



Quality Management Program 2019

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1 Program Structure

1.1 Introduction

Ultimate Health Plans (UHP or “the Plan”) is a Medicare Advantage Plan that offers healthcare and prescription drug (Part D) benefits coverage to Medicare beneficiaries in Citrus, Hernando, Pasco and Pinellas Counties in Florida. UHP is committed to improving the health status of its members and promoting healthy lifestyles. The Quality Management Program (Program) provides the framework for this commitment. (42 CFR§422.152)

This document describes the scope, objectives, activities, and structure of the Program. It defines the organization’s committee structure, to include the roles and responsibilities of the Quality Management Steering Committee (QMSC).

1.2 Program Description

The Program is established at the direction of the Board of Directors (BOD), the governing body for UHP, and is designed to promote quality of care and service excellence, as well as member satisfaction for UHP members. The Program is based on the principles of continuous quality improvement, where performance improvement results from ongoing and systematic measurement, intervention, and follow-up of key clinical and non-clinical aspects of care.

The primary responsibility for administration of the Program is vested in the CEO, Medical Director, and QMSC, however, all UHP employees share in the responsibility to define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on quality outcomes management.

The Program establishes a proactive approach towards performance improvement through identification, tracking, and trending of key clinical and non-clinical performance indicators relevant to the scope of the organization and related to consumer and health care services, including quality of care, access to services, safety, utilization, and member experience. Program activities include selecting and prioritizing quality improvement projects, developing indicators, analyzing performance, identifying and proposing solutions to problems, and facilitating communication of program activities to members and providers.

The Program establishes mechanisms to provide written documentation of targeted improvement activities initiated in response to analysis of measured performance outcomes that include:

- ◆ Analysis of process, satisfaction or outcome trends that are directly related and relevant to the quality of services;
- ◆ Analysis of process, satisfaction or outcome trends using valid and accurate measurement methods; and
- ◆ Mechanisms to communicate results of such activities to relevant staff and the QMSC.

All documentation related to the Quality Management Program is made available to the Centers for Medicare & Medicaid Services (CMS) as requested and during onsite audits. A summary of the annual Quality Management Program is also made available to practitioners and members upon request.

1.3 Scope

The Quality Management Program is a comprehensive program that integrates activities, data, and reports from a variety of sources throughout the organization, including but not limited to: claims, credentialing, enrollment, grievances and appeals, Health Plan Employer Data and Information Set (HEDIS®), the Medicare Health Outcomes Survey (HOS), health services utilization, pharmacy, network management, case management, disease management, population health management, delegation, quality management, risk management, and satisfaction surveys, such as Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

It addresses components of effective health care management such as anticipation, identification, measurement, monitoring, and evaluation of members' health care needs and system performance, and the implementation of effective actions to promote quality of care.

It includes the use of performance data available through standardized measures. Analytical resources are available through Quality Management staffing and through the employment of project-specific experts. Staff has access to end-user data systems for population health, quality, claims/encounter data, enrollment, utilization, grievances, and administrative services. These systems provide the Quality Management staff with the information used to establish performance measures and implement quality improvement activities.

The Program includes quality studies and improvement initiatives established by the Plan as well as regulatory and accreditation agencies. It is designed in compliance with state Codes and Statutes, the Medicare Managed

Care Manual, and the standards and guidelines established by the National Committee for Quality Assurance (NCQA) The quality study design incorporates the establishment of baseline data, data analysis, development and implementation of interventions, and re-measurement to evaluate the effectiveness of interventions and overall sustained improvement.

Member utilization and health services activities are significant components of the Program, including care management activities, monitoring for under and over utilization, and use of clinical practice guidelines and standards, review criteria and clinical peer review of medical appropriateness.

1.4 Goals

UHP is committed to improving the health and well-being of members, adopting “The Ultimate Goal - Five Stars!” and working towards the delivery of Five Star performance throughout the organization.

The Program is designed to achieve quality, cost-effective care and services for members through the development, implementation and ongoing improvement of organizational systems.

The Program is designed to support the following goals:

- ◆ Improve the physical and mental health status of members through high quality, well-coordinated care;
- ◆ Deliver Five Star performance as demonstrated by internal measures and the Centers for Medicare and Medicaid Services (CMS) 5-star rating system;
- ◆ Empower members to develop and maintain healthy lifestyles;
- ◆ Demonstrate member satisfaction with UHP and its providers;
- ◆ Promote use of evidence-based medicine by Plan and network providers;
- ◆ Perform risk identification and stratification for members with special needs for early intervention and care management;
- ◆ Use medical technology and other medical resources efficiently and effectively;
- ◆ Facilitate effective organizational communication of performance improvement initiatives and priorities;
- ◆ Facilitate timely member access and availability to care;
- ◆ Promote member safety in conjunction with effective medical care;
- ◆ Provide culturally and linguistically competent health care delivery and promote health care equity.

1.5 Objectives

Program objectives include:

- ◆ Enhance the efficiency of resource utilization, while ensuring the delivery of high quality and accessible care and treatment;
- ◆ Proactively pursue clinical and non-clinical performance improvement;
- ◆ Design and implement interventions to improve the overall health status of health plan members;
- ◆ Involve members in treatment and care management decision-making;
- ◆ Develop and improve systems to enhance coordination and continuity of care between medical and behavioral health services;
- ◆ Establish indicators and implement monitoring and evaluation activities to measure and improve key aspects of care and services;
- ◆ Educate members, physicians, hospitals and ancillary providers about the UHP’s quality management goals, objectives, structure and processes;

- ◆ Establish mechanisms for the communication of performance improvement activities to Plan staff, members and providers;
- ◆ Promote open communication and interaction between and among providers, members, and the Plan;
- ◆ Establish and maintain a system for the identification and follow-up of potential quality issues.
- ◆ Establish an environment responsive to member concerns and grievances;

1.6 Work Plan

The QMSC oversees a comprehensive Quality Management Work Plan (Work Plan) that identifies specific activities and responsibilities of functional areas. The Work Plan is developed incorporating regulatory and accreditation requirements, Program goals, findings and recommendations from the annual program evaluation, and planned activities for the upcoming year. The Work Plan facilitates the annual evaluation of the Quality Management Program, and is reviewed and approved at least annually.

The Work Plan identifies specific activities and key performance indicators to be reviewed periodically by the QMSC. Included in the annual Work Plan are:

- ◆ Activities, objectives, and planned interventions
- ◆ Responsible departments and individuals
- ◆ Measurement indicator(s)
- ◆ Reporting schedule
- ◆ Timeframe for activity completion
- ◆ Monitoring of previously identified issues

Quality improvement and monitoring activities are developed for the following areas:

- ◆ Quality of clinical care
- ◆ Safety of clinical care
- ◆ Quality of services
- ◆ Service access and accessibility
- ◆ Member experience and satisfaction
- ◆ Provider practice and documentation
- ◆ Care planning and implementation
- ◆ Coordination and continuity of care
- ◆ Member safety
- ◆ Under and over utilization of services
- ◆ Network quality, including credentialing and recredentialing, performance improvement projects, performance measurement, problem resolution and improvement approach and strategy, and metrics related to quality and performance of participating providers related to their continued participation in the network.

The QMSC annually evaluates, updates, and approves the Work Plan. Interim updates to the Work Plan require approval by the QMSC.

1.7 Annual Evaluation

A formal evaluation of the Program is conducted annually. The purpose of the evaluation is to assess the progress made towards meeting the goals of the Program and the effectiveness of the strategies selected to address those goals. The evaluation is performed utilizing information collected via the Plan's health information system, and the results of accreditation surveys and regulatory audits and reports are used to conduct the

evaluation. Program documentation such as quality improvement projects, committee minutes and reports are used as evidence to demonstrate progress towards Program goals.

The evaluation includes:

- ◆ A description of completed and ongoing quality improvement activities that address quality and safety of clinical care and quality of service;
- ◆ Trending outcomes of measures to assess performance in the quality and safety of clinical care and quality of service, including and other organization-specific reports, surveys and data;
- ◆ Results of external reporting and evaluation activities, including measures from Health Effectiveness Data and Information Systems (HEDIS®), Consumer Assessment of Health Plans Systems (CAHPS®), Health Outcomes Survey (HOS), CMS required reporting (Parts C and D);
- ◆ Results of NCQA survey activities and ongoing monitoring to maintain compliance with NCQA standards;
- ◆ Analysis of reports to identify potential opportunities for improvement;
- ◆ Barriers to achieving objectives, if any, and recommended interventions for overcoming them;
- ◆ Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practice;
- ◆ The progress towards meeting Program goals and assessment of the effectiveness of the annual Work Plan;
- ◆ Assessment of the utilization management, care management and risk management programs;
- ◆ The impact and effectiveness of strategies implemented in support of Program goals;
- ◆ The ability of UHP to complete Work Plan tasks in a timely manner;
- ◆ The health information system's capacity to provide information needed to conduct process evaluations and performance improvement projects (to collect, analyze, and report accurate and complete data, both individual and aggregate);
- ◆ Appropriateness and adequacy of Quality Management Program resources;
- ◆ QMSC structure;
- ◆ Practitioner participation and leadership involvement in the Quality Management program;
- ◆ Recommendations for changes in strategies, program management, and resource allocation for the upcoming year.

The QMSC reviews a written evaluation of the Quality Management Program and Work Plan annually. The QMSC uses the Evaluation to revise the Quality Management Program as needed and develop the Quality Management Work Plan for the upcoming year. Any problems or issues that are identified, but not included in performance improvement projects, are addressed by the QMSC.

1.8 Structure, Roles, and Responsibilities

The BOD retains ultimate responsibility and remains accountable for the oversight and improvement of care and services for UHP members. The Board delegates responsibility for the administration and management of the Program to the QMSC, which remains accountable to the Board. The Board approves the Quality Management Program, Utilization Management Program, the annual Quality Management Work Plan, and annual program evaluation and is responsible for the overall program effectiveness and resource allocation.

The Chief Operations Officer (COO) is the designated member of the leadership team with the authority and responsibility for the overall operation of the Program. The CEO works in conjunction with the Medical Director,

Chief Compliance Officer, Chief Operations Officer, quality management leadership, QMSC and other established committees to execute these responsibilities.

The Medical Director is the senior clinical staff member and has the primary responsibility for administration of the clinical aspects of the Program. The Medical Director provides guidance and works closely with the quality management leader, who has responsibility for the day-to-day activities of the Program.

The Chief Operations Officer, senior leadership, and department leadership are responsible for implementing the Program throughout the organization. All Plan employees are responsible for identification of improvement opportunities and participation in quality improvement activities.

2 Committee Structure

UHP committee structure promotes company-wide participation in the development, implementation, and evaluation of quality management and improvement activities, and provides an effective mechanism for communication of information regarding the quality of member care and services. Committees described herein report to the QMSC, which reports to the BOD, which has overall responsibility for oversight of the Program.

Committee charters are included in the Program description and include defined responsibilities designed to fulfill the committee's role in the Program structure.

The Program establishes minimum membership and meeting frequency requirements for each committee. Individuals serving as committee members shall have the requisite seniority, comprehensive experience, and decision-making authority to represent their areas of responsibility. Committee activities, recommendations, and decisions are documented through meeting minutes and associated reports. Committee oversight is conducted through review of meeting minutes and reports.

2.1 Board of Directors (BOD)

The UHP Board of Directors is the governing body of UHP. The BOD maintains oversight of the Quality Management Program and delegates quality management program ongoing activities to the QMSC. The BOD provides strategic direction to the organization for quality management activities and ensures that quality management is integrated into plan operations.

The BOD is responsible for:

- ◆ Development and maintenance of a committee structure to support quality management activities;
- ◆ Providing strategic direction to the quality management program through communications with the executive leadership and the QMSC;
- ◆ Ensuring adequate resources and systems to support quality activities throughout the organization;
- ◆ Review and approval of quality management program documents on at least an annual basis;

2.2 Quality Management Steering Committee (QMSC)

The QMSC is granted authority for quality management activities by the Board. It is responsible for the administration of the Quality Management Program, providing direction and oversight for the development, monitoring, evaluation and enhancement of the Program. The Committee meets at least 4 times a year, or as often as necessary.

Membership is multidisciplinary and includes management level clinical and administrative participation. QMSC membership includes representation by the following positions or departments:

- ◆ Chief Operations Officer – Chairperson (or senior leadership designee)
- ◆ Medical Director
- ◆ Chief Executive Officer
- ◆ Chief Compliance Officer
- ◆ Health Services Manager
- ◆ Quality Manager
- ◆ Claims and Configuration Manager
- ◆ Risk Manager
- ◆ IT Director
- ◆ Credentialing Manager
- ◆ Network Development/Provider Relations Manager
- ◆ Operations Manager
- ◆ Customer Service Representative (ad hoc)
- ◆ Marketing & Sales (ad hoc)

Guests are invited at the discretion of the Chairperson and as appropriate for the agenda. Voting privileges are reserved for Committee members and representatives serving as alternates.

Each position was specifically chosen to provide the Committee with applicable information related to their department or area, in order to identify opportunities for improvement, to monitor implementation of internal initiatives, and to facilitate the success of the company-wide Program. Individual staff members may represent multiple departments in the Committee if they also serve in multiple functions within UHP.

A quorum requires attendance by at least one of the following: Chief Operations Officer, Medical Director, Chief Compliance Officer, or Chief Executive Officer, and at least four (4) of the remaining positions/departments.

Responsibilities of the QMSC include:

- ◆ Oversee development and facilitate implementation of a written Quality Management Program, which incorporates the strategic direction provided by the Board;
- ◆ Establish indicators for monitoring of key organizational processes;
- ◆ Establish and monitor organizational performance goals related to HEDIS® standards and using national Medicare HMO benchmarks;
- ◆ Analyze and evaluate the results of QI activities;
- ◆ Evaluate all grievances, appeals and CTMs data, both individual and aggregate to ensure compliance with regulatory and accreditation requirements;
- ◆ Facilitate and monitor performance improvement activities;
- ◆ Provide guidance to staff on quality improvement priorities and projects;
- ◆ Foster collaboration and effective communication throughout the organization;
- ◆ Approve selection and methodology of quality improvement projects;
- ◆ Conduct oversight for committees reporting to the QMSC through review and approval of committee activities;
- ◆ Conduct oversight of delegated entities and approve delegation decisions;
- ◆ Monitor progress towards meeting quality improvement goals;
- ◆ Evaluate the effectiveness of the Quality Management Program at least annually;
- ◆ Review and approve proposed annual and interim changes to the Program;
- ◆ Identify needed actions and ensures follow-up, as appropriate;
- ◆ Provide ongoing reporting to the Board through committee minutes and written or verbal reports;

- ◆ Make recommendations to the BOD regarding quality policies, projects, and programs;
- ◆ Ensures practitioner participation in the QI program through planning, design, implementation or review;
- ◆ Comply with State and Federal reporting requirements regarding findings and actions of the Credentialing and Peer Review Committees;
- ◆ Maintain approved minutes of all committee meetings.

2.3 Compliance Committee

Corporate Compliance Committee serves as an oversight and decision-making body for UHP's Compliance and Fraud, Waste, and Abuse (FWA) Program. The Committee assists the BOD in overseeing UHP's Compliance Program, policies and procedures, including (1) compliance with federal and state laws, rules and regulations applicable to the business of the Plan: and (2) compliance with UHP's Code of Conduct and Ethics and related policies by associates, officers, directors and other contracted agents, and those providing healthcare services for Plan members.

The Compliance Committee has the authority to conduct any investigation appropriate to fulfill its responsibilities, including direct access to anyone in the company and to any third party who may perform compliance related consulting services to the Company. The Compliance Committee also has direct access to the BOD for any compliance related activities or investigation.

The Committee meets at least 4 times a year, or as often as necessary. A majority of members present at each meeting shall constitute a quorum. Membership includes the following:

- ◆ Compliance Officer, Chairperson
- ◆ Chief Executive Officer (ad hoc)
- ◆ Chief Operations Officer
- ◆ Sr. Manager, Operations
- ◆ Other persons as the Compliance Committee deems appropriate.

Guests may be invited at the discretion of the Chairperson and as appropriate for the agenda. Voting privileges are reserved for Committee members and representatives serving as alternates.

Responsibilities of the Compliance Committee include:

- ◆ Ensure that UHP has a Corporate Compliance Program that meets all federal and state regulatory and accreditation agency requirements, including but not limited to those of the Department of Health and Human Services, Office of Inspector General (HHS-OIG);
- ◆ Ensure the company has appropriate, up-to-date policies and procedures;
- ◆ Develop strategies to promote compliance and the detection of any potential violations;
- ◆ Ensure that training and education are appropriately completed;
- ◆ Develop innovative ways to implement appropriate corrective and preventive action;
- ◆ Provide guidance and resources to the Compliance Officer in the execution of his/her duties;
- ◆ Receive and address reports of monitoring and auditing of areas in which the company is at risk of fraud, waste and abuse, and ensure that corrective action plans are implemented and monitored;
- ◆ Ensure the company has a system for employees, first tier entities, downstream entities, and related entities to ask compliance questions, and report potential instances of fraud, waste or abuse confidentially or anonymously (if desired) without fear of retaliation;
- ◆ Receive reports of risk assessments and recommendations from the Compliance Department staff;
- ◆ Monitor corrective actions plans required by the Compliance Officer and/or any regulatory agency;

- ◆ Receive and address quarterly reports from the Compliance Officer on Compliance Program activities;
- ◆ Provide quarterly reports on the status of compliance to the Board;
- ◆ Provide annual reports to the Board with respect to the operations, effectiveness and evaluation of the UHP Corporate Compliance Program;
- ◆ Maintain approved minutes of all committee meetings.

2.4 Medical Advisory Committee (MAC)

The Medical Advisory Committee is responsible for oversight of clinical quality activities. The MAC reports to the QMSC and meets at least 4 times a year, or as often as necessary. Membership includes at least the following:

- ◆ Medical Director, Chairperson
- ◆ Network providers, at least three (3) credentialed physicians representing the primary care and specialty networks
- ◆ Health services leader
- ◆ Quality management leader
- ◆ Providers with delegated managed care functions (ad hoc)
- ◆ Operations leader (ad hoc)
- ◆ Network Development/Provider Relations leader (ad hoc)

Guests are invited at the discretion of the Chairperson and as appropriate for the agenda. Voting privileges are reserved for Committee members and representatives serving as alternates. A quorum requires attendance by the Medical Director or Health Services Manager and at least two (2) network physicians.

Responsibilities include but are not limited to:

- ◆ Review and approve quality improvement activities;
- ◆ Research, review and approve protocols and evidence-based clinical guidelines and scripts for the provision of acute, chronic and preventive care;
- ◆ Review and approve utilization management guidelines;
- ◆ Periodic evaluation and formulation of recommendations regarding:
 - HEDIS® data,
 - Satisfaction data, member and provider; and
 - Education of members and staff regarding the role of peer review;
- ◆ Participate in the evaluation and enhancement of the Quality Management Program;
- ◆ Identify and respond to trends, including coordination of care and under and over-utilization;
- ◆ Evaluate and approve chronic care improvement programs, as required by the Centers for Medicaid and Medicare Services (CMS);
- ◆ Evaluate information regarding new technologies, participate in communication of information to Health Services staff and network providers;
- ◆ Evaluate health plan performance data and provide recommendations to the Medical Director and QMSC;
- ◆ Provide recommendations and participate in evaluation and decision-making regarding interventions targeting improved member health status;
- ◆ Recommend quality improvement projects utilizing data or information obtained from the following programs: credentialing process, population health management, case management, utilization review, peer review, grievances and appeals, and adverse events.

- ◆ Provides periodic review and oversight of delegated pharmacy activities, including formulary changes, PBM activity, and prescription drug utilization.
- ◆ Maintain strict confidentiality practices regarding information obtained through the committee process;
- ◆ Maintain approved minutes of all committee meetings.

2.5 Peer Review Committee

The Peer Review Committee conducts professional review activities involving the professional competence or conduct of providers that adversely affects or potentially affects member welfare. The Peer Review Committee is a sub-committee of the Credentialing Committee, ultimately reporting to the QMSC. The committee meets on an ad hoc basis, when actual or potential quality of care issues are identified that require peer review.

Membership includes representation of credentialed network providers:

- ◆ Medical Director, Chairperson (voting)
- ◆ Network providers, at least three (3) credentialed, qualified providers, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider involved in the case being reviewed (voting)
- ◆ Ad hoc members appointed as required for specific quality of care issues (voting)
- ◆ Quality leader (non-voting)
- ◆ Health Services Manager (non-voting)
- ◆ Risk Manager

Contracted providers are invited to participate on an ad hoc basis in order to provide appropriate peer/specialty representation for the case or issue being reviewed.

Voting privileges are extended to the licensed health care providers serving as Committee members, the Medical Director, and Risk Manager. Voting privileges are clarified by the Chairperson at the beginning of the meeting and recorded for the minutes. The Chairperson also identifies, for the record, Committee member(s) serving as a clinical peer of the provider involved in the case under review.

A quorum requires attendance by a Medical Director and at least three (3) qualified providers who were not involved in earlier, related decisions. At least one of these must be a participating provider not otherwise involved in network management and is a clinical peer of the provider for the issue being reviewed

Responsibilities include but are not limited to:

- ◆ Participate in development and approval of peer review policies, procedures, and systems designed to standardize severity levels and corrective action plans;
- ◆ Conduct professional evaluation of cases, events or issues with actual or potential impact on quality of care;
- ◆ Make determinations using evidence-based medicine and established standards of care to include:
 - Assign quality of care severity levels to each case reviewed;
 - Recommend corrective action based on the severity level assigned to the case;
- ◆ Provide input into the credentialing process as applicable to peer review activities;
- ◆ Maintain strict confidentiality practices regarding all information obtained through the peer review process;
- ◆ Maintain documentation in compliance with regulatory requirements, accreditation standards, and Plan policy;
- ◆ Maintain approved minutes of all committee meetings.

2.6 Pharmacy & Therapeutics (P&T) Committee (delegated)

UHP contracts with a Pharmacy Benefits Manager (PBM) and delegates the function and responsibilities of the P&T Committee to the PBM Pharmacy and Therapeutics Committee. The Committee's goal is to promote safe, cost-effective and quality drug therapy that reflects community and national standards of practice.

PBM Committee responsibilities include:

- ◆ Review and update, at least annually and more frequently as needed:
 - Formularies, to include inclusion or exclusion of therapeutic classes;
 - Formulary management including additions, deletions, and changes;
 - Clinical guidelines, criteria, and procedures related to the timely use and access to formulary and non-formulary drugs;
 - Medication policies, quality initiatives, and clinical pharmacy interventions;
 - Policies that guide utilization management tools for formulary management;
- ◆ Document in writing decisions regarding formulary development or revision.

Committee members meet regulatory requirements and include both academic and practicing physicians and pharmacists with diverse clinical expertise; the majority are active in clinical practice. They include as a minimum at least one (1) practicing physician and one (1) practicing pharmacist that are expert in the care of elderly or disabled persons and one (1) each who are free of conflict with respect to UHP, the PBM, and pharmaceutical manufactures.

UHP's Medical Director serves as liaison to the PBM and the PBM Pharmacy and Therapeutics Committee.

UHP delegation oversight of Pharmacy and Therapeutics Committee activities includes:

- ◆ PBM Compliance with regulatory and accreditation activities, including approval of PBM policies and procedures;
- ◆ Pre-delegation and annual audits of delegated activities;
- ◆ Review quarterly reports of PBM Pharmacy and Therapeutics Committee decisions and recommendations to the Plan;
- ◆ Review quarterly drug utilization reports.
- ◆ Review quarterly reports of PBM administrative activities related to Part D services and benefits, including coverage determinations, appeals, and redeterminations.

2.7 Credentialing Committee

The Credentialing Committee is responsible for the overall direction of the credentialing program. It is a peer-based committee with the final authority to approve or disapprove provider applications. The Medical Director, the senior clinical staff person of the organization, is responsible for oversight of the clinical aspects of the credentialing program.

The Committee reports to the QMSC and meets at least four times per year and as often as necessary to support network development and adequate access and availability of providers for plan members.

Membership includes representation of credentialed network providers, including at least one who has no other role in organization management.

- ◆ Medical Director, Chairperson
- ◆ Credentialing Manager (non-voting)

- ◆ Network providers, at least three (3) credentialed physicians representing the primary care and specialty networks
- ◆ Health Services Manager (ad hoc)
- ◆ Chief Compliance Officer (ad hoc)

In addition to the standing membership, practitioners may be invited to participate on an ad hoc basis in order to provide appropriate specialty representation for a specific applicant being reviewed.

Voting privileges are extended to the Medical Director, network provider members or their alternates, and ad hoc providers determined appropriate by specialty. Voting privileges of guest health care professionals are determined by the Chairperson in advance of specific case review activities.

A quorum requires attendance by a Medical Director and at least two (2) network physicians.

Responsibilities include but are not limited to:

- ◆ Review and approve credentialing policies and procedures based on regulatory and accreditation requirements;
- ◆ Review criteria and review process for *clean files* which qualify for medical director approval;
- ◆ Review credentialing and recredentialing files which do not meet Plan criteria as “clean files” or medical director approval;
- ◆ Evaluate individual applicants, verifying qualifications and credentials in accordance with regulatory requirements, accreditation standards and plan policy;
- ◆ Evaluate performance data for credentialing and recredentialing decision;
- ◆ Review between cycle sanctions and other performance monitoring reports;
- ◆ Request additional information from providers and/or initiate further investigation of applicants where the credentialing process reveals factors that could adversely impact the quality of care or services;
- ◆ Base credentialing and recredentialing decision on verification of qualifications in accordance with Plan policies and professional assessments regarding whether providers are meeting reasonable standards of care;
- ◆ Respond to recommendations of the Peer Review Committee regarding providers with identified adverse incidents or patterns of performance that could potentially impact member care adversely;
- ◆ Provide guidance to health plan staff on the overall direction of the credentialing program;
- ◆ Maintain strict confidentiality practices regarding all information obtained through the credentialing process;
- ◆ Document all actions and maintain approved minutes of all committee meetings.

2.8 Administrative Dispute Resolution Committee (ADRC):

The Administrative Dispute Resolution Committee provides the mechanism to address alleged violations by participating providers of the requirements of the organization. The ADRC reports to the QMSC, meets on an ad hoc basis, and provides a timely dispute resolution process.

Membership includes the following:

- ◆ Chief Compliance Officer
- ◆ Medical Director or designee
- ◆ Chief Operations Officer (Chairperson)
- ◆ Finance/Accounting leader
- ◆ Manager Sales and Marketing

Alternates:

- ◆ CEO
- ◆ Director, Network Management and Provider Relations
- ◆ Credentialing Manager

Voting privileges are reserved for Committee members and representatives serving as alternates. Individual representatives may not vote on any dispute when they were involved in the initial decision that is the subject of dispute. Alternate members are identified to ensure sufficient representation in the event of significant involvement by primary committee members in a single subject of dispute.

A majority of members/alternates present at each meeting shall constitute a quorum.

Responsibilities include but are not limited to:

- ◆ Conduct objective evaluations of referred administrative disputes using all available information;
- ◆ Identify and re-direct any inappropriate referral, one outside of the scope of the administrative dispute resolution process or committee;
- ◆ Make determinations in accordance with written agreements and in compliance with regulatory requirements and accreditation standards;
- ◆ Notify the designated Plan individual of the outcome of a dispute, initiating the provider notification process and process to effectuate a decision in the event an original decision is overturned by the Committee;
- ◆ Maintain strict confidentiality practices regarding information obtained through the committee process;
- ◆ Maintain approved minutes of all committee meetings.

2.9 Network Status Dispute Committee (NSDC):

The Network Status Dispute Committee provides the mechanism to resolve disputes by participating providers regarding actions by the organization that involve a change in network status for administrative reasons. The Network Status Dispute Committee is a sub-committee of the Administrative Dispute Resolution Committee, ultimately reporting to the QMSC. The Committee meets on an ad hoc basis and provides a timely dispute resolution process.

Membership includes representation of credentialed network providers:

- ◆ Director, Network Development (Chairperson) (non-voting)
- ◆ Medical Director or designee
- ◆ Network providers: at least one is a clinical peer who is not involved in network management, day-to-day operations of UHP, or participation on other committees.

Voting privileges are extended to Committee members or alternates and the majority of voting members must be peers of the disputing provider. Any individual involved in an earlier decision of the subject of dispute may not vote on the related dispute. The professional specialties of all network providers are included in the minutes and the Chairperson identifies, for the record, the network provider(s) serving as a clinical peer of the provider and who is not involved in network management or operations.

Responsibilities include but are not limited to:

- ◆ Conduct objective evaluations of referred provider disputes using all available information;
- ◆ Identify and re-direct any inappropriate referral, such as one outside the scope of the administrative dispute resolution process and the NSDC;

- ◆ Make determinations in accordance with written agreements and in compliance with regulatory requirements and accreditation standards;
- ◆ Notify the appropriate Plan individual of the outcome of a dispute, initiating the provider notification process and process to effectuate a decision in the event an original decision is overturned by the Committee;
- ◆ Maintain strict confidentiality regarding all information obtained through the committee process;
- ◆ Maintain approved minutes of all committee meetings.

2.10 Delegation Committee

The Delegation Committee is responsible for oversight of entities with delegated managed care functions. The Committee reports to the QMSC and meets at least 4 times a year, or as often as necessary.

Membership is multidisciplinary and includes representation from:

- ◆ Chief Compliance Officer - Chairperson
- ◆ Credentialing Manager
- ◆ Sr. Manager, Operations
- ◆ Director, Network Management and Provider Relations
- ◆ Chief Operations Officer
- ◆ Content expert representation specific to a delegated function (ad hoc)

Additional representation and guests are invited at the discretion of the Chairperson and as appropriate for the agenda. Voting privileges are reserved for Committee members and representatives serving as alternates. A majority of members present at the meeting shall constitute a quorum.

Responsibilities include but are not limited to:

- ◆ Evaluate proposals for delegation of managed care functions and make delegation recommendations to the QMSC;
- ◆ Develop and implement a plan for ongoing monitoring of delegated functions;
- ◆ Review reports of delegation audits and monitoring activities to evaluate compliance with delegation agreements;
- ◆ Oversee development and monitoring of corrective action plans as indicated;
- ◆ Maintain approved minutes of all Committee meetings.

3 Quality Management Program Components/Activities

3.1 Member Rights and Responsibilities

UHP acknowledges and respects the rights and responsibilities of its members, and has a written statement of member rights and responsibilities, which is distributed to network providers. Processes are in place to educate members regarding their rights and responsibilities. UHP's employees and contractors are oriented to the rights and responsibilities of members.

3.2 Member Satisfaction and Experience

Member satisfaction is monitored throughout the Plan with the intent of continuously improving the processes and outcomes that affect members. Sources of information include complaints and grievances, appeals, and annual CAHPS® satisfaction data. Satisfaction data is evaluated for issues related to quality of care, access, customer service or attitude, billing issues, utilization management processes, case management,

cultural/linguistic needs, and behavioral health experience. Improvement initiatives are implemented to reverse adverse trends, improve processes, and sustain improved member satisfaction. The Plan evaluates member satisfaction at least annually, develops quality improvement initiatives, as needed, and communicates improvement initiatives to the participating providers.

3.3 Access and Availability

UHP maintains and monitors a network of providers sufficient to provide adequate access to and availability of covered services. Services are geographically distributed to meet the needs of the members. Access and availability standards are established and monitored within the organization. Indicators are monitored with findings incorporated into network development plans with the objective of convenient and timely access to both primary care and specialty care networks. Monitoring and evaluation of access and availability to behavioral health services is performed in conjunction with the delegated behavioral health network.

3.4 Grievance and Appeals

Upon enrollment, members are notified of the overall grievance and appeals process, their appeal rights, and where to obtain assistance with the process if needed. Customer Services personnel are available to assist members with the grievance and appeals process. The grievance and appeals process is designed to handle member and provider disputes regarding benefits in a manner that is fair and equitable and in accordance with regulatory guidelines. Members are notified of appeal rights with notification of an adverse decision.

3.5 Administrative Disputes – Participating Providers

New providers are notified of the overall provider dispute process and how to file a dispute and gain assistance with the process if needed. The dispute process is available to all participating providers, and is designed to respect providers' rights and concurrently protect Plan members.

The dispute process provides a mechanism for participating providers to file administrative disputes not involving a change in network participation status, and administrative disputes for actions resulting in a change in network status for administrative reasons/actions. It also provides a mechanism for disputing actions by the health plan that relate to a participating provider's status within the network or to a provider's professional competency or conduct.

3.6 Health Services

UHP health services include functions related to utilization management, case management, complex case management, and disease management.

3.6.1 Utilization Management

The Utilization Management (UM) Program defines and describes the Plan's multidisciplinary, comprehensive approach and process to manage resource allocation. The UM Program is in place to affect consistent application of members' healthcare benefits in the most appropriate and cost-effective settings without compromising quality care. The health plan does not manage care, but manages members' medical benefits in order to meet established goals within various health plan programs.

The UM Program is based on evidence-based clinical practice guidelines, as well as regulatory and accreditation standards. The program provides the structure for the appropriate and timely management of care and services to members. Policies and procedures related to authorization for services are based on current standards of medical practice. Utilization management activities include the evaluation of medical necessity and appropriateness of health care service, including the appropriate level of care and the members unique

circumstances. Utilization is monitored, patterns evaluated, over- and under-utilization identified, and results used in provider education initiatives. Utilization is reported to the Medical Advisory Committee (MAC) for periodic review of service utilization patterns. Results of utilization monitoring may be used in the re-credentialing of providers. Program activities include prospective review (prior authorization), concurrent review, and discharge planning activities, and retrospective review. Medical management includes continuity and coordination of care related to both medical and behavioral health.

3.6.2 Population Health

UHP maintains a comprehensive approach to population health. The member or population is at the center of the population health strategy, and the care provided under the program addresses the needs, preferences and values of UHP members. The Population Health Management Program is implemented plan-wide, in that it integrates and builds upon initiatives, programs, and strategies employed across the organization. Population Health Management programs and initiatives are designed to integrate with Disease Management Programs, Complex Case Management, Chronic Care Improvement Programs, and HEDIS and CMS Stars improvement initiatives.

The Population Health Management Program is based on an annual assessment of the needs of the population, including those identified through annual health risk assessments as well as other data sources. The population is then stratified and targeted interventions and programs are developed based on the needs of the relevant member subpopulations. The Plan coordinates its population health management activities and initiatives internally, and also with any external management programs, network providers, hospitals, and other entities, and across care settings and levels of care.

Annually, the Plan evaluates the impact of the PHM program on the population, including a quantitative analysis of clinical, cost/utilization and member experience. Results are compared against established goals and benchmarks, and used to identify opportunities and strategies for improvement.

The Medical Advisory Committee (MAC) monitors the programs for overall effectiveness of the program.

3.6.3 Disease Management

Disease management programs are developed based on population characteristics and health care needs of members with chronic diseases, and are designed to improve specific health outcomes and the overall health of the member. The programs are disease-specific and designed using evidence-based clinical guidelines. They involve member education and emphasize self-care efforts. Pre-established criteria determine member eligibility for inclusion in the program and appropriate interventions. Providers and members receive information regarding the specific programs. The Medical Advisory Committee (MAC) monitors the programs for overall effectiveness.

Disease Management activities are focused on members diagnosed with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), cardiovascular disease, hypertension and diabetes.

3.6.4 Case Management

The Case Management Program is designed to enable appropriate coordination of effective care and treatment and to reinforce and motivate members toward positive lifestyle behaviors. It is a collaborative process of assessment, planning, facilitation and advocacy to meet member's needs. Case managers develop individualized care plans to meet the unique needs of the member and serve as a liaison for the member in the treatment and

management process. The Case Management Program targets members impacted by catastrophic events such as an acute disease, traumatic events or diagnosis with specific chronic diseases.

3.6.5 Complex Case Management

Complex case management criteria targets individuals with physical or developmental disabilities, multiple chronic conditions, and severe mental illness. The Complex Case Management Program is designed to benefit members who require extensive use of resources, and help these individuals to navigate the system to receive appropriate delivery of care and services. Members with complex needs are stratified into Level 4 within the Case Management Program and provided with the appropriate services for Level 4 members if they meet any one of the criteria below:

- ◆ A complex clinical condition and/or complication with a major change in cognitive and functional status;
- ◆ Discharge planning needs requiring multiple providers, complex services, and a high level of coordination;
- ◆ Diagnoses associated with any of the following:
 - Complex wound care,
 - Complex infectious conditions; or
 - Complex cognitive, behavioral, medical issues and social issues;
- ◆ Unstable and at risk for complications,
- ◆ Lack of knowledge about illness/disease process and needs maximum assistance to remain compliant with treatment plan; and/or
- ◆ Need for frequent intervention on a daily or bi-weekly basis.

The Plan has adopted the following objectives to ensure that the needs of members with complex needs are met, regardless of whether or not they participate in the Case Management Program:

- ◆ Improve access to primary and specialty care;
- ◆ Ensure that members with complex health conditions receive appropriate services;
- ◆ Coordinate care for members who receive multiple services;
- ◆ Identify and reduce barriers to services for members with complex conditions.

UHP uses a team model approach to coordinate care for members that require integrated care between multiple specialists to address complex comorbidities, co-existing/co-occurring disorders, and/or social determinants that may affect health outcomes. The team is comprised of the Medical Director, the Health Services Manager or designee, and the Case Manager. The team's focus includes, but is not limited to, members with any of the following:

- ◆ Organ transplant;
- ◆ HIV/AIDS;
- ◆ Progressive degenerative disorders; or
- ◆ Metastatic cancers

3.7 Medical Records

UHP disseminates standards for medical record documentation and record keeping practices to network providers. Medical record reviews may be conducted either periodically or in response to identified issues for both medical and behavioral health care, with results and improvement opportunities shared with providers.

The Plan establishes policies and procedures that guard the privacy of protected health information and require staff and network providers to provide for member confidentiality.

3.8 Preventive Health

UHP promotes preventive health care for its members. The Medical Advisory Committee selects, approves and adopts evidenced-based, age-specific, preventive health guidelines. UHP disseminates information regarding guidelines to providers, and makes individual or aggregate data related to preventive care (e.g. HEDIS® data) available to providers periodically.

3.9 Credentialing and Recredentialing

The goal of the credentialing program is to achieve quality care and services for members through the verification and peer-based evaluation of provider qualifications. Program objectives include the credentialing of only qualified providers and the ongoing monitoring and evaluation of the provider network. Processes are in place for the credentialing and recredentialing of all contracted physicians and other health care professionals who practice independently and provide care for members. Processes are in place to comply with regulatory requirements and accreditation standards for the initial and recredentialing of providers. The credentialing/recredentialing process, under the direction of the Medical Director and Credentialing Committee, includes review of applications, verification procedures for applicant qualifications, and confirmation that established criteria are met. The Credentialing Committee, including network providers as voting members, makes recommendations for credentialing decisions.

3.10 Peer Review

A comprehensive peer review process is established for the evaluation of actual, perceived or potential quality of care issues. The Medical Director is responsible for the peer review process. Sources of identification of quality of care concerns include, but are not limited to, data or staff reports from Customer Services, grievance and appeals, health services and case management activities, quality management, and/or from hospitals or individual providers. A formal Peer Review Committee, with network provider representation as voting members, is an integral part of the process.

3.11 Clinical Quality Improvement

One primary objective of the Quality Management Program is to establish clinical improvement initiatives, which consist of quality improvement projects, focus studies, and activities designed to improve the health status of members as demonstrated by selected HEDIS® and other clinical performance measures. Quality improvement initiatives are designed to identify and correct significant problems related to clinical care and service, as well as to systematically improve clinical quality measures.

3.11.1 Quality Improvement Projects (QIPs)

Quality improvement Projects (QIP) are designed and conducted in accordance with applicable regulatory requirements and NCQA accreditation standards. QIPs measure and analyze health plan performance using objective, clearly defined indicators. Projects are evidence-based, and capable of measuring outcomes such as health or functional status, or valid proxies of outcomes. Valid techniques are used to measure baseline data, conduct periodic re-measurement and assess performance and effectiveness of specific interventions. Performance improvement is measured against pre-established, quantifiable goals. When goals are not met, interventions and projects are re-evaluated and may be redesigned.

For any QIPs initiated, UHP follows the PDSA project cycle:

Plan - demonstrates an improvement opportunity, identifies what change(s) will be introduced, who will be involved, and the expected results. The steps include the development of a comprehensive, well-

organized, consistent, and logical plan that is expected to improve health outcomes and member satisfaction. The plan describes the processes, specifications, and outcome objectives used to establish the QIP.

Do - describes how the QIP will be conducted, the progress of the implementation, and the data collection plan.

Study – describes and analyzes findings against the benchmarks(s) or goal(s) as determined by the Plan, and identifies trends over several PDSA cycles that can be considered for the “Act” stage.

Act – summarizes action plan(s) based on findings and describes the differences between the established benchmarks and the actual outcomes, providing information regarding any changes based on actions performed to improve processes and outcomes, including a short description of actions performed.

3.11.2 Quality Improvement Activities

Clinical quality improvement initiatives may be documented in formal quality improvement project descriptions, the quality improvement work plan, or reported in Plan developed projects or study reports.

UHP’s quality improvement activities include the following components:

- ◆ Measure performance, apply interventions to improve performance, evaluate performance, and conduct periodic follow-up to ensure the effectiveness of the intervention;
- ◆ Evaluate performance using quality indicators that are objective, clearly defined, and correspond to measurable outcomes such as changes in health status, functional status, and member satisfaction;
- ◆ Collect, analyze, report, and act on valid and reliable data; and
- ◆ Identify activities to achieve demonstrable improvement from interventions.

The organization contracts with an NCQA licensed HEDIS® auditor and submit audited HEDIS® data for the MA-PD contract in accordance with CMS directive and HEDIS® technical specifications. The Plan analyzes the results in comparison with national and state benchmarks, identifies strengths and improvement opportunities, and designs and implement improvement strategies per direction of the QMSC.

The organization contracts with certified HOS® and CAHPS® vendors and participate in the surveys in accordance with CMS directives. The plan analyzes the results of the survey, identifies improvement opportunities and designs and implements improvement strategies per direction of the QMSC.

The Medication Therapy Management Program (MTMP) is administered by the pharmacy benefits manager (PBM). The PBM collects the data and the Compliance staff submits the reports to CMS. UHP’s Medical Director is consulted and participates in discussions with the PBM to develop programs and improvement initiatives based on the MTMP reports, e.g., programs to review and address high-risk medications and diabetic drugs. These initiatives are part of the overall Program and presented to the MAC and the QMSC.

3.12 Operational Quality Improvement Initiatives

UHP monitors the organization for significant systemic problems through internal surveillance of key operational indicators, and member and provider feedback and complaints. UHP is committed to facilitating timely interventions to improve organizational processes and operational efficiencies. The Committee structure supports both identification and process improvement, and all employees are responsible for participating in these initiatives as appropriate. UHP will correct all problems that come to its attention, which may be identified through internal surveillance, complaints, and other mechanisms.

Operational quality improvement initiatives may be documented in formal quality improvement project descriptions according to regulatory and accreditation requirements or Plan developed project or study reports.

Operational quality improvement initiatives include the following components

- ◆ Measure performance, apply interventions to improve performance, evaluate performance, and conduct periodic follow-up to ensure the effectiveness of the intervention;
- ◆ Evaluate performance using quality indicators that are objective, clearly defined, and correspond to measurable outcomes such as changes in health status, functional status, and member satisfaction;
- ◆ Collects, analyzes, reports, and acts on valid and reliable data, and
- ◆ Identify activities to achieve demonstrable improvement from interventions.

3.13 Chronic Care Improvement Program

The Plan maintains a Chronic Care Improvement Program (CCIP) based on CMS requirements and designed to meet member needs. The goal of the CCIP is to improve and maintain wellness and health outcomes for members with chronic conditions through a program of advocacy, communication, education, identification, and facilitation of services. Effective management of chronic disease is expected to slow disease progression prevent complications and development of comorbidities, reduce preventable emergency room(ER) encounters and inpatient stays, improve quality of life, and save costs for the Plan and member. Through the CCIP, the Plan addresses the ongoing, individual needs of the member. Members identified for the CCIPs have special needs that are not episodic, but rather occur across a continuum of care and in multiple practice settings, with multiple or severe chronic conditions, which would benefit from participation in a chronic care improvement program. CCIPs are conducted over a three-year period.

3.13.1 Current CCIP

UHP's current CCIP focuses on reducing osteoporosis and osteopenia. This CCIP meets the requirements of 42CFR §422.152(c). It was developed as a Quality Improvement Project and implemented as a CCIP during 2018, per CMS directive.

3.13.2 Methodology

UHP identifies quality measures for the CCIP that are objective, well defined, and based on current standards of practice.

UHP follows PDSA project cycle:

Plan - demonstrates an improvement opportunity, identifies what change(s) will be introduced, who will be involved, and the expected results. The steps include the development of a comprehensive, well-organized, consistent, and logical plan that is expected to improve health outcomes and member satisfaction. The plan describes the processes, specifications, and outcome objectives used to establish the CCIP.

Do - describes how the CCIP is conducted, the progress of the implementation, and the data collection plan.

Study – describes and analyzes findings against the benchmarks(s) or goal(s) as determined by the Plan, and identifies trends over several PDSA cycles that can be considered for the “Act” stage.

Act – summarizes action plan(s) based on findings and describes the differences between the established benchmarks and the actual outcomes, providing information regarding any changes based on actions performed to improve processes and outcomes, including a short description of actions performed.

3.13.3 Participant Identification

UHP developed specific criteria for participation in the CCIP. All Plan members who meet program criteria by having a qualifying diagnosis and/or triggering event are eligible for enrollment in the CCIP. Members are identified from information gathered from the Plan's health information system and case/disease management activities.

3.13.4 Activities and Interventions

The Plan develops target interventions to address the areas that require improvement. Interventions typically involve member education outreach, in order to improve member knowledge of their specific condition and compliance with preventive guidelines; and provider education outreach, to educate providers as to clinical practice guidelines.

Interventions also are designed to address barriers to members receiving the care necessary for the chronic disease, and to improve data capture and reporting in order to facilitate the UHP's management of members' chronic conditions. Program activities include monitoring CCIP participants and evaluating individual participant outcomes related to the CCIP goals.

3.13.5 Monitoring and Program Evaluation

The Plan evaluates the overall effectiveness of its CCIP by analyzing annual HEDIS® results. This data is used to monitor the members who participate in the CCIP, and to evaluate the health outcomes, quality indices, and/or improve operational systems post interventions. Results are benchmarked to Medicare HEDIS® rates, and opportunities for improvement are addressed through targeted interventions.

Additionally, UHP may monitor other measures to determine the effectiveness of the CCIP. UHP identifies opportunities for improvement in care and services for members, and designs interventions to address any deficiencies.

UHP documents CCIP program design, ongoing monitoring, and follow up at least annually, under the guidance of the Medical Director and the Medical Advisory Committee. Program design, status and outcomes are reported to CMS as requested.

3.14 Risk Management

The UHP Risk Management Program is a comprehensive program for the identification, reporting, investigation, analysis, evaluation and prevention of problems, including quality of care issues affecting the provision of medical care with the goal of providing the most advantageous method for correcting, reducing or eliminating identifiable risks. The goals of the risk management program are to promote quality of care, improve member satisfaction with their health care providers and the delivery system, and reduce the risk to company resources by minimizing the risk of legal claims and other losses. Program objectives are to conserve company assets and to maintain a positive reputation and public image through risk avoidance. Company employees receive orientation and periodic training regarding risk management, to include identification and reporting of potential risk issues.

Risk management activities are closely aligned with those related to quality of care, critical and adverse incidents, and member safety.

UHP's Risk Manager is responsible for the development, coordination, and oversight of the Risk Management Program. The Program is updated and approved annually by the BOD.

3.15 Member Safety Program

The Member Safety Program promotes member clinical safety in all care settings and environments. Member safety improvement initiatives are incorporated into the Plan's activities and evaluated for effectiveness in promoting safe clinical care. Member safety considerations are incorporated into case management, disease management, utilization management, quality management, credentialing, and other plan processes.

The Plan monitors and facilitates safe clinical practices through the following activities:

- ◆ Initial review of primary care provider (PCP) sites, including potential safety, security and privacy factors;
- ◆ Credentialing and recredentialing review and approval activities to determine whether providers meet basic plan standards for inclusion into the network;
- ◆ Review of member grievances and complaints as a basis for monitoring member care and safety concerns about provider providers and facilities. Each grievance and complaint is addressed individually with the provider, facility or vendor, and grievances are tracked and trended for patterns;
- ◆ Adoption and dissemination of nationally recognized, evidence-based guidelines;
- ◆ Distribution of provider and member education materials to promote compliance with evidence-based standards and guidelines;
- ◆ Monitoring adherence of network providers to clinical standards through HEDIS® and HOS data collection and analysis;
- ◆ Implementation of pharmaceutical procedures to manage drug interaction events, medication compliance issues, and drug recalls;
- ◆ Monitoring planned and unplanned care transitions to coordinate care and promote safe transitions between care settings.

3.16 Delegation

The Plan has processes in place for thorough evaluation of companies seeking or assigned delegated services. Companies with delegated services are held to the same standards of care and service as UHP. Oversight includes pre-delegation and periodic audits to assess compliance with standards and requirements. Delegated entities provide periodic reports of quality activities to appropriate Plan committees. The Delegation Committee provides direction and oversight for delegated functions.

Delegation includes oversight of any contracted managed care functions, including quality management as applicable. Oversight of quality management delegation occurs both for activities completely delegated, as well as those that are not delegated but support the Plan's quality management goals and activities.

3.17 Health Care System Coordination

Effective coordination of care and services is critical to quality care and improved health outcomes. The patient-centered medical home approach promotes a collaborative relationship with providers and facilitates coordinated planning and communication.

The focus on effective coordination is throughout the organization. UHP maintains a provider network with the qualifications and expertise to care for the Medicare population. Processes are in place to assist members and providers with eligibility and benefit issues, authorize medically necessary care, facilitate referrals, coordinate transitions in care settings, identify members for special programs and services, and evaluate the effectiveness of the processes overall.

UHP promotes effective relationships with external entities, establishing and implementing mechanisms to promote collaboration and communication to coordinate health services for consumers. The QMSC is responsible for verifying that appropriate department leaders have primary responsibility for specific contracted vendors and that the organization provides guidance for the coordination through policies and procedures. Periodic reporting to the QMSC includes coordination activities, barriers to coordination with the entity, and barriers to coordination of health services.

3.18 Member and Provider Communication

From the time of member enrollment and provider contracting, the plan makes available information regarding programs and services. Methods and mechanisms for communication with network providers include: provider portal, face-to-face meetings, webinars, fax blasts, audio-conferencing, secure FTP sites, newsletters, and the Quick Reference Guide. In addition, the Provider Relations, Claims, and Customer Services departments have dedicated teams to take provider calls and inquiries.

Communication with members includes the following: member portal, telephone, fax, audio-conference with health services, member newsletters, information posted on UHP's website and email (for those members who request email communication). Members may also meet with our Customer Services representatives face-to-face.

3.19 Health Literacy

UHP recognizes that health literacy is an issue that affects effective communication with members, their health care decisions and outcomes, and ultimately the cost of health care. To promote understanding of health and services information, the organization requires member materials to be written in plain language. All clinically related written member educational materials including quality improvement, member safety, utilization management, and preventive health are developed based on federal health literacy standards to increase members' awareness and understanding of the information being provided. The organization provides information on health literacy and communicating in plain language to Customer Services and Health Services staff that routinely interface directly with members. Materials are translated from English to any language identified as the primary language of at least five (5) percent of the Plan's service area.

Improvement activities include:

- ◆ Provide information, training and tools to staff and practitioners to support member health literacy needs;
- ◆ Monitor member calls and complaints to assess whether health literacy needs are being met.

3.20 Cultural Competency

UHP is committed to supporting diversity in its members, providers, employees, and the communities it serves and promotes the delivery of health care services in a culturally and linguistically appropriate manner. UPH strives to ensure that services are provided to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms, and respects the worth of the individual member and protects and preserves the dignity of each.

Cultural competency goals include:

- ◆ Provide health care services to all Plan members in a culturally competent manner;
- ◆ Meet cultural needs of Plan members;
- ◆ Provide linguistically appropriate services to members with limited or no English proficiency;

- ◆ Respond to demographic changes in the member population;
- ◆ Eliminate disparities in the health status of people of diverse backgrounds;
- ◆ Increase member, provider, and employee satisfaction;
- ◆ Improve network adequacy to meet the needs of underserved groups;
- ◆ Recognize, value, affirm, and respect the worth of individual members, protecting and preserving their dignity.

Program activities include:

- ◆ Assessment of member demographic data related to language requirements;
- ◆ Provide member educational materials and communications consistent with demographic requirements;
- ◆ Monitor complaints and satisfaction reports;
- ◆ Evaluate network adequacy based on member cultural and linguistic needs;
- ◆ Monitor and minimize health care disparities;
- ◆ Provide information, training and tools to staff and practitioners to support culturally competent communication.

UHP considers cultural competency goals and strategies in planning and implementation of Quality Management Program activities. The Plan regularly reviews its Cultural Competency Program and progress toward goals and strategies outlined in this Program. The Plan tracks and trends any issues related to the cultural competency of services provided to Plan members and implements interventions as needed.

3.21 Behavioral Health

The Plan contracts with an NCQA accredited Managed Behavioral Health Organization (MBHO) and adopts the delegate's Quality Program, Utilization Management Program, Case Management Program and policies related to key services and related programs, after the Plan's review and approval of the program. The behavioral health delegate's Medical Director is responsible for the approval and oversight of the delegate's QI program. The Behavioral Health delegate's Medical Director is a Board-Certified Psychiatrist who holds a valid, active and unrestricted medical license to practice at a minimum in the State of Florida.

The Plan incorporates both behavioral and medical care into the overall care systems for plan members. The Plan develops and maintains a close relationship with the behavioral health delegate to coordinate medical and delegated behavioral health services. Quality of care activities promote coordination of care and effective behavioral health services.

The Behavioral Health delegate reports clinical, service and operational activities at least quarterly to the QMSC either directly or through the Medical Advisory Committee. Reports include quality improvement projects, service improvement activities, access and availability, member satisfaction, critical incidents and sentinel events. The behavioral health delegate provides data for HEDIS[®] indicators related to behavioral health.

The Plan has a designated behavioral healthcare practitioner that plays an important and active role in quality improvement. The behavioral health delegate's medical director or designee participates on the Plan's QMSC on quarterly basis to report on behavioral health quality management, utilization management, credentialing and network metrics and activities specific to the Plan. The Quality and Health Services staff participates in the behavioral health delegate's Quality Summit meetings. The Quality Summit is chaired by the behavioral health medical director and includes reporting to the health plans on quality improvement activities, utilization, clinical standards, safety and risk management, coordination of care, provider and consumer satisfaction, and other quality related topics.

The Plan monitors behavioral health care and the coordination of care between medical and behavioral health providers, including utilization, care and case management activities, disease management and wellness initiatives, new technologies for behavioral health, and activities involving behavioral health guidelines. Oversight occurs through delegation audit activities, regular meetings between the Plan and behavioral health delegate, collaborative projects and activities, and reporting to the QMSC by the designated behavioral health practitioner.

3.22 Confidentiality

All employees are required to meet requirements for confidentiality and security of information related to the quality program, and maintain compliance with UHP HIPAA, privacy and security policies.

Documentation related to quality activities is considered confidential and is maintained appropriately. Network providers, providers from delegated entities, and other committee members not employed by UHP demonstrate their understanding and intentions of confidentiality by signing confidentiality statements annually. Peer review documentation is labeled as such and maintained in a secure manner.

3.23 Provider Participation

UHP encourages its providers to participate in plan quality activities and CMS and Department of Health and Human Services (HHS) quality improvement initiatives through the following:

- ◆ Involve providers in design and ongoing review of CCIP and other quality projects and programs.
- ◆ Distributing informational materials about the plan's, CMS and DHHS quality initiatives via:
 - Printed newsletters
 - Website
 - Portal
 - Special mailings
 - Special events
- ◆ Establishing benchmarks for provider performance on QI initiatives;
- ◆ Regularly reporting provider-specific performance data relevant to QI initiatives;
- ◆ Providing training, tools and resources for performance improvement;
- ◆ Providing patients with tools and information to collaborate with their provider on QI initiatives;
- ◆ Recognizing providers who successfully meet QI initiative objectives and/or goals.

3.24 Accreditation Program

In accordance with State of Florida requirements for HMO's, UHP maintains accreditation from an accrediting body approved by the State of Florida.

4 Health Information System

4.1 Health Information Technology/Systems

The Information Technology/Systems (IT) Administrator is responsible for maintaining health information systems, to include meeting applicable regulatory requirements for security, privacy and business continuity. IT is represented on the QMSC and maintains a mechanism for communication with system users. The health information system supports UHP's ability to:

- ◆ Maintains a health information system that collects, analyzes, and integrates the data necessary to implement the QI program;

- ◆ Ensures that the information it receives from providers of services is reliable and complete;
- ◆ Make all collected information available to CMS.

The health information system allows for the collection of valid, reliable data for analysis and integration into quality improvement activities. The mechanisms for monitoring data for accuracy and completeness include contracted services, e.g. HEDIS® compliance audit, and documented internal processes and procedures.

UHP uses a comprehensive benefits administration system, with enrollment, customer service, and claims activities delegated to a third party administrator (TPA). UHP directly manages authorizations, grievance and appeals. The TPA provides a secure provider portal for sharing information with network providers.

UHP uses the eVIPs™ systems for credentialing, contract and quality management. The plan communicates electronically with CMS via the Health Plan Management System (HPMS).

The QMSC has responsibility for evaluating the effectiveness, ensuring appropriate resources are available, and acting on identified improvement opportunities.

4.2 Data Integrity, Accuracy, and Completeness

Providers are required via contract language to submit complete and accurate claims/encounters. Each contract includes provision requesting that all relevant diagnosis and procedural codes, coded to the highest level of specificity, be submitted in order for accurate payment of services. Submission parameters, regarding claims and encounters, are included in provider and vendor contracts.

The Plan is contracted with an external vendor to review medical records to validate accuracy of claims and encounter data submitted for RAPS (Risk Adjustment Process Submission). The vendor reviews medical records, provides files for submission to CMS for RAPS, and educates providers, as needed.

The Plan monitors delegates for compliance with contractual reporting requirements. The Plan also performs annual and ad-hoc claims audits for delegated vendors, including vision, mental health, dental and pharmacy, and credentialing provider files to ensure data is accurate, current and complete. The Plan develops and implements corrective action plans, and conducts on-going monitoring, when a deficiency is identified.

4.3 Quality Program Integration of Health Information and Other Data

Data from the Health Information System is integral to the Quality Management Program. The Quality Management Department collects data from the health information system, case management system and delegated vendors as part of the Quality Management Program. This data is analyzed, reported, and tracked and trended, as part of the overall Quality Management Program, and utilized in Quality Management initiatives when opportunities for improvement or to correct problems are identified (such as those revealed through member complaints and quality improvement activities). Data are also used in developing the Quality Management Work Plan, and evaluating the impact and effectiveness of the Program via the annual Quality Management Program evaluation process.

Data are reviewed by the Quality Management Department, committees, and others, as appropriate, and utilized to suggest new and/or improved quality improvement activities. Quality findings are reported to appropriate executive authority, staff, and Plan departments, primarily through Committee reports. Quality findings are also communicated to relevant stakeholders, such as network providers, primarily via provider newsletters and/or the Plan website.

Additionally, HEDIS®, Health Outcomes Survey (HOS), CAHPS®, Part C and D Reporting Elements (including MTMP measures), and other reporting results are reported internally, and may be used to determine topics for quality

improvement activities in areas that require improvement. The Quality Management Department develops year-over-year reporting results, which are presented to the QMSC. Finally, data from the Health Information System is used to measure the effectiveness of Quality improvement activities or initiatives, as well as the plan's success in implementing its annual Quality Improvement Work Plan, as detailed in the Plan's Quality Management Program Evaluation.

Ultimate corrects all problems brought to its attention. These problems may be identified through:

- ◆ Internal surveillance;
- ◆ Complaints;
- ◆ Other mechanisms, such as periodic and annual reviews of quality data and program elements.

Ultimate routinely monitors the issue resolution process and maintains, aggregates and analyzes information on the nature of issues raised by members and on their resolution. This information may be used to develop quality improvement activities.

Some Plan providers participate in a physician incentive plan (PIP) that places a physician or physician group at financial risk for the care of Medicare members. UHP continuously monitors the potential effects of the incentive plan on access and quality of care. To that end, the QMSC committee reviews utilization data (at least quarterly) to identify patterns of possible under-utilization of services that may be related to the incentive plan, (e.g., low rates of referral services ordered by physicians at risk for the cost of such services). Concerns identified as a result of this monitoring are considered in the development of UHP's focus areas for QIPs. When necessary, educational, corrective and/or remedial actions (up to and including contract termination) are taken to address any access or quality of care issue identified.

4.4 HIPAA and Privacy Law Compliance

UHP utilizes a HIPAA-compliant transaction system. The Compliance Officer is responsible for receiving, reviewing, and disseminating within the Plan all HIPAA and privacy laws, as well as professional standards of health information. The Compliance Officer also conducts periodic reviews of the Plan's operations and evaluates the Plan's operational compliance with confidentiality-related laws and standards.

Access to Plan data is given only to those team-members directly involved with the day-to-day operations of the transaction system, including claims, enrollment, customer service, authorizations and grievance and appeals. IT assigns system-access and authorization protocols for personnel, based on pre-determined categories.

Valid and retrievable back-ups are available for information systems used by the Plan. The Plan utilizes procedures to monitor and track hardware and software containing confidential information, in accordance with HIPAA rules.

Upon discovery of any deficiencies with regard to HIPAA and privacy laws, or professional standards of health information system management, the Compliance Officer develops and communicates a corrective action plan, and oversees implementation of the action plan. The Compliance Officer measures effectiveness of the action plan and implements additional control measures, as necessary to maintain HIPAA-compliant processes and systems.

5 Quality Data Reporting

UHP has processes to develop, compile, evaluate, and report certain measures and other information to CMS, members, and the general public. UHP reports, at the times and in the manner that CMS requires, the following information:

- ◆ Cost of operations;
- ◆ Patterns of utilization of services;
- ◆ Availability, accessibility, and acceptability of Medicare approved and covered services;
- ◆ To the extent practical, developments in the health status of its members;
- ◆ Information demonstrating that UHP has a fiscally sound operation;
- ◆ Other information that CMS may require, including HEDIS®, CAHPS® and HOS measures.

All reports are reviewed by the responsible department, prior to submission to regulatory or accreditation bodies. UHP measures its performance using standard measures established or adopted by CMS and reports its performance to the applicable agency. The Plan will achieve any minimum performance levels established by CMS with respect to the standard measures.

5.1 HEDIS® Reporting

The Plan participates in the annual reporting of Healthcare Effectiveness Data & Information Set (HEDIS®) Performance Measures. These measures allow the Plan to evaluate and monitor improvements. HEDIS® data is comprised of enrollment, claims, encounters, and medical record review.

The Plan contracts with an NCQA-certified auditor and use an NCQA-certified software vendor to collect HEDIS® data and promote data integrity and accuracy. HEDIS® results are submitted to NCQA via the Interactive Data Submission System.

5.2 Health Outcomes Survey (HOS) Reporting

The Plan participates in the annual reporting of outcome related physical and mental health measures through the annual Medicare HOS, per CMS guidelines. The Plan contracts with a vendor to conduct the HOS survey, who submits the required contract information according to CM guidelines. UHP uses results of HOS surveys to identify potential quality improvement activities.

5.3 CAHPS® Survey Reporting

Annually, the Plan participates in the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, to include survey of Plan Medicare members. This survey is conducted by an approved Medicare CAHPS® vendor, using a plan-provided member sample. The vendor conducts the CAHPS® survey and provides CMS and the Plan with the final survey results.

The Quality Management Department analyzes members’ perceived experience with the Plan, based on members’ responses to a survey of care experiences that they think are important and their assessments of the quality of care and services received. Results are analyzed to identify improvements or opportunities for Plan-wide improvements to the quality of care and services provided to Plan members, as well as member satisfaction. Results are compared annually to national benchmarks to assess the Plan’s performance compared to another plans nationally and reported to the QMSC.

5.4 Part C Reporting

The Plan analyzes and reports Medicare Part C data in accordance with CMS requirements and specifications set forth in the Medicare Part C Plan Reporting Requirements and Part C Technical Specifications documents. Reports include grievances and appeals, and organization determinations and reconsiderations. UHP maintains a process to develop, compile, evaluate, and report information to CMS as required.

5.5 Part D Reporting

The Plan analyzes and reports Medicare Part D data in accordance with CMS requirements and specifications set forth in the Medicare Part D Reporting Requirements and Part D Technical Specifications documents. Reports include enrollment and disenrollment, grievances, drug utilization review controls; coverage determinations and redeterminations, and other matters as required by CMS. As part of its Part D reporting, the Plan also follows reporting requirements with regards to its Medication Therapy Management Program (MTMP), which addresses Part D cost control and quality improvement. Pharmacy data is provided by the pharmacy benefits manager, and is maintained as part of the health information system.

6 Quality Program Resources

6.1 Training

Staff affiliated with quality management are expected to maintain updated knowledge about principles of quality management. This includes requirements and protocols developed by regulatory agencies, such as the Centers for Medicare and Medicaid Services and applicable accreditation guidelines.

New employees in departments with member or provider contact receive orientation to quality management and risk management during new employee orientation. Orientation includes member safety, adverse incidents, quality of care issues, and reporting requirements.

6.2 Staffing

The Quality Department includes staff with expertise in quality management and clinical risk management. Staff is required to demonstrate knowledge of quality management principals, data management, and clinical health outcomes.

6.3 Quality Process Documents

The Quality Management Program includes supporting policies and procedures, which outline the processes required for the Program and annual Quality Management Work Plan. These policies and procedures are reviewed at least annually, and updated at the time of any changes to applicable accreditation or regulatory requirements. Quality Management Program policies are incorporated by reference as a component of the Quality Management Program.

7 Program Approvals

The Quality Management Program is reviewed and approved annually by the QMSC and the BOD with documentation of the approval in meeting minutes. Approval dates are indicated on the Program.

7.1 Approvals

Approved by the BOD

Approved by the QMSC

Approval by the Medical Advisory Committee (MAC)