2025 Quality Improvement Program Work Plan

Medicare Advantage

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

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
2024 Quality Improvement 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 Improvement Program Evaluation on 2024 activities.	Quality Program Evaluation	VP, Health Services Quality and Operations			Mar	Mar
2025 Quality Improvement 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 Improvement Work Plan.	Quality Program Work plan	VP, Health Services Quality and Operations			Mar	Mar
2025 Quality Improvement Program Description	Annual review of Quality Improvement Program and structure.	Complete annual Quality Improvement Program Description. Program structure changes made as indicated.	Quality Program Description	VP, Health Services Quality and Operations			Mar	Mar

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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. Meet internal thresholds for appeals and grievances rates per 1,000 for quality of care, access, attitude/service, billing/financial, and quality of practitioner office site.	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
Access and Availability Monitoring	Ensure providers are meeting regulatory access standards. Ensure network is adequate to meet members' needs. Exceed goal of 70% of primary care, specialty care, and mental health and substance use disorder providers meeting appointment availability expectations (goal of 90% for after hours response for primary care). Exceed goal of 90% of members within time and distance criteria for all provider types. Exceed ratio goal of 1:2000 providers to members for all provider types.	Facilitate the network appointment availability assessment process. Monitor and assess geographic accessibility. Determine opportunities to improve access and availability (i.e. contracting opportunities). Review applicable member experience information (i.e. appeals and grievances, CAHPS).	Accessibility Report Availability Report	VP, Provider Network Management			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 quality and safety issues in a timely manner during the interval between formal credentialing. Monitor practitioner-specific adverse events. Report findings semi-annually.	Adverse Events Report-Out	VP, Health Services Quality and Operations	Feb Oct			

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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. Exceed provider directory accurate goal of 90% for office location, accepting new patients, and awareness of contract; and 85% for phone number.	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 Network Management			Jun	
Case 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. Outreach to 100% of identified members eligible for case management and achieve a 20% engagement rate.	Identify, inform, and provide care management services to eligible members. Provide quarterly CM participation reports. Complete annual Care Management Evaluation.	CM Program Evaluation	VP, Integrated Care Management			Mar Jun Sep Dec	
Chronic Care Improvement Program (CCIP)	Reduce inpatient admissions per 1000 rates by 1% each year (when applicable). Reduce emergency department visits per 1000 rates by 1% each year (when applicable).	Quarterly mailing to members with 2-6 chronic conditions. Each mailing includes health education, health tips and resources. Quarterly focus topics include preventive services, medication adherence, stress management and chronic condition management.	CCIP Report	VP, Health Services Quality and Operations			Sep	

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Consumer Assessment of Healthcare Providers and Systems (CAHPS) Report	Launch CAHPS survey and submit data annually in accordance with regulatory requirements. Maintain 5 Stars for CMS CAHPS measures that are currently 5 Stars, and either maintain performance or achieve statistically significant improvement for all other measures. Focus areas: - Rating of Drug Plan - Getting Needed Prescription Drugs	Analyze the results against benchmarks. Identify opportunities for improvement based off trended performance, comparison to 2024 national averages and star rating cut points. Continue and enhance interventions in the following areas: - Customer Service training and improvement. - Member education materials. - Collaboration and engagement with provider groups. - Improved data collection and analytics. - Collaboration with pharmacy benefit manager and mail order vendor.	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. Exceed Customer Service Level and Average Handle Time goals, 80% and 8:00 minutes respectively.	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. Develop Corrective Action Plans (CAPs) based on audit findings.	Delegation Audit Findings	VP, Compliance	Jan July		Dec	

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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	
Health Outcomes Survey (HOS)	Monitor program and determine focus areas for intervention after analyzing year 2 follow-up results. *Measure Focus Areas:* - Monitoring Physical Activity - Improving Bladder Control - Reducing the Risk of Falling	Analyze year 2 follow-up results. Implement interventions to address HOS questions in the CMS Stars program including: provider education, member education, falls prevention mailer and Strong & Stable Kit expansion. Evaluate effectiveness of interventions.	HOS Survey Results	VP, Health Services Quality and Operations			Sep	
Healthcare Effectiveness Data Information Set (HEDIS)	Timely submission of HEDIS MY 2024 results to NCQA in June of 2025. Maintain 5 Stars for CMS CAHPS measures that are currently 5 Stars, and either maintain performance or achieve statistically significant improvement for all other measures. Complete full HEDIS evaluation, including trended performance and benchmarks. Measure Focus Areas*: - Adult Immunization Status (AIS-E) - Breast Cancer Screening (BCS-E) - Colorectal Cancer Screen (COL) - Diabetes Glycemic Poor Control >9 (GSD) - Diabetic Eye Exams (EED) - Diabetic Kidney Health (KED)	Monitor enrollment and evaluate impact on HEDIS reporting. Maintain EHR Exchange Supplemental File and evaluate any enhancement needs. 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	

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	- Controlling High Blood Pressure (CBP) - Transitions of Care (TRC) - Statin Therapy in Cardiovascular Disease (SPC) - Follow-Up ED Visit for Multiple Chronic Conditions (FMC) - Plan All-Cause Readmissions (PCR) **Enrollment and eligible populations were small. These are early/emerging focus areas that are subject to change throughout the year.*							
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.	Annual Non-Discrimination Report	VP, Health Services Quality and Operations	Oct			
Population Health Management	Assess needs of members and determine actionable categories for appropriate intervention. Provide targeted population health activities for members.	Apply Population Health framework/strategy. Annually assess and review the characteristics and needs of members via the population health assessment. Provide targeted population health activities for members, including but not limited to health promotion, health improvement outreach, disease management, care management, behavioral case management, and linking members to community-based resources.	Population Health Strategy and Assessment	VP, Health Services Quality and Operations			Mar	

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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 the resolution timeline. Analyze quarterly trend reports by volume, issues, severity, and outcomes. Provide education and monitor providers as applicable for unsubstantiated/ substantiated cases. Refer to peer review as required. Provide cross-departmental education regarding Quality of Care concerns.	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 VPs 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	Complete quality improvement activities based on Stars ratings. Achieve a 2026 rating of 4.5 Stars. Refer to HEDIS, CAHPS, and HOS activities for detailed focus areas. Focus areas are prioritized using a data analysis platform and supplemental data sources, as well as the impact of the 5x weighted Quality Improvement measures and the Reward Factor.	Meet monthly to develop and implement interventions based on overall Stars ratings to achieve statistically significant improvement. Provide activity reports to QIMM and QIAC. Complete Plan-Do-Study-Act (PDSA) cycle on all interventions. Develop focus areas and interventions in workgroups. Work on areas below the threshold and as identified in the annual evaluation. Analyze impact of the Health Equity Index and establish priorities. Work with Stars consultants and use Hyperlift to set and monitor measure level goals throughout the year.	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
2024 Utilization Management (UM) Evaluation	Complete an annual evaluation of the UM program to determine if the program remains current and appropriate. Meet 95% of turnaround time requirements.	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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2025 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