2025 Quality Improvement Program Description

Medicare Advantage

3/13/25: Approved by Quality Improvement and Medical Management Committee

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Introduction

The Quality Improvement Program (QIP) is the framework for a formal process to assess and monitor our performance through a systematic approach of monitoring and evaluating the quality and effectiveness of care for our members. This approach enables Aspirus Health Plan (AHP) to focus on issues of appropriateness, efficiency, safety, as well as health outcomes and satisfaction of our members and their providers. This is achieved by continuous monitoring of our performance according to, or in comparison with, objective measurable performance standards. The QIP promotes accountability and assures identification and evaluation of issues that impact our ability to better our performance and improve health care and administrative services provided to our members.

This document is specific to Medicare Advantage and is intended to provide detailed information on the Quality Improvement Program structure.

Mission, Vision and Commitment to Our Members

Mission

Aspirus Health Plan will deliver direct access to high-value, personalized health care that aims to improve your health and well-being through all your health care needs.

Quality Vision

The Aspirus Health Plan Quality Improvement Program drives organizational improvement for excellence through efficiencies, increasing the competitive advantage, building trust and recognition in the community to improve the health status, safety, and satisfaction of our members.

Commitment

Provide cost-effective, high-quality health care services. We're working to ensure there is a positive experience with every part of the delivery system—physicians, hospitals, affiliated providers, and corresponding administrative services. We will focus on coordinating care, encouraging overall well-being, and limiting waste.

Integrate your health care so that your personal needs and preferences are considered. We'll work with you to develop your personal path to long-term well-being. Why? Because health care that is appropriate for you is better for your health and better for your wallet. You don't want to waste your time and money going through unnecessary procedures to address a health issue. You want results. With health care and health insurance connected and working for you, your doctor can tailor your treatments for maximum results.

Improve the communities we serve. Aspirus Health Plan is a Wisconsin company with many employees who have grown up in and around the communities that we now serve. Health care is changing—massive, multi-state corporations are attempting to control more health care decisions and centralize services. We are committed to serving, volunteering, and supporting many of the organizations and foundations that make our communities great.

Program Structure and Objectives

The Quality Improvement Advisory Committee (QIAC) provides structure for promoting and achieving excellence in all areas and at all levels of the organization. The QIAC has oversight for the structure

and resources that are to be reviewed throughout the calendar year.

The QIAC relies on industry standards set by regulators, accrediting organizations and "best practices" as a guide throughout the year. The use of data collection and analysis is critical to identifying populations and subpopulations, opportunities for improvement, implementing interventions, evaluating, and measuring effectiveness of those interventions, and process improvement following the Plan-Do-Study Act (PDSA) approach.

Program Goals and Activities

The primary goal is to integrate all existing quality activities into one comprehensive program for monitoring activity, sharing ideas over multiple programs, focusing resources, and promoting programs for the Medicare Advantage population. The QIP goals are achieved through the integration and coordination of Aspirus Health Plan's clinical and non-clinical services. The following goals are the areas of focus and priority. Our guiding principle is to provide services that are evidence-based and data-driven for the safety and welfare of our members.

Goals:

- Improve member health outcomes and member experience by improving from a 4 Star Rating (Star Rating Year 2025) to a 4.5 Star Rating (Star Rating Year 2026 and 2027) in the CMS Medicare Star Ratings program. Focus areas include but are not limited to HEDIS operations, medication adherence, provider engagement, member engagement, and member experience.
- By 12/31/2025, increase engagement in Care Management from 15% to 20% and maintain above 20% engagement in disease management coaching programs.
- By 12/31/2025, achieve a 90% closure of quality of care cases within 90 days of receipt to ensure patient safety.
- By 12/31/2025, achieve a rate of 95% of denial notifications subject to medical necessity review made within specified turnaround time requirements.
- By 12/31/2025, achieve a rate of 98% of appeals and grievances processed within CMS timeline.

Activities:

- Monitor QIP monthly to assess progress and resource allocation.
- Develop, review and report on the annual QIP work plan.
- Assess and evaluate effectiveness of health plan activities.
- Implement a population health management strategy to address the needs of members across the continuum of care, including preventive care outreach and reminders, disease management, medication management support, and care management.
- Enhance HEDIS operations to optimize clinical data used for electronic and hybrid HEDIS reporting.
- Provide an adequate and accessible network of qualified practitioners and providers through credentialing, peer review and contracting processes.
- Monitor Quality of Care for all members by responding to and facilitating resolution of member complaints.
- Analyze member complaints, appeals, survey data (e.g. CAHPS), and member services indicators to develop and implement improvement initiatives.
- Every two years adopt and disseminate updated medical and behavioral health Clinical

Practice Guidelines to be published on the Aspirus Health Plan website.
- Maintain compliance with regulatory requirements.
- Protect confidential personal health information.
- Assess and evaluate delegated activities.

Information about the Aspirus Health Plan QIP is available electronically. Paper copies are available upon request.

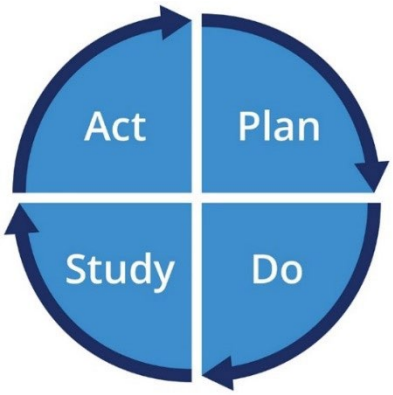
QI Program's Functional Areas and Responsibilities

The QIP includes all aspects of services provided by health plan practitioners, providers, and staff. The plan arranges for the provision of comprehensive health care delivery through a network of primary care and specialty practitioners, behavioral health practitioners and clinicians, ancillary care provider hospitals, pharmacies, and other health facilities.

Aspirus Health Plan credentials providers using workflows and processes aligned with NCQA Health Plan Accreditation requirements and contracts with individual practitioners, provider organizations, facilities, and institutions to deliver health care and service to all members. The QIP provides an organizational process that supports ongoing improvement of care and service. The program is responsive to the changing needs of the health care environment and the standards established by our local medical community and national regulatory and accrediting bodies.

Quality Improvement Framework

In order to achieve the goals of the QIP, interventions are designed to meet the Quintuple Aim of improving quality of care, and member and provider experience while reducing costs and advancing health equity. The goal is to optimize health system performance for members. This process allows AHP to identify target populations, define aims and measures, develop interventions to improve population health, and evaluate and refine interventions based on project results. AHP's improvement goals compare with local and national performance metrics and strive for statistically significant improvement year to year.



AHP uses a systematic and formal framework to design, evaluate and document QI initiatives – the Plan-Do-Study-Act (PDSA) cycle. The PDSA cycle is used as a guide to identify the following areas:

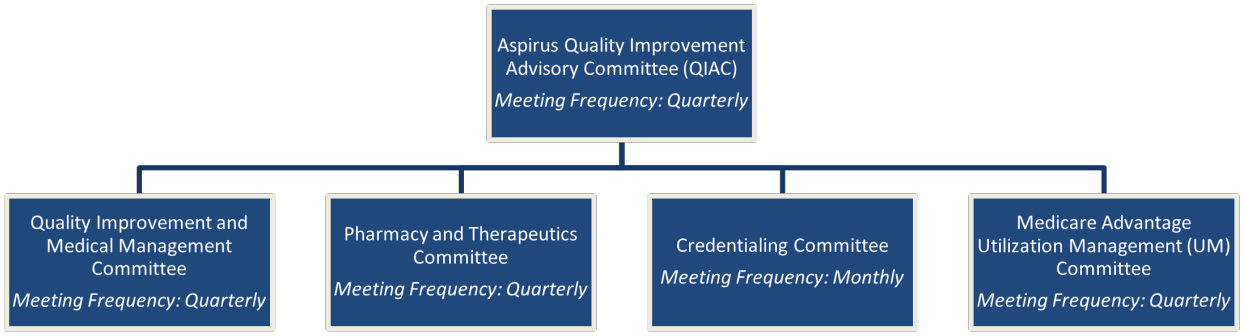
- **Plan:** Identify the objectives of the project and make predictions about what will happen. This step includes answering the following questions:
    - What are we trying to accomplish based on the data points and identified interventions?
    - How will we know a change led to improvement (i.e., quantitative measures)?
    - What change can we make that will result in improvement from this intervention?
- **Do:** Implement the intervention and analyze data.
- **Study:** Summarize what was learned based on the outcome data.
- **Act:** Identify needed changes that should be made to the intervention and repeat PDSA cycle.

QI Committee Organizational Structure

The committee structure and responsibility for the Quality Improvement Advisory Committee (QIAC) is described as follows. The Aspirus Health Plan Board of Directors has designated the Quality Improvement Advisory Committee (QIAC) to oversee quality improvement activities. The Medical Directors oversee QIAC. The QIAC oversees the plan administrators' quality committees and Aspirus Health Plan Grievance and Appeals Committee.

Each committee is required to record meeting minutes. The exception to this is the Grievance and Appeals Committee due to the meeting content being primarily protected health information. Database information and individual files are maintained. All other meetings are dated and signed by the committee chair when approved. Summary reports are submitted to QIAC on, at minimum, a semi-annual basis.

2025 Aspirus Health Plan Quality Improvement Program Structure:



Quality Improvement Program Resources

Aspirus Health Plan - Overarching Committee Members for Medicare Advantage

Medical Directors: Are responsible for oversight of the Medicare Advantage, Commercial and Exchange product lines and supports the evaluation and promotion of activities consistent with high quality clinical standards and appropriate cost-effective use of health care. This is accomplished by seeking input from network providers in the development of criteria and policies utilized for utilization review.

Director of Operations: Is responsible for the Aspirus Health Plan Quality Program and delegation of program components and oversight of regulatory compliance and HIPAA privacy. Assists in the development and monitoring of annual performance and workplans. Presents QIAC minutes and program updates to the Aspirus Health Plan Board of Directors.

Director of Care Coordination: Is responsible for the oversight of Care Coordination which is providing Integrated Care Management to commercial and exchange product lines including Complex Care Management and Disease Management. Responsibilities include monitoring and assessing the quality and safety of care provided and summarizing and presenting performance measures.

Director of Quality: The Director of QM is responsible for the overall direction, implementation, and management of AHP's QM Program in conjunction with executive leadership. Responsibilities include

monitoring and assessing the quality and safety of care provided.

Director of Operations: This position is charged with completing all operations activity so that AHP member receive access to quality care, per the requirements set forth in governing documents. This includes the administration of Care Coordination, Utilization Management and management of the business cycle to ensure deliverables to applicable stakeholders are met.

Director of Compliance: This position is charged with ensuring all services for AHP are within the scope of compliance requirements. This includes, but is not limited to, regulatory requirements and ensuring certain contracted entities provide services to the plan within required guidelines (i.e. delegation oversight audits of certain services).

Plan Administrator – Medicare Advantage

EVP/Chief Medical Officer: The Executive Vice President/Chief Medical Officer serves as a member of the senior management team, participating in strategic planning and policy direction for the organization, providing leadership and guidance on clinical strategic initiatives and operations to ensure high quality, cost-effective care for members. The Chief Medical Officer manages relationships with contracted care systems to ensure implementation of utilization and quality management strategies. The Chief Medical Officer supports the development, implementation, maintenance, and evaluation of quality improvement, population health, utilization review, and care management activities of the health plan in conjunction with other Medical Directors and staff in Integrated Care Management, Health Services Quality and Operations, and Pharmacy.

Vice President of Health Services and Quality Operations: The primary objective of this position is to provide strategic direction and oversight for the Health Services and Quality Operations strategic initiatives. This position provides leadership for the development, implementation, and evaluation of the Quality and Population Health Program. In addition, this position is responsible for the strategic planning and oversight of the Chronic Care Improvement Program and Star Ratings Programs. This position also ensures achievement of operational goals for Credentialing, Appeals and Grievances, and Utilization Management.

Quality and Population Health Director: The Quality and Population Health Director is responsible for the development, management and accountability of quality improvement initiatives within the department in support of the organizational Quality and Population Health Program. This position provides leadership for related projects, surveys, reports, and audits. Additional responsibilities include development and management of the Quality and Population Health teams, oversight of quality and population health strategies, ensuring timeliness of overall quality initiatives, and managing regulatory quality and population health requirements. This position also provides oversight of the Star Ratings programs, Health Effectiveness Data and Information Set (HEDIS) chart retrieval data, and member engagement activities through the Health Improvement Team.

Health Services Operations Director: The Health Services Operations Director is responsible for the oversight of operational processes related to Credentialing and Appeals and Grievances (A&G), which includes creating optimal performance, quality assurance, and efficiencies. This position is responsible for ensuring that Credentialing and A&G meet all regulatory and accreditation requirements based on legislative mandates and strategic direction. In addition, this position

providers leadership for project administration team, including training, vendor management, and special projects.

Utilization Management Director: The Utilization Management Director is responsible for the oversight of operational processes related to Utilization Management, which includes creating optimal performance, quality assurance, and efficiencies. This position is responsible for ensuring that Utilization Management meets all regulatory and accreditation requirements based on legislative mandates and strategic direction.

Health Services and Quality Operations Department: The Health Services and Quality Operations Department includes Appeals and Grievances, Credentialing, Population Health, Quality Improvement, Health Improvement, HEDIS chart retrieval and abstraction, Stars Ratings, Health Services Informatics, Health Equity, Disease Management, and Utilization Management. The functions of each of these areas is described below:

- Appeals and Grievances (A&G): The A&G team receives, processes, and resolves all appeals and grievances from members or member representatives. In addition, this team facilitates Quality of Care.
- Credentialing: The Credentialing team manages data in the credentialing database, processes credentialing and recredentialing applications, and conducts delegation oversight.
- Quality Improvement (QI), Health Improvement, HEDIS, Stars and Population Health: The QI and Stars teams design, develop, implement, evaluate, and report on evidence-based quality improvement programs as they relate to the strategic and annual quality plan. The Health Improvement team leads member engagement activities to provide health education to improve the overall health of our members. The HEDIS team develops and implements initiatives that enhance the organization's medical record review functionality for HEDIS hybrid measures and other needs. The Population Health team develops and maintains the population health strategy, population assessments and supports an inventory and evaluation of programs to support the needs of our members.
- Health Services Analytics: The Health Services Analytics team develops analyses and reporting that support the organization to understand and monitor performance, breakdown key drivers, and identify opportunities for improvement. In addition, the team supports operations and strategy of the organization's clinical documentation system.
- Disease Management: The Disease Management team develops, implements, and evaluates disease management programs and associated clinical initiatives focused on prevention, early identification, and intervention in the chronic disease process.
- Utilization Management: The Utilization Management team implements an evidence-based utilization management program and evaluates and monitors the use of non-behavioral health and behavioral health care services to assess their appropriateness and quality.

Health Care Economics: The Health Care Economics (HCE) department supports quality initiatives through data mining, statistical analysis, quality improvement reporting, clinical support, and actuarial analysis. HCE consolidates claims data with supplemental data, submits the data to the certified HEDIS Vendor, and oversees comprehensive documentation of all HEDIS processes. HCE team supports production of final HEDIS measures, works with the auditor to ensure a timely data audit and submits final rates to NCQA. HCE provides planned and ad hoc reporting and analytic assistance with identification of target population and program evaluations.

Additional Resources: The following individuals and departments provide additional key resources and guidance to the Quality Program: Medical Directors, VP Integrated Case Management and staff, VP Chief Compliance and Ethics Officer and staff, VP Customer Services and staff, VP Government Relations and staff, VP Chief Informatics Officer and staff, VP Chief Marketing and Digital Officer and staff, VP Product Management and staff, and VP Provider Network Management and staff.

Involvement of Designated Physician

Medical Director/CMO: The Medical Director is responsible for the oversight of Medical Management including the QIAC. The Medical Director is responsible for ensuring implementation of all aspects of the Integrated Care Management Program. The Medical Director reports to the President of Insurance Operations and reports to the Executive Staff on Quality issues and updates.

Involvement of Designated Behavioral Healthcare Practitioner

Behavioral Healthcare Practitioners: Behavioral Healthcare Practitioners are involved in the BH aspects of the Quality Improvement Program. BH practitioners serve on the QIAC, Medical Policy Committee, Credentialing Committee and other ad hoc committees and teams. The behavioral healthcare practitioner must be a medical doctor or have a clinical PhD or PsyD and may be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate.

Resources and Analytical Support

The QIP utilizes claims information, medical record information, predictive modeling, and data supplied by delegates to perform program functions. There are robust reporting and analytical resources available to support Medicare Advantage quality improvement activities.

Enterprise Data Warehouse (EDW) integrates data from a variety of sources and supports data and analytics solution needs. EDW data can be accessed using Microsoft™ SQL Server Management Studio,SAS®, Azure Data Studio ™, or Visual Studio Code ™. EDW consolidates and stores clinical and non-clinical data for all members, providers, and products. Examples of data include enrollment, member eligibility, members' demographics, medical and pharmacy claims, providers, clinical, regulatory, legal, and financial data. EDW integrates non-clinical members' and claims information with additional clinical data including lab values, health risk assessments, provider-submitted patient histories, medical record review abstractions, and supplemental files to perform a broad range of analytics. EDW includes John Hopkins ACG™ resource utilization bands. This tool is used to define several strata of illness levels ranging from healthy to medically complex, and multiple categories of increasing levels of illness in between the strata. This is helpful in predicting and prioritizing members for inclusion in population health management gap programs.

Additional analytic tools are used to enhance analytical capabilities and allow for flexibility in analyzing data include Business Objects ™, Python ™, and Tableau™. Business Objects™ is the ETL tool utilized to extract, transform and load data to and from the EDW from multiple disparate sources and to obtain and share data with external partners. It is a centralized suite for data reporting, visualization, and sharing. Python ™ is used to automate SQL code and export to Excel sheets for reporting, and statistical analysis. Potential use cases include forecasting, gaps closures or annual quality ratings. Tableau ™ allows connection to data and visualization using combination of

dashboard views to get richer insight.

Data quality programs are in place to rigorously check and confirm the quality and timeliness of the EDW data, including completeness and consistency with originating data sources.

In addition, a NCQA-certified HEDIS software vendor supports, calculates, and measures HEDIS results. An NCQA accredited auditor performs auditing of final rates prior to reporting them to NCQA. An external vendor is also used to conduct standard survey and analysis for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and Health Outcomes Survey (HOS).

HealthEdge's GuidingCare Platform integrates all activities and functions required for optimal population health management and care coordination, including case management, disease management, behavioral health, health promotions, utilization review and appeal and grievance cases. It enables all users along the care continuum, including case managers, health coaches, member engagement specialists, clinical pharmacists, and utilization reviewers, to interact, collaborate and share a single member record.

Delegated QI Activities

Aspirus Health Plan has designated two plan administrators as delegates for its products, including a plan administrator for Medicare Advantage. The Medicare Advantage plan administrator is responsible for services described in the Master Services Agreement and Delegation Agreement, including Quality and Medical Management. Aspirus Health Plan formally adopts its delegates' documented processes through its governing body. Aspirus Health Plan remains responsible for and has appropriate structures and mechanisms to oversee delegated QI activities.

Aspirus Health Plan has additional delegates in the areas of Credentialing and Recredentialing, Utilization Management, and Member Experience.

The QIAC monitors delegated agency performance through approval of the delegate's program, routine reporting, and annual (or more frequent) evaluations and/or audits to determine whether the delegated activities are being carried out in accordance with the delegation agreement and CMS Medicare Managed Care Manual. If monitoring reveals deficiencies in the delegate's processes, Aspirus Health Plan will work with the delegate to set priorities and correct the problem(s).

The Credentialing Committee monitors subdelegate performance through initial review and approval of the delegate's program, routine reporting, and annual evaluations to determine whether the delegated activities are being carried out in accordance with NCQA and health plan standards. If monitoring reveals deficiencies, the plan administrators will work with the delegate to establish a corrective action plan and resolve the problem(s).

Collaborative QI Activities

A focus of the QIP, in conjunction with the Quality Team, is to conduct outreach and collaborate with provider groups. The goals for outreach include quality improvement project collaboration, HEDIS improvement opportunities, and medical coding best practices.

Quality Improvement Project Collaboration:
The Quality Teams will continue to develop and maintain relationships with provider groups, state, CMS, and community partners to achieve the QIP goals. The goal is to collaboratively identify opportunities for improvement and work together on joint initiatives to strengthen the level of service for our members.

HEDIS Improvement Opportunities:
The Quality Teams will collaborate with NCQA Certified HEDIS vendors to report Medicare Advantage HEDIS data for Aspirus Health Plan in 2025 for the HEDIS Measurement Year 2024. Analyses in 2024 were conducted and opportunities for improvement were identified and appropriate work plans developed to address these opportunities. Continued monitoring of HEDIS rates and analysis with be conducted in 2025 to determine impact of improvement efforts.

Medical Coding Best Practices:
The Medical Coding team works to identify common medical coding errors seen in claims from our main provider groups. The purpose is to find trends that can be easily corrected through outreach and education to reduce errors and speed up the claims adjudication process.

Behavioral Healthcare (BH)

Aspirus Health Plan partners with professionally trained and licensed BH providers and practitioners to improve the overall mental health and substance use disorder outcomes of its members. Through participation in QIAC and quality committees, physicians and licensed clinical social workers provide key input and insights, assisting Aspirus Health Plan in building a strong, robust BH program and network to support all members.

BH QI activities are integrated into the QIP through regular reporting and through regularly scheduled workgroup meetings, which provide ongoing monitoring of BH services. Focus areas include:

- Develop collaborative partnerships and initiatives to monitor and improve behavioral health care.
- Collaborate with BH network providers in identifying and resolving gaps of access for our members.
- Analyze claims reporting and pharmacy data to identify the behavioral health needs of our members.

Patient Safety

Aspirus Health Plan fosters a supportive environment to help practitioners and providers improve safety of their practices through the following activities:

- **Clinical Practice Guideline Process:** Establishes best practice criteria based on national and state evidence-based practice guidelines to reduce variation in the care delivered to members.
- **Credentialing/Re-credentialing Process:** Ensures members are provided with a choice of qualified, competent practitioners and providers. Criteria for credentialing and re-credentialing include primary source verification, practitioner/provider specific complaint data, and practice site/medical recordkeeping assessment where indicated. In addition, the Credentialing Committees meets monthly for the ongoing monitoring of practitioner sanctions and complaints between credentialing cycles.

- **Care Coordination:** Monitors members and alerts physicians when the member changes status to higher risk.
- **Expedited Appeals Process:** Provides for the assessment of and action on an appeal of a medical necessity denial based on the urgency of the request.
- **Evaluation of New Technology:** Evaluates the efficacy of new and existing technology based on national research data and local medical practice to ensure members have equitable access to safe and effective care.
- **Member Complaint Process:** Complaints are tracked and trended by category and reported at least semiannually to QIAC. When a complaint suggests there is a potential for poor quality of care, the complaint is referred to a Medical Director and further review and investigation is completed. If there is a question of poor quality of care or unsafe practice, the occurrence is referred to the Credentialing Committee.
- **Quality of Care Complaints:** A documented process for addressing member quality of care complaints to ensure patient safety.
- **Pharmaceutical Management Program:** Development and maintenance of drug usage criteria, assessment of the efficacy of new drugs or a new use for an existing drug, monitoring of indicators relating to polypharmacy and misuse of medication. Monitoring of drug interactions to ensure patient safety.
- **Population Health Management Program:** Population Health Management Strategy includes four areas of focus that monitors member's health status:
    1. Keeping Members Healthy
    2. Managing Members with Emerging Risk
    3. Chronic Condition Management
    4. Managing Multiple Chronic Conditions/Complex Chronic.

Serving a Diverse Membership:

Aspirus Health Plan's objectives for serving a culturally and linguistically diverse membership are to:

- Evaluate membership demographics using internal data, US Census Reports and CAHPS profile.
- Maintain and monitor interpreter services lines to support culturally competent communication.
- Monitor CMS Health Equity Index and impact on CMS Star Ratings.
- Monitor and review an action plan to address the cultural and linguistic needs of our membership if warranted by the above activities including availability of appropriate educational materials and information updates for members.

Annual QIP Work Plans

The requirements for a Quality Improvement (QI) Work Plan are set out below. The Work Plan addresses ongoing activities completed throughout the year. These activities address:

- Yearly planned QI activities and objectives.
- Time frame for each activity's completion.
- Staff members responsible for each activity.
- Monitoring of previously identified issues.
- Evaluation of the QI Program.

Annual QIP Evaluation

The QIP is evaluated annually by the QIAC. The QI Program evaluation includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of measures of performance in the quality and safety of clinical care and quality of service.
- Analysis of the results of quality improvement initiatives, including barrier analysis.
- Evaluation of the overall effectiveness of the QI program and of its progress toward influencing networkwide safe clinical practices.

The QIP evaluation findings are used to identify issues to demonstrate the impact of the program and to guide the development of the Work Plan for the following year.