2023 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
2022 Annual Program Evaluation (on 2022 QI Activities)	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, Quality Management and Population Health			Mar	Mar
2024 Annual Quality 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, Quality Management and Population Health			Dec	Dec
2024 Quality Program Description	Annual review of Quality Program and structure.	Complete annual Quality Program Description.	Quality Program Description	VP, Quality Management and Population Health			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, Quality Management and Population Health			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 (i.e., contracting opportunities). Review applicable member experience information (i.e., Appeals and Grievances).	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, Quality Management and Population Health	Feb Aug			
Assessment of Provider Directory Accuracy	Evaluate and identify opportunities to improve the accuracy of provider directories. Take action to improve the accuracy of the information in the provider directories.	Conduct data validation to determine accuracy of the provider 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 (on 2022 CM Activities)	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. Complete annual Care Management 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, Quality Management and Population Health			Sept	

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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. Assess current and potential interventions and alignment with CAHPS.	Committee Updates	VP, Quality Management and Population Health			Jun	
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, Quality Management and Population Health	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) Annual Report (on 2022 DM Activities)	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, Quality Management and Population Health			Mar Jun Sept Dec	

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Health Outcomes Survey (HOS)	Monitor program and determine focus areas for early intervention when year 2 follow-up results are available (2024).* **AHP qualified for HOS in 2022 and the first survey was fielded in August of 2022. Results will not be available until 2024.*	Implement interventions to address HOS questions in the CMS Stars program. Continue to monitor baseline trends.	Committee Updates	VP, Quality Management and Population Health			Jun	
Healthcare Effectiveness Data Information Set (HEDIS)	Timely submission of HEDIS MY 2022 results to NCQA in June of 2023. Measure focus areas include preventative and routine care, such as Annual Wellness Visits and cancer screenings.* **Enrollment and eligible populations from HEDIS MY 2021 were very 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, collect data and evaluate to determine if early intervention is appropriate.	HEDIS Survey Results	VP, Quality Management and Population Health			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, Quality Management and Population Health	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 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, Quality Management and Population Health			Sep	

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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, Clinical Services VP, Mental Health and Substance Use Disorder Services 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.	Quality of Care Trend Report	VP, Clinical Services			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	
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.	Committee Updates	VP, Quality Management and Population Health			Mar Nov	Dec

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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, Clinical Services VP, Mental Health and Substance Use Disorder Services				Dec
Utilization Management (UM) Evaluation (on 2022 UM Activities)	Complete 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, Clinical Services VP, Mental Health and Substance Use Disorder Services			Mar	Mar
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 behavioral healthcare aspects of the program. - Involvement of a designated senior-level physician in UM program monitoring. - Involvement of a designated behavioral healthcare practitioner in the behavioral healthcare 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, Clinical Services VP, Mental Health and Substance Use Disorder Services			Mar	Mar