPI Program, the Medical Management Programs, and the Grievance System.

Quality VP	The VP/Director of Quality is a registered nurse or other qualified person with experience in health care, data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to the members. The Quality VP/Director reports to identified executive leadership and is responsible for directing the activities of the quality staff in monitoring and auditing the health plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality, and clinical quality. The Quality VP/Director assists the senior executive staff, both clinical and non-clinical, in overseeing the activities of the operations to meet the goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Quality VP/Director coordinates the Quality Improvement Committee proceedings in conjunction with the Chief Medical Officer~~Director~~, supports corporate initiatives through participation on committees and projects as requested, reviews statistical analysis of clinical, service and utilization data, and recommends performance improvement initiatives while incorporating best practices as applicable.
Senior Director of Quality	**The Sr. Director of Quality is a registered nurse or other qualified person with experience in health care, data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to the members. The Sr. Director of Quality responsibilities include: leading and collaborating with others on National Committee for Quality Assurance (NCQA) Accreditation and/or Healthcare Effectiveness Data and Information Set (HEDIS) performance; quality improvement aspects of risk adjustment processes for all products; researching and incorporating best practices into operations; organizing and controlling activities, methods, and procedures to achieve business objectives; reviewing and implementing new technological tools and processes; fostering team concept with internal and external constituencies; presenting results of improvement efforts and ongoing performance measures to senior management; formulating and establishing policies, operating procedures, and goals in compliance with internal and external guidelinesThe Sr. Director of Quality reports to the Quality VP.** ~~The Senior Director of Quality Improvement is a registered nurse or other qualified person with experience in health care, data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to Plan members. The QI Director reports to the VP of Quality and is responsible for leading and collaborating with other applicable parties on NCQA Accreditation and HEDIS performance. The QI Director organizes and controls activities, methods, and procedures to achieve business objectives and presents results of improvement efforts and ongoing performance measures to senior management~~.
Quality Improvement Coordinator	Quality Improvement Coordinators are highly trained clinical and non-clinical staff with significant experience in a health care setting; experience with data analysis and/or

	project management. At least one of the health plan's Quality Improvement Coordinators is a registered nurse. Quality Improvement Coordinators scope of work may include medical record audits, data collection for various quality improvement studies and activities, data analysis and implementation of improvement activities, and complaint response with follow up review of risk management and sentinel/adverse event issues. A Quality Improvement Coordinator may specialize in one area of the quality process or may be cross-trained across several areas. The Quality Improvement Coordinator collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through health plan's quality improvement activities and quality of care reviews
Quality **Additional Staff**	EPSDT Coordinator Quality Abstractor

HEDIS Manager	The HEDIS Manager is a highly trained individual with significant experience in managed health care, data analysis, and project management. The HEDIS Manager is responsible for maintaining departmental documentation to support state contract requirements and accreditation standards including, but not limited to, applicable policies and procedures, quality focus studies, quality improvement activities, routine control monitoring reports, meeting minutes, access and availability analysis, member experience analysis, continuity and coordination of care, delegated vendor oversight, and annual evaluation of effectiveness of the QAPI Program. The HEDIS Manager collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through the health plan's quality improvement activities and quality of care reviews. Additionally, the HEDIS Manager coordinates the documentation, collection and reporting of HEDIS measures to both NCQA and the State as required.
HEDIS **Additional Staff**	HEDIS Coordinator HEDIS Abstractor Healthcheck Coordinator Data Analysts

Accreditation Manager	The responsibilities of the Accreditation Manager include: ensuring compliance with NCQA accreditation requirements, conducting routine readiness assessments, evaluating policies and procedures, and reviewing processes and records. He or she develops, implements, and leads a process for ensuring that the health plan achieves and maintains NCQA accreditation. The incumbent establishes and implements objectives, policies and strategies to maintain a continual state of accreditation readiness and to achieve successful accreditation status for the health plan. The Accreditation Manager serves as the Subject Matter Expert for accreditation for the health plan

Director of Quality	**The Director of Quality is responsible for the appropriate processing of member grievances and appeals as well as requests for State Fair Hearings and external reviews. Director of Quality is required to attend and represent grievances and appeals in multiple internal health plan committees as needed. This position manages grievance and appeal data and reports and the day to day responsibilities of the Grievance & Appeals Coordinator. The Director of Quality reports to the Quality VP/Director.** ~~The Director of Quality responsibilities include: leading and collaborating with others on National Committee for Quality Assurance (NCQA) Accreditation and/or Healthcare Effectiveness Data and Information Set (HEDIS) performance; quality improvement aspects of risk adjustment processes for all products; collaboration with Medicare STARS team to improve overall STARS ratings for Medicare products; researching and incorporating best practices into operations; organizing and controlling activities, methods, and procedures to achieve business~~

	~~objectives; reviewing and implementing new technological tools and processes; fostering team concept with internal and external constituencies; presenting results of improvement efforts and ongoing performance measures to senior management; formulating and establishing policies, operating procedures, and goals in compliance with internal and external guidelinesThe Director of Quality reports to the Quality VP.~~
Grievance & Appeals Coordinator	The Grievance & Appeal Coordinator logs member grievances and appeals, and refers those pertaining to potential quality of care issues to a Quality Coordinator (or Medical Director as appropriate) for investigation and resolution. The Grievance & Appeal Coordinator evaluates complaints and grievances by type, location, and region to identify trends indicating potential areas in need of further analysis and intervention. The Grievance & Appeal Coordinator also tracks and resolves all administrative member grievances. The Grievance & Appeals Coordinator reports to the Director of Quality.
Clinical Appeals Coordinator	The Clinical Appeals Coordinator (CAC) is a registered nurse. The CAC acts as a liaison for all statewide appeals, and state fair hearings. The CAC reviews clinical information for all appeals utilizing nationally recognized criteria to determine medical necessity of services requested. The CAC prepares response letters for member and provider clinical appeals and ensures letters are compliant with State and NCQA standards while maintaining files and logs for all appeals. The CAC coordinates with the Medical Director(s) to clarify medical determinations or clinical rationale. The Clinical Appeals Coordinator reports to the Director of Quality.

INTER/INTRADEPARTMENTAL QAPI PROGRAM RESOURCES

The Quality Department maintains strong inter/intradepartmental working relationships, with support integrated throughout the health plan to address the goals and objectives of the QAPI Program and assess effectiveness of the program. Collaborative activities include development of department objectives and plans, coordination of activities to achieve department goals, and participation on quality committees as needed to support the QAPI Program. Partnerships include, but are not limited to, the health plan departments/functional areas identified below:

- Medical Management Operations
- Pharmacy
- Provider Engagement/Provider Relations
- Network/Contracting
- Member Services
- Compliance
- Grievances and Appeals

ADDITIONAL PROGRAM RESOURCES

The management information systems supporting the QAPI Program allow key personnel the necessary access and ability to manage the data required to support the reporting and measurement aspects of quality improvement activities.

- **Centelligence™ -** ~~A comprehensive family of integrated decision support and health care informatics solutions. The Centelligence platform integrates data from internal and~~

~~external sources, producing actionable information: care gap and wellness alerts, key performance indicator (KPI) dashboards, provider clinical profiling analyses, population level health risk stratifications, HEDIS and hybrid HEDIS reporting, and unique operational and state compliance reports. The web-based reporting platform provides advanced capabilities for provider practice pattern and utilization reporting, supporting both quality staff and providers with summary and detailed views of clinical quality and cost profiling information. Centelligence includes a predictive modeling application with care gap and health risk identification applications to identify and report potentially significant health risks at multiple population, provider, and member levels. The Enterprise Data Warehouse (EDW) receives, integrates, and continually analyzes transactional data, such as medical, behavioral, and pharmacy claims, lab test results, health screenings/assessments, service authorizations, and member and provider information as required for the QAPI Program.~~

Internal monitoring processes are supported by Centelligence, a family of integrated decision support and health care informatics solutions that facilitates use of data by collecting, integrating, storing, analyzing, and reporting data from all available sources. Centelligence also powers the Louisiana Healthcare Connections ~~[Health Plan Name]~~ provider practice patterns and provider clinical quality and cost reporting information products. Centelligence includes a suite of predictive modeling solutions incorporating evidence-based, proprietary care gap/health risk identification applications that identify and report significant health risks at population, member, and provider levels.

The Centelligence platform receives, integrates, and continually analyzes large amounts of transactional data, such as medical, behavioral, and pharmacy claims; lab test results; health screenings and assessments; service authorizations; member information (e.g., current and historical eligibility and eligibility group; demographics including race and ethnicity, region, and primary care provider assignment; member outreach), and provider information (e.g., participation status; specialty; demographics; languages spoken). The Centelligence analytic and reporting tools provide Louisiana Healthcare Connections ~~[Health Plan Name]~~ the ability to report on all datasets in the platform, including HEDIS and EPSDT, at the individual member, provider, and population levels. These AMISYWSanalytic resources allow key quality personnel the necessary access and ability to manage the data required to support the measurement aspects of the quality improvement activities and to determine intervention focus and evaluation Through Centelligence, Louisiana Healthcare Connections~~[Health Plan Name]~~ develops defined data collection and reporting plans to build custom measures and reports, as applicable. Louisiana Healthcare Connections ~~[Health Plan Name]~~ analyzes population demographics, including disease prevalence and healthcare disparities, at the state and regional level, to identify opportunities for improvement and trends that indicate potential barriers to care that can potentially affect the results of interventions and initiatives. Demographic analysis is used to appropriately design quality improvement projects and interventions and to evaluate the results of performance measures, analyzing population results by gender, age, race/ethnicity, geographic region, etc.

- **Enterprise Data Warehouse (EDW) – The foundation of Louisiana Healthcare Connections~~[Health Plan Name]'s~~ Centelligence proprietary data integration and reporting strategy is the EDW, powered by high performance Teradata technology. The EDW systematically receives, integrates, and transmits internal and external**

administrative and clinical data, including medical, behavioral, and pharmacy claims data, as well as lab test results and health screening/assessment information. EDW supplies the data needed for all of Centelligence' s analytic and reporting applications while orchestrating data interfaces among core applications. Housing all information in the EDW allows Louisiana Healthcare Connections ~~[Health Plan Name]~~ to generate standard and ad-hoc quality reports from a single data repository.

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- **AMISYS Advance -** AMISYS provides claims processing with extensive capabilities for administration of multiple provider payment strategies. AMISYS Advance receives appropriate health plan member and provider data systematically from Member Relations Manager and Provider Relations Manager systems, receives service authorization information in near real time from TruCare, the clinical documentation and authorization system, and is integrated with encounter production and submission software.

- **TruCare -** Member-centric health management platform for collaborative care coordination, and case, behavioral health, condition, and utilization management. Integrated with Centelligence for access to supporting clinical data, TruCare allows Medical Management and Quality department staff to capture utilization, care, and population health management data, to proactively identify, stratify, and monitor high-risk enrollees, to consistently determine appropriate levels of care through integration with InterQual criteria and clinical policies, and capture the impact of programs and interventions. TruCare also houses an integrated appeals management module, supporting the appeals process from initial review through to resolution, and reporting on all events along the process, and a quality of care module to track and report potential quality of care incidents and adverse events.

- **Certified HEDIS Engine – a software system used to monitor, profile, and report on the treatment of specific episodes, care quality, and care delivery patterns. The HEDIS Engine is certified by NCQA and produces NCQA-certified HEDIS measures; its primary use is for the purpose of building and tabulating HEDIS and other state required performance measures. The Engine enables the health plan to integrate claims and member, provider, and supplemental data into a single repository by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information. Additionally, the system provides an integrated clinical and financial view of care delivery, which enables the health plan to identify cost drivers, help guide best practices, and to manage variances in its efforts to improve performance. Data is updated at least monthly by using an interface that extracts claims, member, provider, and financial information and then summarized with access for staff to view standard data summaries and drill down into the data or request ad-hoc queries.**

- **Scorecards - Centene Quality Analytics produces monthly scorecards for ratings systems such as Medicare Stars, Marketplace Quality Rating System, and Medicaid**

NCQA Health Plan Rating System. In addition, scorecards are produced for any Quality-related Pay for Performance programs outlined in contracts between states and health plans. Scorecards contain the most up-to-date HEDIS, CAHPS, and operational rates, where applicable, from our source-of-truth HEDIS engine, certified CAHPS vendor, and CMS HPMS and Complaint Tracker Module, and Acumen pharmacy data. Additional data points provided are source-of-truth rates from prior year final rates, prior year current month, and star or rating assignment (1-5) at the measure level. Domain- and overall-level roll-up ratings are estimated using calculations modeled from CMS or NCQA Technical Specifications. Roll-up overall Stars are estimated for current rates, and final overall Star ratings from prior year are provided for comparison. Month-over-month and year-over-year graphs are provided to show trending performance across current and prior measurement year. Finally, most current available benchmarks are provided, and current numerator and denominator, where relevant, are provided at the measure level to show health plans the benchmark currently achieved and distance, in numerator hits, to all remaining benchmarks not met.

- Predictive Analytics – Louisiana Healthcare Connections~~[Health Plan Name]'s~~ predictive analytics engine examines large data sets daily, providing a comprehensive array of targeted clinical and quality reports. This includes the regular re-computation and interpretation of a member's clinical data, delivering actionable insights for HEDIS, pay-for-performance, and Risk Adjustment scores, as well as enhanced drug safety and quality of care metrics. The predictive analytics tool applies clinical predictive modeling rules, supplying care teams, Quality staff, providers, and members with actionable, forward-thinking care gap and health needs information to guide decisions and program development.

- Clinical Decision Support – State-of-the-art predictive modeling software is used to identify members who may be at risk for high future utilization through risk score assignment. The Clinical Decision Support application is a multi-dimensional, episode-based predictive modeling and Care Management analytics tool that allows the Quality and Care Management teams to use clinical, risk, and administrative profile information obtained from medical, behavioral, and pharmacy claims data and lab value data to identify high risk members. The EDW updates the Clinical Decision Support system bi-weekly with data, including eligibility, medical, behavioral and pharmacy claims data, demographic data, and lab test results to calculate and continuously update each member's risk score. The application supports the Quality team in identifying target populations for focused improvement intervention based on risk score and need.

- Customer Relationship Management (CRM) Platform – The Customer Relationship Management (CRM) platform enables Louisiana Healthcare Connections~~[Health Plan Name]~~ to identify, engage, and serve members, providers, and federal/state partners in a holistic and coordinated fashion across the wellness, clinical, administrative, and financial matters. The CRM platform captures, tracks, and allows Louisiana Healthcare Connections~~[Health Plan Name]~~ staff to manage complaints, grievances, and appeals for all required reporting.

- **Quality Spectrum Insight - XL (QSI-XL) and INDICES** - an Inovalon software system used to monitor, profile, and report on the treatment of specific episodes, care quality, and care delivery patterns. QSI-XL produces NCQA-certified HEDIS measures and is an NCQA-certified software, its primary use is for the purpose of building and tabulating HEDIS and other state required performance measures. QSI-XL enables the health plan to integrate claims and member, provider, and supplemental data into a single repository by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information. Additionally, the system provides the health plan with an integrated clinical and financial view of care delivery, which enables the health plan to identify cost drivers, help guide best practices, and to manage variances in its efforts to improve performance. QSI-XL and INDICES are updated at least monthly by using an interface that extracts claims, member, provider, and financial data. Data are mapped into QSI-XL and summarized. Staff is given access to view standard data summaries and drill down into the data or request ad-hoc queries.

- **Impact Pro™** – is a state-of-the-art predictive modeling software used to identify members who may be at risk for high future utilization through risk score assignment. Impact Pro is a multi-dimensional, episode-based predictive modeling and care management analytics tool that will allow the Integrated Care Team (ICT) to use clinical, risk, and administrative profile information obtained from medical, behavioral, pharmacy claims data (as available from LDH) and lab value data (as available from network lab vendors) to identify high risk members. Our enterprise data warehouse (EDW) will update Impact Pro bi-weekly with data, including eligibility, medical, behavioral and pharmacy claims data, demographic data, and lab test results to calculate and continuously update each member's risk score. Identifying members and measuring their risk, using Impact Pro involves the following key steps:
  - Identification of the clinical risk markers observed for a patient. Clinical risk markers describe a patient's array of clinical conditions (based on Symmetry Episode Treatment Groups established from claim data) and their use of health care services in the context of those conditions. Impact Pro risk markers are important in defining a member's clinical profile and how that clinical profile can be used in differentiating their risk versus the risk of other members.
  - Assignment of risk weights to each clinical risk marker. The risk weights describe the incremental contribution to risk of having a clinical marker. Different risk outcomes in Impact Pro use different risk weights. A risk weight is assigned to each marker of risk for the member.
  - Calculation of patient risk – a patient's risk score for an outcome is the sum of the risk weights for all their markers of risk observed.

Louisiana Healthcare Connections obtains data and analytical support through the Information and Management Systems Department, Corporate Quality, Health Economics, and other support resources as deemed necessary, which may include corporate and health plan resources.

DOCUMENTATION CYCLE

The QAPI Program incorporates an ongoing documentation cycle that applies a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and evaluation. Several key quality instruments demonstrate Louisiana Healthcare Connections' continuous quality improvement cycle using a pre-determined documentation flow such as the:

- QAPI Program Description

- Quality Work Plan
- QAPI Program Evaluation

QAPI Program Description: The QAPI Program Description is a written document that outlines Louisiana Healthcare Connections' structure and process to monitor and improve the quality and safety of clinical care and the quality of services. The QAPI Program Description includes at least the following **at minimum: the scope and structure of the Quality Program, including the behavioral health aspects of the program;** ~~:~~ **the specific role, structure, function, and responsibilities of the** ~~**{Quality Committee Name}**~~**QAPI Committee and subcommittees/work groups, including meeting frequency and accountability to the governing body; a description of dedicated Quality Program staff and resources, including involvement of a designated physician and behavioral health care practitioner; the behavioral health aspects of the program, and how the health plan serves a diverse membership. No less than annually, ideally during the first quarter of each calendar year, the designated Quality Department staff prepares, reviews, and revises as needed the Quality Program Description. The Quality Program Description is reviewed and approved by the** ~~**{Quality Committee Name}**~~**QAPI Committee and Board of Directors on an annual basis. Changes or amendments are noted in the "Revision Log". {Health Plan Name} Louisiana Healthcare Connections submits any substantial changes to its Quality Program Description to the** ~~**{Quality Committee Name}**~~**QAPI Committee and appropriate state agency for review and approval as required by state contract, if applicable**~~specific roles, structure, and function of the QAPIC and subcommittees/work groups, including meeting frequency and accountability to the governing body, a description of dedicated QAPI Program staff and resources, and behavioral health care involvement. No less than annually, ideally during the first quarter of each calendar year, the designated quality staff prepares, reviews, and revises as needed the QAPI Program Description. The QAPI Program Description is reviewed and approved by the QAPIC and Board of Directors on an annual basis. Changes or amendments are noted in the "Revision Log". Louisiana Healthcare Connections submits any substantial changes to its QAPI Program Description to the QAPIC and appropriate state agency for review and approval as required by state contract, if applicable.~~

At the discretion of Louisiana Healthcare Connections, the QAPI Program Description may include structure and process outlines for applicable functional areas within the health plan, or departments may maintain their own program description. In either case, all program descriptions are formally approved or accepted by the QAPIC at least annually.

Quality Work Plan: To implement the comprehensive scope of the QAPI Program, the Quality Work Plan clearly defines the activities to be completed by each department and all supporting committees throughout the program year, based on the QAPI Program Evaluation of the previous year.

The Work Plan is developed annually after completing the QAPI Program Evaluation for the previous year, and includes all recommendations for improvements from the annual Program Evaluation. The Work Plan reflects the ongoing progress of the quality activities, including:

- Yearly planned quality activities and objectives for improving quality of clinical care, safety of clinical care, quality of services and member experience;
- Timeframe for each activity's completion;
- Staff members responsible for each activity;

- Monitoring of previously identified issues; and
- Evaluation of QAPI Program.

Louisiana Healthcare Connections utilizes the existing Work Plan and confirms compliance with the health plan's current needs, the most recent updates from NCQA, and assures the Work Plan reflects all current state and/or federal requirements. Work Plan status reports are reviewed by the QAPIC on a regular basis (e.g. quarterly or semiannually). The Work Plan is a fluid document; designated quality staff make frequent updates to document progress of the QAPI Program throughout the year.

At the discretion of Louisiana Healthcare Connections, the Quality Work Plan may include activities of all applicable departments (Member Services, Utilization Management, Care Management, Provider Services, Credentialing, etc.) within the health plan, or each department may maintain their own work plan independently. In either case, all work plans are formally approved or accepted by the QAPIC at least annually.

QAPI Program Evaluation: The QAPI Program Evaluation includes an annual summary of all quality activities, the impact the program has had on member care, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications. The Program Evaluation outlines the completed and ongoing activities of the previous year for all departments within the health plan, including activities regarding provider services, member services, utilization management, care management, complex case management, condition management, and safety of clinical care. Program Evaluation findings are incorporated in the development of the annual QAPI Program Description and Quality Work Plan for the subsequent year. The senior quality executive and Quality VP/Director are responsible for coordinating the evaluation process and a written description of the evaluation and work plan is provided to the QAPIC and Board of Directors for approval annually. The full annual evaluation is submitted to LDH following approval by the BOD.

The annual QAPI Program Evaluation identifies outcomes and includes evaluation of the following:

- Analysis and evaluation of the overall effectiveness of the QAPI Program, including progress toward influencing network-wide safe clinical practices;
- An evaluation of completed and ongoing QI activities pertaining to the behavioral health population with performance measure results, addressing below threshold/goals and trend analysis;
- A description of completed and ongoing quality activities that address quality and safety of clinical care and quality of service;
- Trending of measures collected over time to assess performance in quality of clinical care and quality of service;
- Interventions implemented to address the issues chosen for performance improvement projects and focused studies;
- Measurement of outcomes;
- Measurement of the effectiveness of interventions;

- Measurement of the quality and appropriateness of care furnished to enrollees with special health care needs;
- An analysis of whether there have been demonstrated improvements in the quality of clinical care and/or quality of services;
- Identification of limitations and barriers to achieving program goals;
- Recommendations for the upcoming year's Quality Work Plan;
- An evaluation of the scope and content of the QAPI Program Description to ensure it covers all types of services in all settings and reflects demographic and health characteristics of the member population;
- An evaluation of the adequacy of resources and training related to the QAPI Program; and
- The communication of necessary information to other committees when problems or opportunities to improve member care involved more than one committee's intervention.

At the end of the QAPI Program cycle each year (calendar year, unless otherwise specified by state contract), the Quality Department facilitates/prepares the QAPI Program Evaluation. The evaluation assesses both progress in implementing the quality improvement strategy and the extent to which the strategy is in fact promoting the development of an effective QAPI Program. Recommended changes in program strategy or administration and commitment of resources that have been forwarded and considered by the QAPIC should be included in the document.

In addition to providing information to the QAPIC, the annual Program Evaluation, or an executive summary as appropriate, can be used to provide information to a larger audience such as, accrediting agencies, regulators, stockholders, new employees, and the Board of Directors.

Louisiana Healthcare Connections~~[Health Plan Name]~~ provides general information about the Quality Program to members and providers on the website or member/provider materials such as the member handbook or provider manual. If required, communication includes how to request specific information about Quality Program goals, processes, and outcomes as they relate to member care and services and may include results of performance measurement and improvement projects. Information available to members and providers may include full copies of the Quality Program Description and/or Quality Program Evaluation, or summary documents.

CLINICAL PERFORMANCE MEASURES

Louisiana Healthcare Connections will collect and report clinical and administrative performance measures (PM) data in accordance with the *Quality Companion Guide and MCO Behavioral Health Companion Guide* as published by LDH. The data will demonstrate adherence to clinical practice guidelines and/or improvement in patient outcomes for both medical and behavioral health populations. PM include Healthcare Effectiveness Data and Information Set (HEDIS) rates, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and/or other measures as determined by LDH. Performance measures are used to monitor, assess and promote patient safety and quality of care.

Louisiana Healthcare Connections will perform a minimum of two (2) LDH-approved PIPs for the initial three-year term of the contract.

Louisiana Healthcare Connections may select and LDH may require an additional project each year to reach a maximum of four (4) projects. Louisiana Healthcare Connections will perform a minimum of (1) additional LDH-approved behavioral-health PIP each contract year.

The QI department will calculate and analyze performance measure results and report work plan progress to appropriate QI committee/subcommittee and LDH. Clinical performance measures will be reviewed and submitted at least annually, administrative performance measures will be reviewed and submitted semi-annually, and all performance measures will be available to LDH upon request. Louisiana Healthcare Connections will actively participate with LDH to review the results of performance measures in comparison to established benchmarks. In order to facilitate External Quality Review Organization (EQRO) analytical review to assess the quality of care and service provided to members and to identify opportunities for improvement, Louisiana Healthcare Connections will provide claims and Encounter Data to the EQRO and will work collaboratively with State Agency and the EQRO to assess and implement interventions for improvement.

PROMOTING MEMBER SAFETY AND QUALITY OF CARE

The QAPI Program is a multidisciplinary program that utilizes an integrated approach to monitor, assess, and promote patient safety and quality of care. Louisiana Healthcare Connections has mechanisms to assess the quality and appropriateness of care furnished to all members including those with special health care needs, as defined by the State. These activities are both clinical and non-clinical in nature and address physical health, behavioral health, and social health services, and include but are not limited to, the following:

Member safety is a key focus of the Louisiana Healthcare Connections QAPI Program. Monitoring and promoting member safety is integrated throughout many activities across the health plan, including through identification of potential and/or actual quality of care events and critical incidents, as applicable. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of member care, is not compliant with evidence-based standard practices of care, or signals a potential sentinel event, up to and including death of a member. Employees (including medical management staff, member services staff, provider services staff, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, state partners, Medical Directors, state partners, or the Board of Directors may inform the Quality Department of potential quality of care issues and/or critical incidents. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action, up to and including review by the Peer Review Committee as indicated. Potential quality of care issues and critical incidents received in the Quality Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

In addition, the health plan monitors for quality of care and/or adverse events through claims-based reporting mechanisms. An adverse event is an event over which health care personnel could have exercised control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred. Although occurrence of an adverse event in and of itself is not necessarily a preventable quality of care issue, Louisiana Healthcare

Connections monitors and tracks these occurrences for trends in type, location, etc., to monitor member safety and investigates further and/or requests a corrective action plan any time a quality of care issue is definitively substantiated.

The QAPI Program also supports member safety initiatives in the education of practitioners, providers, and members about safe practice protocols and procedures. These initiatives include utilizing provider and member newsletter articles and mailings to communicate information regarding member safety. Louisiana Healthcare Connections may incorporate the review of practitioner and provider initiatives to improve member safety.

Access and Availability - Louisiana Healthcare Connections' QAPIC provides oversight to the provider network in order to ensure adequate numbers and geographic distribution of primary care, specialists, hospitals and behavioral health practitioners, while taking into consideration the special and cultural needs of members.

Practitioner availability is analyzed at least annually by the Network/Contracting or Provider Relations Department. Results are reviewed and recommendations are made to the QAPIC to address any deficiencies in the number and distribution of primary care, specialty, and behavioral health practitioners. Availability of hospitals, ancillary, and other provider types is also assessed per applicable state or federal contract requirements. The QAPIC sets standards for the number and geographic distribution of the above listed practitioners/providers in accordance with state or federal requirements, with consideration of clinical safety and appropriate standards for the applicable service area.

The Quality Department analyzes practitioner appointment accessibility (primary, specialty, and behavioral health care practitioners) and Member Services telephone accessibility at least annually. Results are reviewed by the QAPIC and included in the annual QAPI Program Evaluation to ensure compliance with contractual, regulatory, and accreditation requirements and to maintain appropriate appointment access and availability.

After Hours Access – Louisiana Healthcare Connections~~[Health Plan Name]~~ annually conducts after hours call surveys to assess compliance with non-business hours telephone coverage standards. Member complaints/grievances to identify potential issues are also analyzed, and PCP offices surveyed after hours to verify availability of a live respondent or appropriate messaging about how to reach the covering doctor.

Out-of-Network Services and Second Opinions – if the provider network is unable to provide adequate and timely services as required by established standards, Louisiana Healthcare Connections ~~[Health Plan Name]~~ arranges for the timely provision of services through a licensed, qualified out-of-network provider until a network provider is available. If an in-network provider is not available to offer a member a second opinion, Louisiana Healthcare Connections ~~[Health Plan Name]~~ will arrange for the member to obtain a second opinion outside the network, at no cost, if requested by the member. Staff identifies a provider to meet the member's needs and execute a Single Case Agreement (SCA) to solidify payment terms, authorization parameters, and treatment plans to ensure thorough coordination of the member's care and appropriate transition to in-network services, if warranted. Once the member's immediate needs are addressed, Network/Contracting staff may attempt to recruit the provider and execute an agreement. Louisiana Healthcare Connections ~~[Health Plan~~

~~Name]~~ **coordinates with out-of-network providers for payment of services and ensure the cost to the member is not greater than it would be if the services were furnished within the network.**

Louisiana Healthcare Connections ~~[Health Plan Name]~~ educates members about accessing out-of-network benefits, and obtaining second opinions in the Member Handbook, on the member website, and in interactions with Member Services staff, as applicable. If a member is obtaining services from an out-of-network provider, staff outreach to and educate the member about transitioning to a network provider as soon as appropriate for their health and safety, and assists the member with identifying network providers that meet the member's needs as well as facilitate the transfer of records

Member and Provider Experience - Louisiana Healthcare Connections supports continuous ongoing measurement of clinical and non-clinical effectiveness and member and provider experience by monitoring member and provider complaints and appeals, member and provider satisfaction surveys, and member and provider call center performance. The health plan collects and analyzes data at least annually to measure its performance against established benchmarks or standards and identifies and prioritizes improvement opportunities. Specific interventions are developed and implemented to improve performance and the effectiveness of each intervention is measured at specific intervals, applicable to the intervention.

Louisiana Healthcare Connections solicits feedback from members, medical consenters, and caregivers to assess satisfaction using a range of approaches, such as the CAHPS member satisfaction survey, monitoring member complaints/grievances, and direct feedback from member focus groups and/or the Member Advisory Committee. The Quality Department is responsible for coordinating the CAHPS surveys, aggregating and analyzing the findings and reporting the results. Survey results are reviewed by the QAPIC, with specific recommendations for performance improvement interventions or actions. The Member Advisory Committee or other member focus group may also review survey results. Member Satisfaction Survey Reports and a description of the survey process will be submitted to LDH ~~120 days after the end of the plan year as~~**as required** as part of the QI Program Evaluation.

LHCC also assesses member satisfaction with behavioral health services by administering an annual member satisfaction survey. Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. The Quality Department is responsible for coordinating the provider satisfaction survey, aggregating and analyzing the findings, and reporting the results to appropriate committees. Survey results are reviewed by the QAPIC, with specific recommendations for performance improvement interventions or actions. The Provider Satisfaction Survey tool will be submitted to LDH for approval prior to administration. The results of the report summarizing survey methods and findings regarding opportunities for improvement will be submitted to LDH 120 days after the end of the plan year as part of the QI Program Evaluation.

Member Grievances and Provider Complaints - The Quality Department investigates and resolves member quality of care concerns/grievances. Member grievances related to quality of care and service are tracked, classified according to severity, reviewed by the Medical Directors, categorized by the Quality Department, and analyzed and reported on a routine basis to the QAPIC. The QAPIC recommends specific practitioner/provider improvement activities as needed.

All member grievances are tracked and resolution is facilitated by the Grievance and Appeal Coordinator. Data are analyzed and reported to the QAPIC on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Grievance reports are submitted to the QAPIC, along with recommendations for quality improvement activities based on results.

All provider complaints are tracked and resolution is facilitated by the Provider Services Department. Data are reported to and analyzed by the QAPIC on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Provider complaint reports are submitted to the QAPIC, along with recommendations for quality improvement activities based on results.

Practice Guidelines - Preventive health and clinical practice guidelines assist practitioners, providers, members, medical consenters, and caregivers in making decisions regarding health care in specific clinical situations. Guidelines are adopted in consultation with network practitioners/providers (including behavioral health as indicated) and based on the health needs and opportunities for improvement identified as part of the QAPI Program, valid and reliable clinical evidence or a consensus of health care professionals in the particular field, and needs of the members. Louisiana Healthcare Connections adopts clinical practice guidelines for at least two (2) non-preventive acute or chronic medical conditions and at least two (2) behavioral health conditions (preventive or non-preventive) relevant to the target population. At least two (2) of the adopted clinical practice guidelines directly correspond with disease management programs offered by the health plan. Louisiana Healthcare Connections also adopts preventive health guidelines for perinatal care, care for children, and care for adults. Clinical and preventive health guidelines are updated upon significant new scientific evidence or change in national standards or at least every two (2) years. Guidelines are distributed to providers via the Provider Manual, website, and/or provider newsletters and are available, upon request, to members, potential members, medical consenters, and caregivers.

Practitioner adherence to health plan's adopted preventive and clinical practice guidelines may be encouraged in the following ways: new provider orientations include the practice guidelines section of the Provider Manual with discussion of health plan expectations; measures of compliance are shared in provider newsletter articles available on the provider web site; targeted mail outs that include guidelines relevant to specific provider types underscore the importance of compliance; and the Provider Profiling program, as discussed later in this document, also work to promote compliance with practice guidelines.

Louisiana Healthcare Connections uses applicable HEDIS measures to monitor practitioner compliance with adopted guidelines. If an appropriate HEDIS measure~~s~~ does not exist, the analysis methodology must allow Louisiana Healthcare Connections to aggregate results and analyze areas or parts of the guidelines that are not being used. If performance measurement rates fall below the health plan/state/accreditation goals, Louisiana Healthcare Connections implements interventions

for improvement as applicable. Monitoring outcomes and analysis is presented to the QAPIC at least annually.

Clinical guidelines that will be monitored for provider compliance include, but are not limited to: Asthma, Diabetes, ADHD, and Depression. Details can be found in the QI Work Plan.

Continuity and Coordination of Care – the health plan monitors and takes action as needed to improve continuity and coordination of care across the health care network. This includes continuity and coordination of medical care through collection of data on member movement between practitioners *and* data on member movement across settings. Annually, this data is collected and analyzed to identify opportunities for improvement, opportunities for improvement are selected, and actions to improve coordination of medical care are implemented. The effectiveness of improvement actions are also measured annually and remeasurement results analyzed.

Continuity and coordination between medical care and behavioral healthcare is also monitored on an annual basis. Data is collected in the following areas to identify opportunities for collaboration: exchange of information; appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care; appropriate use of psychotropic medications; management of treatment access and follow-up for members with coexisting medical and behavioral disorders; primary or secondary preventive behavioral healthcare program implementation; and special needs of members with severe and persistent mental illness. The health plan collaborates with behavioral healthcare practitioners to complete analysis of the data collected in the areas noted above, and identify opportunities for improvement. Opportunities for improvement are then selected and actions taken to improve continuity and coordination between medical care and behavioral healthcare, with the effectiveness of improvement actions measured and remeasurement results analyzed annually.

Continuity and coordination of medical care and between medical care and behavioral healthcare may be assessed via several different measures or activities. These include but are not limited to, HEDIS measures, CAHPS or other member experience survey results, provider satisfaction surveys, etc.

Medical Record Documentation Standards - As required by state and federal regulations, Louisiana Healthcare Connections monitors network practitioners for maintenance of medical records in a current, detailed, and organized manner which permits effective and confidential patient care and quality review. The minimum standards for practitioner medical record keeping practices, which include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of member information, are outlined in the Provider Manual. Additionally, the health plan may conduct medical record reviews for purposes including, but not limited to, utilization review, quality management, medical claim review, or member complaint/appeal investigation. Physicians must meet 80% of the requirements for medical record keeping; elements scoring below 80% are considered deficient and in need of improvement. Louisiana Healthcare Connections will work with any physician who scores less than 80% to develop an action plan for improvement. Medical record review results are filed in the Quality Improvement department and shared with the Credentialing department to be considered at the time of re-credentialing.

Monitoring Utilization Patterns - To ensure appropriate care and service to members, the Medical Management Committee performs at least an annual assessment of utilization data to identify potential over- and under-utilization issues or practices. Data analysis is conducted using various data sources such as medical, behavioral health, pharmacy, dental, and vision encounter data reporting to identify patterns of potential or actual inappropriate utilization of services. The Medical Management Department works closely with the Quality Department, Chief Medical ~~Director~~**Officer**, VP Medical Management, and Medical Directors to identify problem areas and provide improvement recommendations to the QAPIC for approval. Once approved, the Quality and Medical Management departments implement approved actions to improve appropriate utilization of services.

Preventive Health Reminder Programs are population-based initiatives that aim to improve adherence to recommended preventive health guidelines for examinations, screening tests, and immunizations promoting the prevention and early diagnosis of disease. These programs utilize various member and provider interventions and activities to improve access to these services and to increase member understanding and engagement. Examples of preventive health reminder programs include, but are not limited to:

- General and supportive member and provider education such as articles in member and provider newsletters, face-to-face interactions, and written educational materials provided to members at health fairs, diaper distribution events, etc.
- Targeted telephonic and/or written outreach to members/parents/guardians to remind of applicable preventive health screenings and services due or overdue and assistance with scheduling appointments and transportation to the appointments as needed.
- Targeted written and/or face-to-face education and communication to providers identifying assigned members due or overdue for preventive health screenings such as annual well visits, immunizations, lead testing, cervical cancer screening, breast cancer screening, etc.

Chronic Care and Complex Care Management - provides care and condition management for members identified at risk, intervenes with specific programs of care, and measures clinical and other health-related outcomes. Decision support encourages informed health care decisions by providing members with education about their conditions and treatment options, and by supporting members to make informed treatment decisions in collaboration with their providers. Louisiana Healthcare Connections' condition management and population health management programs help members understand their diagnoses, learn self-care skills, and adhere to treatment plans. All clinical management programs include the use of general awareness and targeted outreach and educational interventions, including but not limited to, newsletter articles, advertising regarding available programs, direct educational/informational mailings, and care management. Clinical care management programs include asthma, behavioral health, diabetes, ~~lead poisoning~~**sickle cell**, and high risk OB management. The Care Management Program Description further outlines the health plan's approach to addressing the needs of members with complex health issues, which may include: physical disabilities, developmental disabilities, chronic conditions, and severe and persistent mental illness.

Practitioner/Provider Profiling - as part of its network performance strategy, the health plan systematically profiles the quality of care delivered by high-volume PCPs or other network practitioners to improve provider compliance with preventive health and clinical practice

guidelines and clinical performance indicators. By providing quantitative feedback on clinical measures, the health plan promotes the success of providers and the health of members. The profiling system is developed with input from Louisiana Healthcare Connections network providers to ensure the process has value to practitioners, providers, members, and may include a financial component as noted below.

Louisiana Healthcare Connections works with network providers to build useful, understandable, and relevant analyses, and reporting tools to improve care and compliance with practice guidelines. These analyses are delivered in a timely manner in order to support member outreach and engagement. This collaborative effort helps to establish the foundation for practitioner and provider acceptance of results leading to continuous quality improvement activities that yield performance improvements.

Profiles include a multidimensional assessment of a PCP or other practitioner's performance using clinical and administrative indicators of care that are accurate, measurable, and relevant to the target population. To support providers in their delivery of robust preventive and interventional care, Louisiana Healthcare Connections provides quantitative and actionable analyses of the providers' member panel via analytic tools.

The health plan offers a population health management tool designed to support providers in the delivery of timely, efficient and evidence-based care to members. Claims data is used to create a detailed profile of each member with the ability to organize members by quality measures and disease conditions. This provider analytics tool includes:

- Disease registries
- Care gap reporting at member and population levels
- Claims-based patient histories
- Exportable patient data to support member outreach

Additional assessment, at Louisiana Healthcare Connections' discretion, may include such elements as availability of extended office hours, member complaint rates, and compliance with medical record standards.

The health plan implements a provider profiling program that transitions to an incentive program after adequate time has elapsed for testing the measures and incorporating provider feedback as indicated. To support providers in their incentive programs, Louisiana Healthcare Connections provides quantitative and actionable analyses of the provider's performance via portal-based tools.

Louisiana Healthcare Connections offers a cost and utilization tool designed to support providers who participate in a value-based program in order to identify provider performance opportunities and assist with population health management initiatives. Provider analytics prioritizes measures based on providers' performance to help identify where to focus clinical efforts in order to optimize pay-for-performance (P4P) payouts, which may include:

- Key performance indicators
- Cost and utilization data
- Emergency room cost, utilization, and trending data
- Pharmacy comparisons of brand vs. generic
- Value-Based Contracting performance summaries

Through these supporting platforms, the health plan works to keep providers engaged in the delivery of value-based care by promoting wellness and incentivizing the prudent maintenance of chronic conditions. This engagement helps providers identify performance insights as well as identify opportunities for improvement. Practitioners who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by Louisiana Healthcare Connections in publications such as newsletters, bulletins, press releases, and recognition in the provider directories.

Interventions are discussed with the practitioner to address practitioners' performance that is out of range (outliers) from their peers, and such interventions may include, but are not limited to, provider education, sharing of best practices and/or documentation tools, assistance with barrier analysis, development of corrective action plans, ongoing medical record reviews, and potential termination of network status when recommended improvements are not implemented. Providers identified as significantly outside the norm are re-measured at six (6) month intervals.

PERFORMANCE IMPROVEMENT ACTIVITIES

Louisiana Healthcare Connections' QAPIC reviews and adopts an annual QAPI Program and Quality Work Plan that aligns with the health plan's strategic vision and goals and appropriate industry standards. The Quality Department implements at least two clinically related quality improvement activities and at least two service activities that are designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. The QI department will also implement at least one LDH approved behavioral health PIP annually, as directed by LDH.
The health plan utilizes traditional quality/risk/utilization management approaches to identify activities relevant to the health plan programs or a specific member population and that describe an observable, measurable, and manageable issue. Initiatives are identified through analysis of key indicators of care and service based on reliable data which indicate the need for improvement in a particular clinical or non-clinical area. Baseline data may come from: performance profiling of contracted providers, mid-level providers, ancillary providers and organizational providers; provider office site evaluations; focus studies; utilization information (over-and under-utilization performance indicators); sentinel event monitoring; trends in member complaints, grievances and/or appeals; issues identified during care coordination; the annual Population Analysis; and/or referrals from any source indicating potential problems, including those identified by affiliated hospitals and contracted providers. Other initiatives may be selected to test an innovative strategy or as required by state or federal contract. Projects and focus studies reflect the population served with consideration of social determinants of health, age groups, disease categories, and special risk status.

The QAPIC assists in prioritizing initiatives focusing on those with the greatest need or expected impact on health outcomes and member experience. Performance improvement projects, focused studies, and other quality initiatives are designed to achieve and sustain, through ongoing measurements and interventions, significant improvement over time in clinical and non-clinical care areas in accordance with principles of sound research design and appropriate statistical analysis. The QAPIC helps to define the study question and the quantifiable indicators, criteria, and goals to ensure the project is measureable and able to show sustained improvement. Evidence-based guidelines, industry standards, and contractual requirements are used as the foundation for

developing performance indicators, setting benchmarks and/or performance targets, and designing projects and programs that assist providers and members in managing the health of members. If data collection is conducted for a random sample of the population, baseline and follow-up sampling is conducted using the same methodology and statistical significance and a 90% or more confidence level is determined.

The QAPIC or subcommittee/work group may also assist in barrier analysis and development of interventions for improvement. Data are re-measured at predefined intervals to monitor progress and make changes to interventions as indicated. Once a best practice is identified, control monitoring reports are implemented to monitor for changes in the process and need for additional intervention. Improvement that is maintained for one (1) year is considered valid and may include, but is not limited to, the following:

- The achievement of a pre-defined goal and/or benchmark level of performance;
- The achievement of a reduction of at least 10% in the number of members who do not achieve the outcome defined by the indicator (or, the number of instances in which the desired outcome is not achieved); and
- The improvement is reasonably attributable to interventions undertaken by the health plan.

Within three (3) months of execution of the MCO Provider Agreement and at the beginning of each Provider Agreement year thereafter, Louisiana Healthcare Connections will submit in writing, a general and a detailed description of each required PIP to LDH for approval or as otherwise specified by LDH. Louisiana Healthcare Connections will use the CMS or NCQA QI Project template to document projects. PIPs will be completed in a reasonable time period so as to generally allow information on the success of the Project in aggregate to produce new information on quality of care every year. Outcomes of PIPs will be submitted to LDH at least annually as specified in the *MCO Quality Companion Guide* or as otherwise requested by LDH.

The detailed PIP description submitted to LDH will include:

- An overview explaining how and why the project was selected, as well as its relevance to the plan members and providers.
- The study question and population.
- Goals, benchmark, baseline methodology, data sources, data collection methodology, and plan, data collection cycle, analysis cycle and plan, results with quantifiable measures, analysis with time period and the measures covered, analysis and identification of opportunities for improvement with explanation of all interventions to be taken.

COMMUNICATING TO MEMBERS AND PROVIDERS

At least annually, Louisiana Healthcare Connections provides information, including a description of the QAPI Program and a report on the health plan's progress in meeting QAPI Program goals, to members and providers. At a minimum, the communication addresses how to request information about QAPI Program goals, processes, and outcomes as they relate to member care and service which includes health plan specific data results such as HEDIS, CAHPS surveys, and results of performance improvement projects. Primary distribution source is through the Member/Provider Newsletter and Louisiana Healthcare Connections website. Information about how to obtain a hard copy description of the program and/or program outcomes is included on the website and/or in the Member Handbook and Provider Manual. Information available to members

and providers may include full copies of the QAPI Program Description and/or QAPI Program Evaluation (when requested), or summary documents. Member materials are written at an appropriate reading level or as mandated by state or federal contract and monitored for compliance. Members requiring/requesting receipt of information in an alternative format are identified by Louisiana Healthcare Connections, either through a direct request or through normal member service and/or medical management functions, taking into consideration the member's special needs, including those who are visually impaired, have limited reading proficiency or cultural differences. Louisiana Healthcare Connections communicates this need to the Corporate Communications Department who works with external vendors to create the alternative format on an as needed basis.

REGULATORY COMPLIANCE AND REPORTING

Louisiana Healthcare Connections departments perform required quality of service, clinical performance, and utilization studies throughout the year based on contractual requirements, requirements of other state and regulatory agencies and those of applicable accrediting bodies such as NCQA. All functional areas utilize standards/guidelines from these sources and those promulgated by national and state medical societies or associations, the Centers for Disease Control, and the federal government. The Quality Department maintains a schedule of relevant quality reporting requirements for all applicable state and federal regulations and accreditation requirements, and submits reports in accordance with these requirements. This includes any federal/state requirements that apply to joint contracts (e.g., dual eligible Special Needs Plans, Financial Alignment Demonstrations, etc.). Additionally, the QAPI Program and all health plan departments fully support every aspect of the federal privacy and security standards, Business Ethics and Integrity Program, Compliance Plan, and Waste, Fraud and Abuse Plan.

Louisiana Healthcare Connections acknowledges and will fully cooperate with performance review by LDH to evaluate the QAPI Program, PMs, and PIPs at least one (1) time per year at dates to be determined by LDH, or as otherwise specified by the Provider Agreement. Louisiana Healthcare Connections shall cooperate with LDH, the independent evaluation contractor (External Quality Review Organization), providing all information requested including but not limited to, quality outcomes concerning timeliness of, and member access to, core benefits and services and medical record review. If LDH determines that Louisiana Healthcare Connections' quality performance is not acceptable, LDH will require Louisiana Healthcare Connections to submit a corrective action plan (CAP) within thirty (30) calendar days of the date of notification or as specified by LDH for each unacceptable performance measure. Within thirty (30) days of receiving the CAP, LDH will either approve or disapprove the CAP. If disapproved, the plan shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by LDH.

Upon approval of the CAP, whether the initial CAP or the revised CAP, the plan shall implement the CAP within the time frames specified by LDH. LDH may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

NCQA ACCREDITATION

Louisiana Healthcare Connections is accredited through the National Committee for Quality Assurance (NCQA). In order to maintain an accredited status with NCQA, our Quality department completes ongoing performance improvement projects, audits for compliance with NCQA standards and action plans. Louisiana Healthcare Connections will submit application for renewal of accreditation and complete renewal survey in 2020.

DELEGATED SERVICES

The QAPIC may authorize participating provider entities such as independent practice associations or hospitals, or organizations such as disease management companies to perform activities (such as utilization management, care management, credentialing, or quality) on the health plan's behalf. Louisiana Healthcare Connections evaluates each delegated entity's capacity to perform the proposed delegated activities prior to the execution of a delegation agreement. A mutually agreed upon delegation agreement, signed by both parties, includes, but is not limited to, the following elements:

- Responsibilities of the health plan and the delegate
- Specific activities being delegated
- Frequency and type of reporting (i.e. minimum of semiannual reporting)
- The process by which the health plan evaluates the delegate's performance
- Explicit statement of consequences and corrective action process if the delegate fails to meet the terms of the agreement, up to and including revocation of the delegation agreement
- The process for providing member experience and clinical performance data to the delegate when requested

If the delegation arrangement includes the use of protected health information (PHI) the delegation agreement also includes PHI provisions, typically accomplished in the form of a Business Associate Agreement signed by the delegated entity.

Louisiana Healthcare Connections retains accountability for all functions and services delegated, and as such monitors the performance of the delegated entity through annual approval of the delegate's programs (Credentialing, Utilization Management, Care Management, Quality, etc.), routine reporting of key performance metrics, and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to health plan and regulatory requirements and accreditation standards. Louisiana Healthcare Connections Medical Management, Quality and/or Compliance designees, in conjunction with Centene Corporate Compliance designees, conduct an annual evaluation and documentation review that includes the delegate's program, applicable policies and procedures, applicable file reviews, and review of meetings minutes for compliance with health plan, state and federal requirements and accreditation standards. The health plan retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

Delegated services may include dental care, vision services, pharmacy management services, transportation, nurse hotline, and disease management services. See individual delegation agreements for specifics on delegated activities.

Louisiana Healthcare Connections QAPIC has reviewed and adopted this document, including the Quality Work Plan (Program Approval Signature on file within the Quality Department).
ENDORSEMENT OF THE QAPI Program Description
The QAPI Program Description has been reviewed and endorsed by the quality senior leadership effective this day of _____, month of _____, _____.

_____
[Vice President/Director] Quality

_____
Chief Medical ~~Director~~ **Officer**

ENDORSEMENT OF THE QAPI Program Description
The QAPI Program Description has been reviewed and endorsed by the Board of Directors effective this day of _____, month of _____, _____.

_____
Board of Directors Chairman