Aspirus Health Plan, Inc.

Commercial – Exchange
Medicare Advantage

Quality Improvement Program Description

2024

Contents

Mission, Vision and Commitment to our Members

Introduction

The Quality Improvement Program (QIP) is the framework for a formal process to assess and monitor our performance through a systematic approach of monitoring and evaluating the quality and effectiveness of care for our members. This approach enables Aspirus Health Plan (AHP) to focus on issues of appropriateness, efficiency, safety, as well as health outcomes and satisfaction of our members and their providers. This is achieved by continuous monitoring of our performance according to, or in comparison with, objective measurable performance standards. The QIP promotes accountability and assures identification and evaluation of issues that impact our ability to better our performance and improve health care and administrative services provided to our members.

AHP's QIP applies to the following products:

- Individual & Family Plans On and Off Exchange
- Fully Insured Small & Large Group Commercial
- Medicare Advantage

Mission

AHP will deliver direct access to high-value, personalized health care that aims to improve your health and well-being through all your health care needs.

Quality Vision

The AHP Quality Improvement Program drives organizational improvement for excellence through efficiencies, increasing the competitive advantage, building trust and recognition in the community to improve the health status, safety, and satisfaction of our members.

Commitment

Provide cost-effective, high-quality health care services. We're working to ensure you have a positive experience with every part of the delivery system—physicians, hospitals, affiliated providers, and corresponding administrative services. We will focus on you by coordinating care, encouraging overall well-being, and limiting waste.

Integrate your health care so that your personal needs and preferences are considered. We'll work with you to develop your personal path to long-term well-being. Why? Because health care that is appropriate for you is better for your health and better for your wallet. You don't want to waste your time and money going through unnecessary procedures to address a health issue. You want results. With health care and health insurance connected and working for you, your doctor can tailor your treatments for maximum results.

Improve the communities we serve. AHP is a Wisconsin company with many employees who have grown up in and around the communities that we now serve. Health care is changing—massive, multi-state corporations are attempting to control more health care decisions and centralize services. We are committed to serving, volunteering, and supporting many of the organizations and foundations that make our communities great.

Program Structure & Objectives

The Quality Improvement Advisory Committee (QIAC) provides structure for promoting and achieving excellence in all areas and at all levels of the organization. The QIAC has oversight for the structure and resources that are to be reviewed throughout the calendar year.

The QIAC relies on industry standards set by regulators, accrediting organizations and "best practices" as a guide throughout the year. The use of data collection and analysis is critical to identifying populations and subpopulations, opportunities for improvement, implementing interventions, evaluating and measuring effectiveness of those interventions, and process improvement following the Plan-Do-Study Act (PDSA) approach.

Program Goals

The primary goal is to integrate all existing quality activities into one comprehensive program for monitoring activity, sharing ideas over multiple programs, focusing resources and promoting programs. The QIP goals are achieved through the integration and coordination of AHP's clinical and non-clinical services guided by these specific goals and key objectives. The following goals are the areas of focus and priority. Our guiding principle is to provide services that are evidence-based and data-driven for the safety and welfare of our members.

Goals:

- Ensure an objective and systematic approach to monitoring, evaluating, improving and communicating the quality, safety and value of care and services provided to AHP members and other customers.
- Maintain National Committee for Quality Assurance (NCQA) accreditation for Commercial and Exchange plans.
- Maintain compliance with accreditation and regulatory requirements.
- Protect confidential personal health information.
- Provide an adequate and accessible network of qualified practitioners and providers through credentialing, peer review and contracting processes.
- Exceed member experience expectations.
- Monitor the quality of care provided for our members and address their concerns.
- Implement a population health management strategy to address the needs of members across the continuum of care and address social risk factors and health care disparities.
- Focus on maintaining and improving member health through Medicare Star Ratings by a achieving a 4 Star Rating for Star Year 2025.

Objectives:

- Monitor QIP quarterly to assess progress and resource allocation.
- Develop, review and report on the annual QIP work plan.
- Assess and evaluate effectiveness of health plan activities.
- Monitor Quality of Care for all members by responding to and facilitating resolution of member complaints.
- Assess and evaluate delegated activities.
- Monitor and align accreditation with process improvement teams.

Information about the AHP QIP is available electronically. Paper copies are available upon request.

QI Program's Functional Areas and Responsibilities

The QIP includes all aspects of services provided by health plan practitioners, providers, and staff. The plan arranges for the provision of comprehensive health care delivery through a network of primary care and specialty practitioners, behavioral health practitioners and clinicians, ancillary care provider hospitals, pharmacies, and other health facilities.

AHP credentials providers using workflows and processes aligned with NCQA Health Plan Accreditation requirements and contracts with individual practitioners, provider organizations, facilities, and institutions to deliver health care and service to all members.

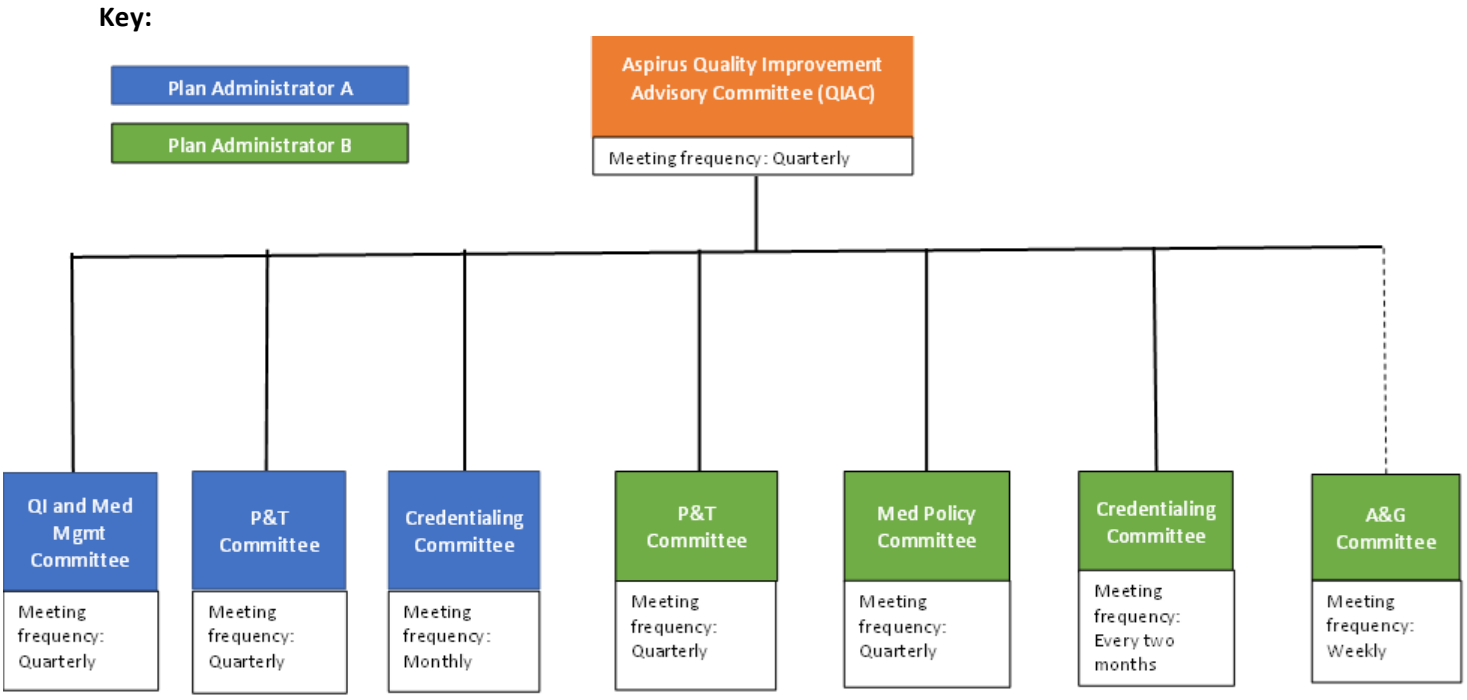
The QIP provides an organizational process that supports ongoing improvement of care and service. The program is responsive to the changing needs of the health care environment and the standards established by our local medical community and national regulatory and accrediting bodies.

QI Committee Organizational Structure

The committee structure and responsibility for the Quality Improvement Advisory Committee (QIAC) is described as follows. The AHP Board of Directors has designated the Quality Improvement Advisory Committee (QIAC) to oversee quality improvement activities. The Medical Directors oversee QIAC. The QIAC oversees the plan administrators' quality committees and AHP Grievance and Appeals Committee.

Each committee is required to record meeting minutes. The exception to this is the Grievance and Appeals Committee due to the meeting content being primarily protected health information. Database information and individual files are maintained. All other meetings are dated and signed by the committee chair when approved. Summary reports are submitted to QIAC on, at minimum, a semi-annual basis.

2024 Aspirus Health Plan Quality Improvement Program Structure



P&T = Pharmacy and Therapeutics
A&G = Appeals and Grievances
QI = Quality Improvement

Quality Improvement Program Resources

Overarching Committee Members for Medicare Advantage, Commercial & Exchange Product Lines:

Medical Directors: Are responsible for oversight of the Medicare Advantage, Commercial and Exchange product lines and supports the evaluation and promotion of activities consistent with high quality clinical standards and appropriate

cost-effective use of health care. This is accomplished by seeking input from network providers in the development of criteria and policies utilized for utilization review.

Director of Operations and Compliance: Is responsible for the Aspirus Health Plan Quality Program and delegation of program components and oversight of regulatory compliance and HIPAA privacy. Assists in the development and monitoring of annual performance and workplans. Presents QIAC minutes and program updates to the Aspirus Health Plan Board of Directors.

Quality Improvement Specialist: Is responsible for the Aspirus Health Plan Quality Program, oversight of delegation agreements, NCQA standards, Stars Program, and Population Health Management.

Director of Care Coordination: Is responsible for the oversight of Care Coordination which is providing Integrated Care Management to commercial and exchange product lines including Complex Care Management and Disease Management. Responsibilities include monitoring and assessing the quality and safety of care provided and summarizing and presenting performance measures.

Director of Behavioral Health (BH): The Director of Behavioral Health is involved in the BH aspects of the Quality Improvement Program. BH practitioners serve on the QIAC, Medical Policy, Credentialing and other ad hoc committees and teams.

Director of Government and Pharmacy Programs: Is responsible for overseeing government lines of business, pharmacy programs for all lines of business, and vendor issues related to the plan's Pharmacy Benefit Manger (PBM).

Commercial & Exchange Product Lines:

Chief Medical Officer (CMO): The CMO supports relationships with contracted care systems to ensure implementation of utilization and quality management strategies. The CMO supports the evaluation and promotion of activities consistent with high quality clinical standards and appropriate cost-effective use of health care resources. The CMO creates and facilitates an environment that is conducive to and supportive of the exchange of ideas and information to encourage the delivery of high quality medical services within network. This is accomplished by seeking input from network providers in the development of criteria and policies utilized for utilization review. Specific responsibilities of the CMO include review of individual cases for medical necessity/appropriateness, review/oversight of quality of care complaint investigations, review of credentialing activities, and oversight of mechanisms to monitor, evaluate and improve upon the appropriateness, effectiveness and efficiency of services delivered within the network.

Associate Medical Director for Behavioral Health: The Associate Medical Director for Behavioral Health is a physician with education, training, and professional experience in medical practice specific to behavioral health. They assist in providing guidance and evaluation for mental and substance-related disorders activities which affect the services provided to health plan members. Specific responsibilities include: review of individual cases for medical necessity/appropriateness; review and advise on necessary mechanisms to monitor, evaluate, and improve the appropriateness, efficiency and effectiveness of services delivered; review and advise on the development and use of guidelines and protocols; review quality of care complaints related to the delivery of services and advise on appropriate actions; advise on payer, provider, and patient communications to make them consistent with high-quality service standards; and represent the organization as requested on matters of clinical practice before such groups as: the organization's clinical practitioners/providers, contracting employers; the community; and legislative or regulatory agencies. This position reports to the CMO.

Director of Quality Management (QM): The Director of QM is responsible for the overall direction, implementation, and management of QM Program in conjunction with executive leadership. Responsibilities include monitoring and

assessing the quality and safety of care provided and developing an annual QM work plan and program evaluation. Staff associated with the program support QM activities by managing quality improvement initiatives, analyzing performance measures, reviewing clinical records, overseeing the quality of care complaint investigation process, following up on corrective actions, and preparing and presenting summary reports of performance measures.

Quality Improvement Specialist: The Quality Improvement Specialist is responsible for assisting with the operational components of the Quality Improvement Program and NCQA Accreditation. This includes project coordination of Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems surveys (CAHPS), other quality initiatives, and state and federal reporting requirements. The Quality Improvement Specialist reports to the Director of Quality Management.

Healthcare Analytics Team: The Healthcare Analytics Team, including a dedicated Health Care Analyst, generates reports and statistical analysis to assist with HEDIS/CAHPS, NCQA Accreditation and other quality initiatives. This position reports to the Manager, Analytics Support Team.

Additional resources: The following individuals and departments provide additional key resources and guidance to the Quality Program: Provider Contract Managers, BPO Medical Management Manager and staff, Associate Director of Operations Support and staff, Operations Manager and staff, and the Director of Data Science and staff.

Medicare Advantage Product Line:

EVP/Chief Medical Officer: The Executive Vice President/Chief Medical Officer serves as a member of the senior management team, participating in strategic planning and policy direction for the organization, providing leadership and guidance on clinical strategic initiatives and operations to ensure high quality, cost-effective care for members. The Chief Medical Officer manages relationships with contracted care systems to ensure implementation of utilization and quality management strategies. In addition to these key responsibilities, the Chief Medical Officer supports the development, implementation, maintenance, and evaluation of quality improvement, population health, utilization review, and care management activities of the health plan in conjunction with other Medical Directors and staff in Clinical Services, Health Services Operations, Mental Health and Substance Use Disorder Services, Pharmacy, and Care Coordination and Long Term Services and Supports (LTSS).

Vice President of Health Services and Quality Operations: The primary objective of this position is to provide strategic direction and oversight for the Health Services and Quality Operations strategic initiatives. This position provides leadership for the development, implementation, and evaluation of the Quality and Population Health Program. In addition, this position is responsible for the strategic planning and oversight of the Chronic Care Improvement Program and Star Ratings Programs. This position also ensures achievement of operational goals for Credentialing, Appeals and Grievances, and Utilization Management.

Quality and Population Health Director: The Quality and Population Health Director is responsible for the development, management and accountability of quality improvement initiatives within the department in support of the organizational Quality and Population Health Program. This position provides leadership for related projects, surveys, reports and audits. Additional responsibilities include development and management of the Quality and Population Health teams, oversight of quality and population health strategies, ensuring timeliness of overall quality initiatives, and managing regulatory quality and population health requirements. This position also provides oversight of the Star Ratings programs, Health Effectiveness Data and Information Set (HEDIS) chart retrieval data, and member engagement activities through the Health Improvement Team.

Health Services Operations Director: The Health Services Operations Director is responsible for the oversight of operational processes related to Credentialing and Appeals and Grievances (A&G), which includes creating optimal performance, quality assurance, and efficiencies. This position is responsible for ensuring that Credentialing and A&G

meet all regulatory and accreditation requirements based on legislative mandates and UCare's strategic direction. In addition, this position providers leadership for project administration team, including training, vendor management, and special projects.

Utilization Management Director: The Utilization Management Director is responsible for the oversight of operational processes related to Utilization Management, which includes creating optimal performance, quality assurance, and efficiencies. This position is responsible for ensuring that Utilization Management meets all regulatory and accreditation requirements based on legislative mandates and UCare's strategic direction.

Health Services and Quality Operations Department: The Health Services and Quality Operations Department includes Appeals and Grievances, Credentialing, Population Health, Quality Improvement, Health Improvement, HEDIS chart retrieval and abstraction, Stars Ratings, Health Services Informatics, Health Equity, Disease Management, and Utilization Management. The functions of each of these areas is described below:

- Appeals and Grievances (A&G) and Credentialing: The A&G team receives, processes, and resolves all appeals and grievances from members or member representatives. In addition, this team facilitates Quality of Care. The Credentialing team manages data in the credentialing database, processes credentialing and recredentialing applications, and conducts delegation oversight.
- Quality Improvement (QI), Health Improvement HEDIS, Stars and Population Health: The QI and Stars teams design, develop, implement, evaluate and report on evidence-based quality improvement programs as they relate to the strategic and annual quality plan. The Health Improvement team leads member engagement activities to provide health education to improve the overall health of our members. The HEDIS team develops and implements initiatives that enhance the organization's medical record review functionality for HEDIS hybrid measures and other Quality Management needs. The Population Health team develops and maintains the population health strategy, population assessments and supports an inventory and evaluation of programs to support the needs of our members.
- Health Services Informatics: The Health Services Informatics team develops analyses and reporting that support the organization to understand and monitor performance, breakdown key drivers, and identify opportunities for improvement. In addition, the team supports operation and strategy of the organization's clinical documentation system.
- Disease Management: The Disease Management team develops, implements, and evaluates disease management programs and associated clinical initiatives focused on prevention, early identification, and intervention in the chronic disease process.
- Utilization Management: The Utilization Management team implements an evidence-based utilization management program and evaluates and monitors the use of non-behavioral health and behavioral health care services to assess their appropriateness and quality.

Health Care Economics: The Health Care Economics (HCE) department supports quality initiatives through data mining, statistical analysis, quality improvement reporting, clinical support, and actuarial analysis. HCE consolidates claims data with supplemental data, submits the data to the certified HEDIS Vendor, and oversees comprehensive documentation of all HEDIS processes. HCE team supports production of final HEDIS measures, works with the auditor to ensure a timely data audit and submits final rates to NCQA. HCE provides planned and ad hoc reporting and analytic assistance with identification of target population and program evaluations.

Additional resources: The following individuals and departments provide additional key resources and guidance to the Quality Program: CEO, Medical Directors, Mental Health and Substance Use Disorder Services Medical Director, VP Clinical Services and staff, VP Mental Health and Substance Use Disorder Services and staff, VP Chief Compliance and Ethics Officer and staff, VP Customer Services and staff, VP Government Relations and staff, VP Chief Informatics Officer

and staff, VP Chief Marketing and Digital Officer and staff, VP Product Management and staff, and VP Provider Relations and Contracting and staff.

Involvement of Designated Physician

Medical Director: The Medical Director is responsible for the oversight of Medical Management including the QIAC. The Medical Director is responsible for ensuring implementation of all aspects of the Integrated Care Management Program. The Medical Director reports to the President of Insurance Operations and reports to the Executive Staff on Quality issues and updates.

Involvement of Designated Behavioral Healthcare Practitioner

Behavioral Healthcare Practitioners: Behavioral Healthcare Practitioners are involved in the BH aspects of the Quality Improvement Program. BH practitioners serve on the QIAC, Medical Policy Committee, Credentialing Committee and other ad hoc committees and teams. The behavioral healthcare practitioner must be a medical doctor or have a clinical PhD or PsyD and may be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate.

Resources and Analytical Support

Data Sources and Monitoring Methods

The QIP utilizes claims information, medical record information, predictive modeling, and data supplied by delegates to perform program functions. Resources currently available for support of quality improvement activities include the following:

Commercial & Exchange Product Lines:

- FACETS System – System used for enrollment, premium billing, claims payment, Integrated Care Management, member services, phone log and complaint tracking. Data from the system populates in the data warehouse and is used for a variety of purposes.
- Aerial and iExchange are used for prior authorizations and Integrated Care Management operations.
- Grievance – Database used to track Grievances. Includes various coding for report generation to use for tracking and trending data.
- Provider Network Database – Used to track provider contract information, locations, specialties, and billing addresses. It is used to generate provider directories.
- Optum – HEDIS software and analysis.
- Advent Advisory – Auditor of HEDIS data.
- Press Ganey – Vendor used to conduct standard survey and analysis for CAHPS, and Enrollee Experience Survey (QHP).
- Other resources allocated as needed.

The Director of Analytics is responsible for having the Analytics Team generate reports and statistical analysis to assist with HEDIS, CAHPS/QHP, NCQA accreditation and other quality initiatives.

Medicare Advantage Product Line:

Enterprise Data Warehouse (EDW) integrates data from a variety of sources and supports data and analytics solution needs. EDW data can be accessed using Microsoft™ SQL Server Management Studio or SAS®. EDW consolidates and stores clinical and non-clinical data for all members, providers, and products. Examples of data include enrollment, member eligibility, members' demographics, medical and pharmacy claims, providers, clinical, regulatory, legal, and financial data. EDW integrates non-clinical members' and claims information with additional clinical data including lab values, health risk assessments, provider-submitted patient histories, and medical record review abstractions to perform

a broad range of analytics. EDW includes John Hopkins ACG™ resource utilization bands. This tool is used to define several strata of illness levels ranging from perfectly healthy to critically ill, and multiple categories of increasing levels of illness in between the strata. This is helpful in predicting and prioritizing members for inclusion in population health management gap programs. Additional analytic tools are used to enhance analytical capabilities and allow for flexibility in analyzing data include Business Objects ™, Python ™, Tableau™. Business Objects™ is the ETL tool utilized to extract, transform and load data to and from the EDW from multiple disparate sources and to obtain and share data with external partners. It is a centralized suite for data reporting, visualization, and sharing. UCare is using Python ™ to automate SQL code and export to Excel sheets for reporting, and statistical analysis. Potential use cases include forecasting, gaps closures or annual quality ratings (Stars, QRS, Medicaid). Tableau ™ allows connection to data and visualization using combination of dashboard views to get richer insight.

Data quality programs are in place to rigorously check and confirm the quality and timeliness of the EDW data, including completeness and consistency with originating data sources.

In addition, a NCQA-certified HEDIS software vendor supports, calculates, and measures HEDIS results. An NCQA accredited auditor performs auditing of final rates prior to reporting them to NCQA. An external vendor is also used to conduct standard survey and analysis for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and Health Outcomes Survey (HOS).

Altruista Health's GuidingCare Platform integrates all activities and functions required for optimal population health management and care coordination, including case management, disease management, behavioral health, health promotions, utilization review and appeal and grievance cases. It enables all users along the care continuum, including case managers, health coaches, member engagement specialists, clinical pharmacists, and utilization reviewers, to interact, collaborate and share a single member record.

Delegated QI Activities

AHP has designated two plan administrators as delegates for its products. In the scope of NCQA Standards, many Quality Management and Improvement, Population Health Management, Network Management, Utilization Management, Credentialing and Recredentialing, and Member Experience standards have been delegated to these plan partners to perform on AHP's behalf. AHP formally adopts its delegates' documented processes through its governing body.

Plan administrator delegates will conduct delegation oversight of AHP's other delegate partners to fulfill oversight requirements.

AHP has additional delegates in the areas of Credentialing and Recredentialing, Utilization Management, and Member Experience.

The QIAC monitors delegated agency performance through approval of the delegate's program, routine reporting, and annual (or more frequent) evaluations and/or audits to determine whether the delegated activities are being carried out in accordance with NCQA and/or and CMS Medicare Managed Care Manual. If monitoring reveals deficiencies in the delegate's processes, AHP will work with the delegate to set priorities and correct the problem(s).

The Credentialing Committees monitor subdelegate performance through initial review and approval of the delegate's program, routine reporting, and annual evaluations to determine whether the delegated activities are being carried out in accordance with NCQA and health plan standards. If monitoring reveals deficiencies, the plan administrators will work with the delegate to establish a corrective action plan and resolve the problem(s).

Collaborative QI Activities

A focus of the QIP, in conjunction with the Quality Team, is to conduct outreach and collaborate with provider groups. The goals for outreach include quality improvement project collaboration, HEDIS improvement opportunities, and medical coding best practices.

Quality Improvement Project Collaboration:

The Quality Team will continue to develop and maintain relationships with provider groups, state and community partners to achieve the QIP goals. The goal is to collaboratively identify opportunities for improvement and work together on joint initiatives to strengthen the level of service for our members. These initiatives focus on coordination and continuity of care between medical facilities and behavioral health services and the expansion of availability to behavioral health services overall.

HEDIS Improvement Opportunities:

The Quality Teams will collaborate with NCQA Certified HEDIS vendors to report Medicare Advantage, Commercial, and Exchange HEDIS data for AHP in 2024 for the HEDIS Measurement Year 2023. Analyses in 2023 were conducted and opportunities for improvement were identified and appropriate work plans developed to address these opportunities. Continued monitoring of HEDIS rates and analysis with be conducted in 2024 to determine impact of improvement efforts.

Medical Coding Best Practices:

The Medical Coding team works to identify common medical coding errors seen in claims from our main provider groups. The purpose is to find trends that can be easily corrected through outreach and education to reduce errors and speed up the claims adjudication process.

Behavioral Healthcare (BH)

AHP partners with professionally trained and licensed BH providers and practitioners to improve the overall mental health and substance use disorder outcomes of its members. Through participation in QIAC and quality committees, physicians and licensed clinical social workers provide key input and insights, assisting AHP in building a strong, robust BH program and network to support all members.

BH QI activities are integrated into the QIP through regular reporting and through regularly scheduled workgroup meetings, which provide ongoing monitoring of BH services. Focus areas include:

- Develop collaborative partnerships and initiatives to monitor and improve behavioral health care.
- Collaborate with BH network providers in identifying and resolving gaps of access for our members.
- Analyze claims reporting and pharmacy data to identify the behavioral health needs of our members.
- Collaborate with our BH providers to improve continuity and coordination of care between behavioral and medical health care providers.

Patient Safety

AHP fosters a supportive environment to help practitioners and providers improve safety of their practices through the following activities:

- **Clinical Practice Guideline Process**: Establishes best practice criteria based on national and state evidence-based practice guidelines to reduce variation in the care delivered to members.
- **Credentialing/Re-credentialing Process**: Ensures members are provided with a choice of qualified, competent practitioners and providers. Criteria for credentialing and re-credentialing include primary source verification, practitioner/provider specific complaint data, and practice site/medical recordkeeping assessment where

indicated. In addition, the Credentialing Committees meets monthly for the ongoing monitoring of practitioner sanctions and complaints between credentialing cycles.

- **Care Coordination**: Monitors members and alerts physicians when the member changes status to higher risk.
- **Expedited Appeals Process:** Provides for the assessment of and action on an appeal of a medical necessity denial based on the urgency of the request.
- **Medical Technology Request:** Allows for review of the efficacy of the technology based on national research data and local medical practice.
- **Member Complaint Process**: Complaints are tracked and trended by category and reported at least semiannually to QIAC. When a complaint suggests there is a potential for poor quality of care, the complaint is referred to a Medical Director and further review and investigation is completed. If there is a question of poor quality of care or unsafe practice, the occurrence is referred to the Credentialing Committee.
- **Quality of Care Complaints**: A documented process for addressing member quality of care complaints to ensure patient safety. Documented process is separate from Medicare Advantage to Commercial/Exchange.
- **Pharmaceutical Management Program:** Development and maintenance of drug usage criteria, assessment of the efficacy of new drugs or a new use for an existing drug, monitoring of indicators relating to polypharmacy and misuse of medication. Monitoring of drug interactions to ensure patient safety.
- **Population Health Management Program:** Population Health Management Strategy includes four areas of focus that monitors member's health status: 1) Keeping Members Healthy, 2) Managing Members with Emerging Risk, 3) Patient Safety or Outcomes Across Settings, 4) Managing Multiple Chronic Illnesses.

Serving a Diverse Membership

AHP's objectives for serving a culturally and linguistically diverse membership are to:

- Evaluate membership demographics using internal data, US Census Report by county and CAHPS profile.
- For commercial and exchange, monitor availability of practitioners speaking foreign language with sufficient fluency to treat a member who only speaks that language.
- Monitor responses from the group enrollment questionnaire regarding languages spoken by employees.
- Maintain and monitor interpreter services lines to support culturally competent communication.
- Monitor and review an action plan to address the cultural and linguistic needs of our membership if warranted by the above activities including availability of appropriate educational materials and information updates for members.

Serving Members with Complex Health Needs

AHP helps members with multiple or complex conditions to obtain access to care and services and coordinates their care. AHP annually assesses the needs of the member population, identifies candidates for the program through a series of algorithms and clinical intelligence rules, and assists the identified population using an evidence-based program.

Clinical Outcomes

Clinical quality and outcomes will meet or exceed regionally and/or nationally established standards. Objectives:

- Incremental positive improvements to strive to move the organization to a 5-Star rating by NCQA and CMS for Commercial and Exchange.
- Achieve a 4 Star Rating for CMS Medicare Stars for 2025 ratings for Medicare Advantage.
- Every two years adopt and disseminate updated medical and behavioral health Clinical Practice Guidelines to be published on the AHP website.
- Annually review and adopt updated versions of MCG Clinical Guidelines for coverage determination.

- Promote preventive care guidelines to improve HEDIS effectiveness such as well child visits and immunizations.
- Collaborate and participate with the Chronic Disease Quality Improvement Project for the State of Wisconsin to promote our Population Health Management program of Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Hypertension and Diabetes.
- Support member health through wellness and prevention programs.
- Support and collaborate with network providers exchange of data analytics for population health management.
- Analyze and address the existence of significant health care disparities in clinical areas.

Member Experience Outcomes

Members will experience the highest level of quality service. This includes positive interactions between our members and our staff. Objectives:

- Analyze CAHPS and Enrollee Experience Survey results annually and target improvement initiatives for low scoring areas.
- Analyze member complaints and grievances semi-annually to initiate improvements as needed.
- Analyze member service and telephone access indicators semi-annually.
- Survey key leaders of provider networks regarding clinical criteria for utilization management decisions and new technology.
- Collaborate with the AHP Member Advocates for addressing general member concerns.
- Continue to assess the need for culturally competent communication and provide information, training and tools as needed.

Commercial and Medicare Advantage Annual Quality Improvement Work Plans

A separate Quality Improvement Program Work Plan is formulated annually for the commercial product line and Medicare Advantage product line. The Work Plans include the following:

- Quality Initiatives
- QI Activities and Key Objectives
- Program Scope
- Quality and Safety Initiatives
- Timeframes within which each activity is to be achieved
- Monitoring of previously identified issues
- Staff member(s) responsible for each activity
- Additional Resources
- Assessment and Evaluation of the Work Plan Activities

Separate Work Plan documents for Commercial/Exchange and Medicare Advantage products are developed and monitored. Where there are areas of collaboration across products it is noted as such.

Annual QIP Evaluation

The QIP is evaluated annually by the QIAC. The assessment and evaluation include the following:

- Description of completed and ongoing quality improvement activities from the work plan that addresses quality and safety of clinical care and quality of service.
- Trending of measures to assess performance in the quality and safety.
- Analysis of the results of quality improvement initiatives, including barrier analysis.
- Assessment and evaluation of the overall effectiveness of the Quality Improvement Program.

Separate Quality Program Evaluations for Commercial/Exchange and Medicare Advantage products are developed. The QIP evaluation findings are used to identify issues to demonstrate the impact of the program and to guide the development of the Work Plan for the following year.