2024 Quality Program Work Plan

Medicare Advantage

Committees	
CR	Credentialing Committee
P&T	Pharmacy and Therapeutics Committee
QIMM	Quality Improvement and Medical Management Committee
QIAC	Quality Improvement Advisory Committee

Activity	Yearly Objective	Planned Activities	Deliverable(s)	Owner	CR	P&T	QIMM	QIAC
2023 Quality Program Evaluation	Evaluate the overall effectiveness of the Quality Program and evaluate performance in quality and safety of clinical care and quality of services.	Complete annual Quality Program Evaluation.	Quality Program Evaluation	VP, Health Services Quality and Operations			Mar	Mar
2024 Quality Program Work Plan	Define quality related planning and monitoring of activities as well as clinical and operational improvement for the coming year.	Complete annual Quality Work Plan.	Quality Program Work plan	VP, Health Services Quality and Operations			Dec	Dec
2024 Quality Program Description	Annual review of Quality Program and structure.	Complete annual Quality Program Description. Program structure changes made as indicated.	Quality Program Description	VP, Health Services Quality and Operations			Dec	Dec
Appeals and Grievances (A&G) Trend Report	Support members by resolving issues of dissatisfaction. 98% of members appeals and grievances are processed within CMS timeline.	Track complaints, assess trends, and establish that corrective action is implemented and effective in improving the identified problems. Serve as member advocates by processing concerns in a timely manner. Provide internal training on appeal and grievances trends.	A&G Trend Report	VP, Health Services Quality and Operations			Mar Jun Sep Dec	Jun Dec

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Access and Availability Monitoring	Ensure providers are meeting regulatory access standards. Ensure network is adequate to meet members' needs.	Facilitate the network appointment availability assessment process. Monitor and assess geographic accessibility. Determine opportunities to improve access and availability. Review applicable member experience information.	Accessibility Report Availability Report	VP, Provider Relations and Contracting			Jun	
Adverse Events Bi-Annual Report	Ongoing monitoring of adverse events between Recredentialing cycles, and take appropriate action against practitioners when occurrences of poor quality are identified.	Identify and when appropriate, act on important quality and safety issues in a timely manner during the interval between formal credentialing. Monitor practitioner-specific adverse events. Report findings at least semi-annually.	Adverse Events Report-Out	VP, Health Services Quality and Operations	Feb Aug			
Assessment of Provider Directory Accuracy	Evaluate and identify opportunities to improve the accuracy, and take action to improve the accuracy of the information in the physician directories.	Conduct data validation to determine accuracy of the physician directory. Identify and act on opportunities for improvement. Conduct calls to verify accuracy of provider information.	Physician and Hospital Directories Accuracy Report	VP, Provider Relations and Contracting			Jun	
Care Management (CM) Evaluation	Help members regain optimum health or improve functional capability, in the right setting and in a cost-effective manner. Coordinate services for the highest risk members with complex conditions and help them access needed resources. Address the needs of members with co-occurring behavioral and physical health conditions.	Identify, inform, and provide care management services to eligible members. Provide quarterly CM participation reports. Complete annual CM Evaluation.	CM Program Evaluation	VP, Clinical Services VP, Mental Health and Substance Use Disorder Services			Mar Jun Sep Dec	
Chronic Care Improvement Program (CCIP)	Reduce inpatient admissions per 1000 rates by 1% each year. Reduce emergency department visits per 1000 rates by 1% each year.	Quarterly mailing to members with 2-6 chronic conditions. Each mailing includes a quarterly focus, healthy recipe, health tips and resources. Quarterly focus topics include preventive services, medication adherence, stress management and hypertension/obesity.	CCIP Report	VP, Health Services Quality and Operations			Sep	

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Clinical Practice Guidelines	Ensure that guidelines are adopted, approved, reviewed and monitored.	Existing guidelines are reviewed and updated every two years. Distribute to providers and members according to State and Federal standards.	<u>Medical</u> Asthma, Diagnosis and Management; Diabetes in Adults Type 2 Diagnosis and Management; Management of Heart Failure in Adults; Obesity in Adults Prevention and Management; Prevention Services for Adults <u>Mental Health and Substance Use</u> Management of Posttraumatic Stress Disorder and Acute Stress Disorder; Treatment of Patients with Major Depressive Disorder; Treatment of Patients with Schizophrenia; Treatment of Patients with Substance Use Disorders; Treatment of Opioid Disorders	VP, Clinical Services VP, Mental Health and Substance Use Disorder Services VP, Health Services Quality and Operations			Sep	Sep

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Consumer Assessment of Healthcare Providers and Systems (CAHPS) Report	Track enrollment to determine when the plan is eligible for the CAHPS survey.* Finalize a plan to administer CAHPS if/when eligibility criteria is met. **Must meet a minimum threshold of 600 eligible members.*	Monitor enrollment and evaluate impact on CAHPS. Analyze CAHPS results, if applicable. Assess current and potential interventions and alignment with CAHPS.	CAHPS Survey Results	VP, Health Services Quality and Operations			Sep	
Credentialing Plan	Annual review of the Credentialing Plan, which applies to all providers defined by AHP subject to credentialing.	Review and approve annually. Make the document available on AHP website for providers and share with AHP delegates.	Credentialing Plan	VP, Health Services Quality and Operations	Apr			
Customer Service Report	Monitor and improve key customer service metrics to ensure members are receiving timely and accurate support.	Monitor, at a minimum, metrics in the Master Service Agreement and CMS requirements. Trend metrics to identify opportunities for improvement. Identify and act on opportunities for improvement.	Customer Service Report	VP, Customer Service			Jun	
Delegation Oversight	Perform oversight of delegated facilities and responsibilities in accordance with regulatory and contractual delegation agreements. Determine and follow up on opportunities for improvement.	Annual audit of delegated entities. Annual schedule submitted to the state identifying delegated functions. Develop Corrective Action Plans (CAPs) based on audit findings. Provide member and clinical data, as applicable.	Delegation Audit Findings	VP, Compliance	Jan July		Dec	
Disease Management (DM) Evaluation	Help members regain optimum health and/or improve functional capability, in the right setting and in a cost-effective manner. Provide DM health coaching for members and help them access needed resources.	Identify relevant process or outcome measures, analyze results and identify opportunities for improvement. Identify and inform eligible members of the DM program. Provide quarterly DM participation reports. Complete annual Disease Management Evaluation.	DM Annual Evaluation	VP, Health Services Quality and Operations			Mar Jun Sept Dec	

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Health Outcomes Survey (HOS)	Monitor program and determine focus areas for intervention after analyzing year 2 follow-up results.	Analyze year 2 follow-up results. Implement interventions to address HOS questions in the CMS Stars program.	HOS Survey Results	VP, Health Services Quality and Operations			Sep	
Healthcare Effectiveness Data Information Set (HEDIS)	Timely submission of HEDIS MY 2023 results to NCQA in June of 2024. Achieve a 4 Star Rating, if enough measures reportable to receive a Medicare Star Rating. Complete full HEDIS evaluation, including trended performance and benchmarks. Measure Focus Areas*: - Adult Immunization Status (AIS-E) - Colorectal Cancer Screen (COL) - Diabetes HbA1c Poor Control >9 (HBD) - Diabetic Eye Exams (EED) - Diabetic Kidney Health (KED) - Controlling High Blood Pressure (CBP) - Transitions of Care (TRC) **Enrollment and eligible populations were small. These are early/emerging focus areas that are subject to change.*	Monitor enrollment and evaluate impact on HEDIS reporting. For reported measures, identify interventions to improve performance. For measures below the denominator threshold of >30 for formal reporting, data will be collected and evaluated to determine if early intervention is appropriate.	HEDIS Survey Results	VP, Health Services Quality and Operations			Sep	
Non-Discrimination Report	Identify and track incidences of discrimination in the Credentialing process.	Complete audits of credentialing files to monitor the Credentialing and Recredentialing process to prevent and/or identify any discriminatory practices. Complete audits of practitioner complaints for evidence of alleged discrimination.	Annual Non-Discrimination Report	VP, Health Services Quality and Operations	Oct			

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Population Health Management	Assess needs of members and determine actionable categories for appropriate intervention. Provide targeted population health activities for members.	Apply Population Health Management (PHM) framework/strategy. Annually assess and review the characteristics and needs of members. Provide targeted population health activities for members, including but not limited to health promotion, disease management, care management, behavioral case management, and linking members to community-based resources.	Population Health Management Strategy and Assessment	VP, Health Services Quality and Operations			Jun	
Prior Authorization (PA) Grids	Ensure prior authorization processes meet the needs of members and providers.	Review PA requirements and update as needed.	Medical Services Authorizations Mental Health and Substance Use Disorder Authorizations Medical Injectable Drug Authorizations	VP, Health Services Quality and Operations VP, Pharmacy		Sep	Sep	
Quality of Care Reviews	Complete quality reviews/investigations in a timely manner to ensure a safe and quality provider network. Close 90% of Quality Care cases within 90 days of receipt.	Monitor percent of cases closed that meet resolution timeline. Analyze quarterly trend reports by volume, issues, severity, and outcome. Provide education and monitor providers included unsubstantiated cases. Refer to peer review as required. Provide cross-departmental education regarding Quality of Care concerns. Provide quarterly reports.	Quality of Care Trend Report	VP, Health Services Quality and Operations			Mar June Sep Dec	
Regulatory Oversight	Ensure results from the CMS Medicare program audit are reviewed and acted upon (as applicable).	Identify number of deficiencies and mandatory improvements in audit reports (as applicable). Discuss mandatory improvements with appropriate VP/Directors and receive written confirmation from VP's of next steps (as applicable). CAPs relating to the audit deficiencies are complete or in process (as applicable).	CMS Audit	VP, Compliance			Sep	

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Star Ratings	Monitor CMS Star Rating program and enrollment criteria for qualification of first Star Rating.* **Must meet a minimum measure threshold to receive a Medicare Star Rating for both Part C and Part D measures.*	Monitor enrollment and evaluate impact on Star Ratings. Implement interventions to support Star performance such as incentives, outreach activities, and member score cards. Meet monthly to review rate trends, industry updates, and develop interventions for success.	Committee Updates	VP, Health Services Quality and Operations			Mar Jun Sep Dec	Dec
Utilization Management (UM) Criteria Review	Annual review of UM written criteria based on sound clinical evidence to make utilization decisions, and specify procedures for appropriately applying the criteria.	Review and apply objective and evidence-based criteria, and take individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.	UM Criteria	VP, Health Services Quality and Operations			Dec	Dec
2023 Utilization Management (UM) Evaluation	Complete an annual evaluation of the UM program to determine if the program remains current and appropriate.	Evaluate the UM program structure, scope, processes, and information sources used to determine benefit coverage and medical necessity. Evaluate the level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program. Identify relevant measures and analyze results to identify opportunities for improvement, depending on volume of services.	Utilization Management Evaluation	VP, Health Services Quality and Operations			Mar	Mar

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2024 Utilization Management (UM) Plan	Ensure UM program is well structured and makes utilization decisions affecting the health of members in a fair, impartial, and consistent manner. Ensure the UM program has clearly defined structures and processes, and assigns responsibility to appropriate individuals.	Annually review UM plan and ensure it includes the following: -A written description of the program structure. -The mental health and substance use aspects of the program. -Involvement of a designated senior-level physician in UM program monitoring. -Involvement of a designated mental health practitioner in the mental health and substance use aspects of the UM program. -The program scope and process used to determine benefit coverage and medical necessity. -Information sources used to determine benefit coverage and medical necessity.	Utilization Management Plan	VP, Health Services Quality and Operations			Mar	Mar