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 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 a provider (Innovative Clinical Partners) to review medical records to validate accuracy of claims and encounter data submitted for RAPS (Risk Adjustment Process Submission). The provider 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), developing the Quality Management Work Plan, and evaluating the impact and effectiveness of the Program via the annual Quality Management Program evaluation process.

Data is reviewed by the Quality Management Department, Committees, and others, as appropriate, and utilized to suggest new and/or improved Quality Management 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 enrollees 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 enrollees. 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 Ultimate'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, enrollees, 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 enrollees;
- Information demonstrating that UHP has a fiscally sound operation;
- Other information that CMS may require (e.g. 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 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 will also participate in the annual reporting of specific out-come related physical and mental health measures via the annual Medicare HOS, per CMS guidelines, once membership requirements are met. The Plan will annually contract with a HOS vendor to conduct the HOS survey, and will submit the required contract information according to CM guidelines.

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 analyzes the sample, conducts the CAHPS® survey and provides 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 received. Results are reported to the Quality Management Steering Committee, and are analyzed by the Committee and the Quality Management Department to identify improvements or opportunities for Plan-wide improvements with regard to the quality of care and services provided to Plan

members, as well as member satisfaction. Results are compared annually to benchmarks (National CAHPS Benchmarking Database) to assess the Plan's performance compared to other Plans nationally.

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 Technical Specifications Document". Reports include benefit utilization, procedure frequency, serious reportable adverse events, provider network adequacy, grievances and appeals, and organization determinations and reconsiderations.

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" document. Statistics include the cost of operations; patterns of utilization of services; availability, accessibility, and acceptability of services; information demonstrating the Plan maintains a fiscally sound operation; and other matters as required by CMS, and as defined by requirements in the application, guidance, or other documents. 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 obtained from the pharmacy benefits manager, and is maintained as part of the health information system.

6 Quality Program Resources

6.1 Training

All staff in the Quality Management department and participants in the Quality Management Steering Committee receive specific training regarding quality. This training includes 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. Both internal and external 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 Quality Management Steering Committee 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 Quality Management Steering Committee (QMSC)

Approval by the Medical Advisory Committee (MAC)