Lighthouse
HEALTH PLAN

QUALITY IMPROVEMENT PLAN
2020 Program Description

Table of Contents

1. Introduction

Lighthouse Health Plan (the health plan) combines the resources of the region's premier hospitals and experienced physicians to provide a plan focused on providing members with access to services delivered through a network of practitioners who are treated as allies and who are trusted with, and held accountable for, decisions that affect their patients' care. The key to the organization's success is the valuable input of network practitioners who make decisions and recommendations based on valid, reliable data and sound measurement methodology. As a quality-focused organization, the health plan measures and monitors performance for various aspects of care and service delivered to members with a constant focus on desired outcomes.

The Quality Improvement Plan (QI Plan) program description and QI Workplan (*Attachment 2020 QI Workplan*) define the scope, goals, objectives, and necessary structure for promoting and improving quality of care and services while delivering health care in a cost-effective manner.

The QI Plan objectively and systematically monitors and evaluates access to care, and the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees, thereby promoting quality of care and quality patient outcomes in service performance to its enrollees. (42 CFR 438.330(a)(1) and (3); 42 CFR 438.330(b)(4); 42 CFR 438.340)

Program Scope

The health plan's QI program ensures enhancement of quality of care and emphasizes improving the quality of patient outcomes, including establishing metrics for monitoring the quality and performance of each participating provider. The health plan evaluates the provider's performance and determines continued participation in the network as specified by Florida Agency for Health Care Administration (AHCA) requirements.

The QI Plan provides an infrastructure to collect meaningful data, identify root causes, develop appropriate solutions, and implement plans to provide better health care. These improvements can occur at the individual level or system wide. The QI Plan establishes the framework to continuously improve the medical and mental health care services received by our members. The purpose of the QI Plan is to provide ongoing monitoring, evaluation and improvement in care, safety, and service to all members and practitioners/providers.

Program Goals

The QI Plan goals include:

- Provide high quality, accessible, and affordable health care and service to the membership through a qualified network of practitioners and providers who are

systematically selected and retained through the credentialing and performance appraisal process
- Maintain a health plan model that empowers the practitioner to make medical decisions, and enables the practitioner to proactively manage health care
- Coordinate preventive care, wellness efforts and chronic care management, ensuring efforts are member-centric
- Conduct operations in a manner that protects the confidentiality, safety, and dignity of all members
- Verify that the QI Plan is in compliance with, and responsive to, applicable requirements of federal and state regulators and appropriate accrediting bodies
- Meet the guiding principles of the Triple Aim by:
  - Improving the health of our members
  - Enhancing the member experience
  - Controlling the cost of care

Program Objectives

The QI Plan program objectives include:
- Prioritize activities that focus on issues relevant to the health care needs and the associated risks of our health plan membership
- Implement activities that address the cultural and linguistic diversity of the membership
- Establish a program to serve members with complex health needs
- Continuously monitor, evaluate, and improve the health delivery services, whether clinical or administrative, through the use of:
  - Credentialing and re-credentialing of practitioners and providers
  - Utilization, case, and population health management
  - Member satisfaction, inquiry, complaint, grievance and appeal monitoring
  - Practitioner / provider access and availability monitoring
  - Delegation oversight
  - Ongoing evaluation of continuity and coordination of care and service
  - Ongoing evaluation of patient safety
  - The refinement and provision of reliable, valid, and meaningful data necessary for the ongoing assessment of quality health care
  - Practitioner involvement in all aspects of the quality improvement process
  - Investigation of poor quality, poor service and patient safety issues when the potential is identified
  - Cultural and linguistic needs analysis of the membership

The Quality Improvement Process

In every approach to quality improvement, the health plan follows a consistent process. This process starts with understanding the needs and the relevance of these needs to our member population. It then continues with a traditional quality improvement approach, as described below.

This approach is applied towards improving areas of clinical importance, as well as the member experience. Quality improvement is implemented through a cross functional team approach, as evidenced by the Quality Improvement Committee (QIC) that is empowered to oversee and address the quality improvement activities of the health plan.

Through the continuous quality improvement cycle of Plan, Do, Study, Act, the health plan:

- Identifies, evaluates and prioritizes change or improvement opportunities based on the relevance to the health plan population (high-risk/high-volume)
- Uses a structured and systematic approach to identify opportunities for improvement in the effectiveness and efficiency of the health care delivery process
- Implements appropriate remedial action to achieve continuous quality improvement
- Provides common language and tools for problem solving techniques such as fishbone diagramming.
- Supports the basic quality value of managing by data and increases credibility and reproducibility of data by:
  - determining current performance
  - identifying benchmarks and establishing goals
  - performing root cause analysis
  - designing interventions and implementing improvement plans
  - monitoring and reporting results / findings to appropriate committee and/or authority, staff or department
  - holding gains made
  - continuing the cycle of improved performance by monitoring and identifying additional improvement opportunities and activities

The health plan identifies and tracks adverse or critical incidents and reviews and analyzes adverse or critical incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues. The health plan will make such tracking available to the AHCA upon request.

2. Accountability and Committee Structure

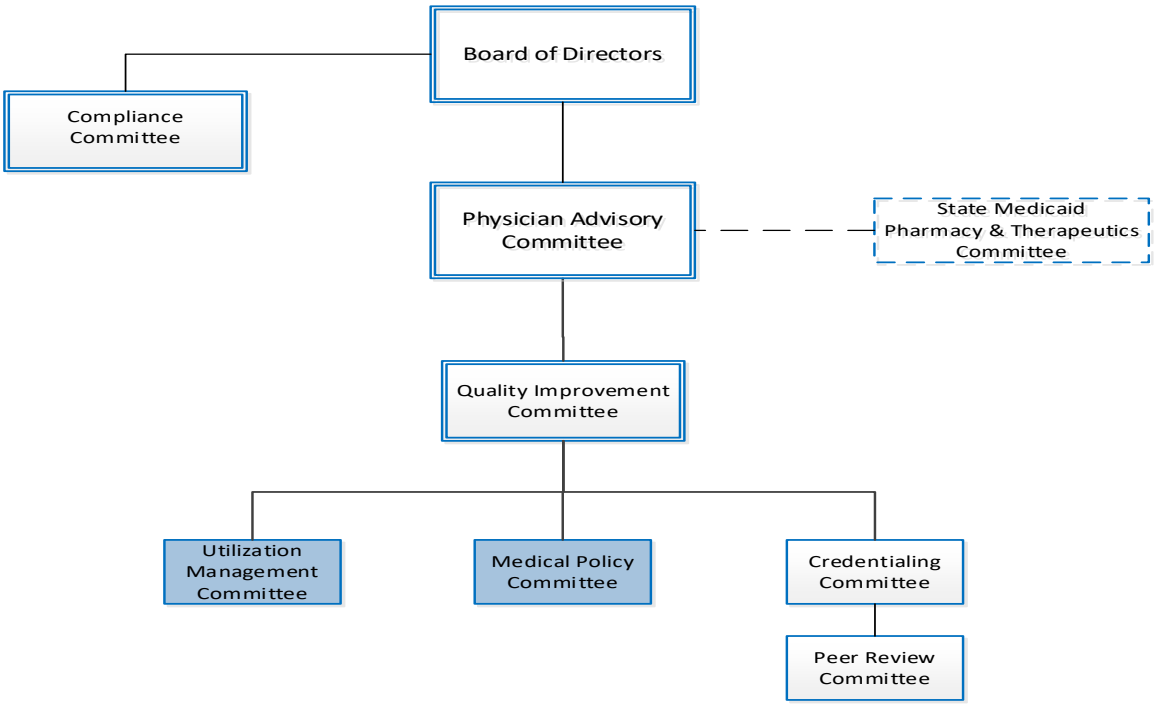
The QI Plan is ultimately accountable to the Board of Directors. The Board of Directors has delegated authority for oversight to the QIC. The Board of Directors shall oversee and evaluate the impact and effectiveness of its QI program. (42 CFR 438.330(e)(2); 42 CFR 438.310(c)(2)) The role of the Board of Directors shall include providing strategic direction to the QI program, as well as ensuring the QI plan is incorporated into processes throughout the health plan.

The health plan shall cooperate with the Agency and the EQRO including a cooperative agreement with the Florida Medical School Quality Network Initiatives (FMSQN) as directed by the Agency. The health plan shall use the methodology and standards for QI set by AHCA.

The Chief Medical Officer is responsible for oversight of medical and behavioral health clinical programs and functions, as well as medical policy and clinical practice guidelines. The Chief Medical Officer for the health plan is chair of the QIC and may be a member of other committees. In these roles he/she is directly involved with the review, evaluation, and recommendations related to the selection and ongoing monitoring of quality improvement and provider performance activities.

The QIC structure is designed to continually reinforce the practitioner-driven approach to quality care and service. The participating practitioner is the heart of the program, making decisions and designing methods to effectively and efficiently deliver care to members, with a continual focus on desired outcomes. The reporting structure is displayed in the following organizational chart followed by description of the committee's role, membership, role and responsibilities as required by AHCA.

QI Program Committee Structure



= delegated committee

The roles and responsibilities of these committees are outlined in the next pages. Some committee responsibilities may be delegated.

Board of Directors

Ultimate accountability for the QI Plan lies with the Board of Directors, which receives periodic performance monitoring reports and/or minutes from the QIC. The Board also reviews the annual program evaluation, work plan and program description.

Physician Advisory Committee

The Physician Advisory Committee has a role in supporting the design of clinical programs, Care Management and Utilization Management alignment including BH and Physical health, risk adjustment practice operations, population health quality programs, clinical ownership of medical expense, design of population health reports to physicians, physician and enrollee engagement and communications, as well as physician input into incentive and Value Base Care designs.

Quality Improvement Committee (QIC)

Membership: Chaired by the health plan Chief Medical Officer, the membership includes network physicians, a behavioral health care practitioner when needed, and individuals from key functional areas including but not limited to Appeals & Grievance, UM, CM, Credentialing, Risk Management, Member Services, and Provider Relations. This committee membership will be in alignment to AHCA contractual requirement.

The committee composition is designed to bring Medical Directors, network physicians and subject matter experts from various functional areas present quarterly reports to monitor and evaluate Health Plan program outcomes and trends.

Each of the committee members has a unique critical role to QI Program:

- Medical Director, Network physicians & Behavioral health care practitioner:
    - Chosen to serve in QIC so the Committee can obtain feedback directly from the provider community as these physicians are practicing in the region and are familiar with Medicaid population the health plan will serve. This is in addition to the physicians bringing clinical expertise and guidance to the health plan QI Program.
    - Provide clinical specialty expertise and oversight of quality and clinical programs, medical policy/clinical practice guidelines.
    - Review, evaluate, and recommend the selection and ongoing monitoring of quality improvement and provider performance activities.
    - Guide the QI Plan in addressing barriers using best practices
- Appeals & Grievances Representative
    - Chosen to serve in QIC as A&G representative has the direct communication with member, member's parent/guardian and provider as well has a firsthand experience on appeals, grievances and complaints outcomes, trends, barriers, and best practices.

    - Present quarterly G&A trends report and summaries
    - Identify barriers and opportunity for improvement as well as design mitigation strategies in consultation and collaboration with QIC
- UM / CM Clinician
    - Chosen to serve in QIC as UM and CM clinicians have the firsthand interaction and communication with members, parents/guardians, physicians and community resources.
    - Present quarterly Utilization Management and Care Management trend reports and summaries
    - Identify barriers and opportunity for improvement as well as design mitigation strategies in consultation and collaboration with QIC
- Credentialing Representative
    - Chosen to serve in QIC as the expert of credentialing process from application to credentialing committee. The expertise and knowledge in Credentialing processes, including but not limited to network/credentialed providers, network gaps, sanctions, networks concern etc. will be an asset to QIC.
    - Present quarterly Credentialing and Re-Credentialing report and summaries
    - Identify barriers and opportunity for improvement as well as design mitigation strategy in consultation and collaboration with QIC
- Member Service Representative
    - Chosen to serve in QIC, MS Representatives are the voice of members, parents/guardians and providers and will be able to bring concerns and solutions to QIC which will impact service delivered and satisfaction of our members and providers.
    - Present quarterly Member Service reports (call volume, abandon rate etc..) trend reports and summaries
    - Identify barriers and opportunity for improvement as well as design mitigation strategy in consultation and collaboration with QIC
- Provider Relations Representative
    - Chosen to serve in QIC, PR Representatives are the voice of providers and community resources that have a direct link between providers, members, members' parents/guardians and health plan.
    - Present quarterly Provider Relation trend report and summaries
    - Identify barriers and opportunity for improvement as well as design mitigation strategy in consultation and collaboration with QIC

Meeting Frequency: Quarterly, at a minimum, and more frequent as needed
Role/Responsibility: Review, evaluate, and provide direction with regard to performance evaluation, performance initiatives, monitoring and quality improvement activities as well as appropriateness of care provided to enrollees. This committee is also delegated authority by the Board of Directors for oversight of the quality improvement program not limited to trend

of quality of care and service concerns grievances, enrollee rights, adverse events, patient safety and utilization review processes through ongoing reporting by the appropriate department (Grievance & Appeals, UM etc.). The QIC receives information regularly on indicators including, but not limited to, medical, pharmacy and behavioral health utilization, member and practitioner satisfaction, clinical outcome metrics and initiatives, credentialing activities, clinical guidelines, quality of care review, health management initiatives, behavioral health initiatives, oversight of delegated activities, member safety, and confidentiality issues. The committee has the responsibility of evaluating and analyzing results of QI activities and recommending policy decisions, as well as specifying follow-up action and verifying that these actions are carried out. The QIC also has the responsibility of ensuring that there is practitioner participation in all areas of the QI program to receive input, direction, recommendations through well-defined discussions that are properly documented in meeting minutes. This structure and organization of QIC ensures appropriate program design and oversight are in place meeting enrollees' need and AHCA requirements.

State Medicaid Pharmacy and Therapeutics Committee (Delegated to Evolent Health)

Membership: Membership includes pharmacists and physicians from various specialties.
Meeting Frequency: Four times per year
Reports: Quarterly to the QIC
Role/Responsibility: Review, evaluate, and make recommendations related to pharmacy services. This includes utilization (under and over) of drugs, additions and deletions to the formulary, and monitoring and review of pharmacy programs and program results, as well as medical policies related to pharmacy utilization. Pharmacy functions, including formulary management, drug use evaluation (DUE), and authority for decision-making are delegated.

Utilization Management Committee (Delegated to Evolent Health)

Membership: Chaired by a physician, the membership includes medical directors, UM leadership and staff, and representatives from compliance, quality, analytics and network management.
Meeting Frequency: Four times a year, more frequent if necessary.
Reports: Quarterly to the Quality Improvement Committee
Role and Responsibility: Provide medical and behavioral health expertise with regard to medical necessity criteria development, evaluation of the results of performance monitoring on decision-making timeliness and communication to members and providers, appropriate utilization of health care services, and coordination of care.
The utilization management functions for medical and behavioral health are fully delegated to NCQA accredited organizations. The accreditation status of the Managed Behavioral Health Organization (MBHO) is aligned with AHCA contractual requirements. The Quality Improvement Committee is responsible for and reviews all reports relative to delegated arrangements.

Medical Policy Committee (Delegated to Evolent Health)

Membership: The Medical Policy Committee membership is composed of physicians, with support from clinical experts from the field of medicine being evaluated. Non-physicians (e.g. PhDs and LCSWs) are involved in the review process on an ad hoc basis.
Meeting Frequency: Quarterly
Reports: To the health plan Medical Director as medical policy recommendations are made and are presented at the Utilization Management Committee for discussion and approval as well presented at Quality Improvement Committee quarterly for oversight.
Role/Responsibility: The objective, function, and responsibility of the Medical Policy Committee is to review and make recommendations if new technologies and/or new applications of existing technologies should be included in the health plan benefit package. Technologies evaluated by the committee may include vaccines, devices, diagnostic or screening procedures, behavioral health services, medical treatments, or procedures. Technologies are selected for review based on acute or potential demand and potential benefit from the new technology. Recommendations are made following a thorough analysis and consideration of clinical and scientific evidence, applicable laws and regulations, and community practice standards.

Credentialing Committee

Membership: Chaired by a health plan Chief Medical Officer, the committee membership includes network practitioners with a firm understanding of the credentialing and re-credentialing process, staff responsible for network adequacy, and additional health plan staff as necessary.
Meeting Frequency: Monthly as needed
Reports: At least annually to the QIC
Role/Responsibility: The Credentialing Committee has decision-making authority regarding credentialing and re-credentialing of individual practitioners, providers and facilities, and recommends approval or denial of initial and continued participation within the health plan network. The committee reviews the professional competence and conduct of practitioners whose actions affect or could adversely affect the health or welfare of members. The Credentialing Committee also re-evaluates all applicants at the time of re-credentialing, which includes a review of performance information, conduct provider disciplinary process and recommend disciplinary action. In addition, the committee reviews network adequacy reports and works to ensure the plan is compliant with standard and regulations related to network adequacy.

The credentialing function, including the authority for decision-making, is fully delegated for behavioral health and vision networks. The Credentialing Committee is responsible for and reviews all credentialing reports relative to delegated credentialing arrangements and retains the right to approve, suspend and terminate individual practitioners and sites[1].

[1] NCQA 2020 HP Accreditation Credentialing 8 Element A Standard

Meeting Minutes and Documentation

All activities of the committees, including the QIC, are documented in a standard format and include the following:

- Presentation of information or documents to the committee members
- Discussion by the committee members
- Recommendations and decisions of the committee
- Actions requiring follow-up

The appropriate committee reviews and approves (and where appropriate amends) the minutes at the next scheduled meeting. Unless otherwise stated, a quorum for each committee is reached when a simple majority of the voting membership is in attendance.

3. Quality Plan Structure

Outlined below are senior-level staff who support QI Plan functions.

Chief Medical Officer

Reporting to the Chief Executive Officer of the health plan, the Chief Medical Officer is responsible for oversight of clinical programs and functions, as well as, medical policy/clinical practice guidelines. As the chairperson and member of other health plan committees, he/she is directly involved with the review, evaluation, and recommendations related to the selection and ongoing monitoring of quality improvement and provider performance activities. The QIC chair is the Chief Medical Officer.

Director, Pharmacy

The Director of Pharmacy is responsible for drug-benefit design, clinical program development, formulary management, manufacturer rebate administration, clinical call center operations and the overall performance of the pharmacy services division. The Director of Pharmacy may also serve as a member of the Pharmacy and Therapeutics Committee.

Associate Director, Quality Improvement

The Associate Director of Quality Improvement is responsible for clinical and operational quality and quality improvement activities which includes administration of CAHPS and HEDIS as well as overseeing the design, implementation and monitoring of Performance Improvement Projects (PIP), and Quality Improvement Projects (QIP) to improve quality measures and member satisfaction. Responsibilities include the evaluation of the clinical aspects of services and maximization of the effectiveness of health care resources. The

Director is responsible for monitoring and ensuring completion of the annual QI trilogy documents (QI Program Description, QI Work Plan and QI Annual Evaluation), and NCQA Health Plan Accreditation (HPA).

Director, Utilization Management

The Utilization Management Director is responsible for all utilization management programs, as well as having oversight of clinical appeals. Working with the Medical Director of Utilization Management, he or she is involved in pre-service, concurrent and post-service reviews in all clinical settings.

Managing Director, Clinical Operations

The Managing Director of Clinical Operations is responsible for the oversight of all Care Management programs. Responsibilities include ensuring compliance with the model of care, ongoing monitoring of Care Management engagement and timeliness standards and adherence to applicable Star measures.

4. Management and Oversight of Delegated Activities

The health plan conducts oversight of delegated activities in accordance with plan policies and procedures, regulatory requirements and NCQA standards. Activities and metrics of delegated functions are reported on a regular basis to the QIC.

Oversight consists of:

- a pre-delegation review to verify the delegate has appropriate policies, staff and experience to perform the necessary function(s)
- review of regular reports of the delegate's activities
- an annual review of the delegate’s programs
- corrective actions plans when appropriate

The following functions have been delegated:

- Pharmacy management (to CVS)
- Credentialing/CVO (to Aperture)
- Provider Network Management (to HEOPS)
- Behavioral health management excluding CM (to Access Behavioral Health)
- Vision network Plan excluding Member Services & UM (to iCare Health)
- Transportation Service (to OneCall)
- Utilization Management (excluding Grievance & Appeals to Evolent)
- Care Management (to Evolent)
- Third party administrator functions (to Evolent)
  - Claims processing
  - Member services
  - Provider services

There is annual approval of the delegate's QI Plan program descriptions, annual work plan, and annual evaluation by the QIC.

Continuous Monitors and Indicators

Clinical and service indicators of quality such as CAHPS and HEDIS are established and monitored on a regular basis in order to assess performance in the management of clinical care and service. Performance measures and indicators are designed to reflect the demographic characteristics, prevalence of disease, and/or utilization of services of the membership as well meet the AHCA contractual requirements and performance targets. The performance measures and indicators have established targets and are measured on a periodic basis. Benchmark information such as NCQA Quality Compass may be used in setting targets. Clinical and service indicators are reported to the QIC. All indicators are trended for change over time and are included in periodic reports to the Board of Directors. Results outside of the established control limits provide the basis for quality improvement projects.

Among the types of indicators monitored are but not limited to:

- HEDIS outcomes for:
    - Mental Health and Substance Abuse
    - Well Child and Adolescent Well Care visits
    - Preventive health screening and care services
    - Prenatal/Perinatal and postpartum care
    - Chronic and Acute Care such as Diabetes, Asthma, High Blood Pressure
- Member satisfaction surveys such as CAHPS
- Service monitors including grievance and appeals
- Clinical monitors focused on disease entities
- Member safety and Quality of Care

5. Quality Improvement Program Components

Clinical Practice Guidelines

Clinical practice guidelines are established or adopted in areas identified as relevant and critical to achieving positive care outcomes or when practice variation and differences in care outcomes are identified. The Utilization Management Committee has the responsibility to review and approve clinical practice guidelines.
All practice guidelines are reviewed on at least a biennial basis and updated as needed to reflect changes in recent scientific evidence or technology.

Disparities, Cultural and Linguistic Differences

Several methods are utilized for meeting the cultural, linguistic, or socioeconomic disparities of the membership. Membership is analyzed to better understand opportunities for

improvement. Disparities and cultural and linguistic differences continue due to economic, medical, psychosocial and behavioral factors. Therefore, targeted interventions are designed and implemented to address these differences.

Practice Profiles

Practice profiles are utilized as a tool for initiating performance improvement and for reducing practice variation. A comprehensive practitioner program includes a comprehensive report listing chronic care metrics such as HEDIS, readmission rates, generic medication utilization, monitoring of certain medications, and level of electronic medical record. Individual practice results are provided. A detailed member gap in care list accompanies the practice profile. Reports are generated on a periodic basis.

Preventive Health

The health plan realizes the importance of prevention, wellness and improvements in lifestyle risks and works with network physicians and health plan members to encourage the use of preventive services and programs to assist with changing lifestyle risks, such as smoking. In order to monitor adherence to recommended preventive services, adult preventive guidelines are adopted and distributed to both members and practitioners annually. Adherence to the preventive health guidelines is measured and evaluated at least annually, and quality improvement strategies are initiated where opportunities are identified through HEDIS measurements and gaps in care reporting. Health plan services or initiatives are in place to assist members such as the availability of health risk appraisals, innovations in member services, and reminders encouraging wellness and prevention.

Through member outreach and support, including health advocacy and health management programs, the health plan promotes member wellness and prevention of illness. Members eligible for activities are identified using multiple data sources such as claims data, pharmacy data, health assessment results and data collected through the case management and utilization management processes. Targeted follow-up with members provides specific activities to support member wellness and achieve optimal health status.

Patient Safety

Patient safety is an important component of the quality program that includes a plan for collecting and providing information on provider and practitioner safety. The goal is to provide an environment conducive to improving the safety of members and to support practitioners and providers in their efforts to promote safe care. Access is provided to comparative quality and/or safety data from several nationally recognized, publicly available sources to members that improves their knowledge about clinical safety and can be used to facilitate informed health care decisions. Existing quality improvement and case management activities focus on improving patient safety by:

- trending adverse event reporting to identify system issues that contribute to poor safety

- analyzing and taking action on complaint data that relates to clinical safety
- implementing pharmaceutical medication therapy management reviews that will decrease adverse events
- monitoring provider “never event” occurrences and serious adverse events

Practitioner/Provider Appeals

The health plan monitors and manages practitioner and facility appeals. This activity is performed in accordance with the health plan’s policies and procedures and any regulatory requirements. Ongoing tracking and reporting of this activity is performed and reported to the appropriate departments and committees.

Performance Improvement Projects

The health plan conducts Performance Improvement Projects (PIPs) in accordance with the Agency for Health Care Administration (AHCA) contractual requirements. The purpose of the studies is to apply quality improvement processes to an identified clinical and/or administrative area of focus to improve performance and services. PIP topics are selected, reviewed and approved by the AHCA as well as coordinated by the External Quality Review Organization (EQRO) to address identified areas of importance or opportunity for improvement applicable to the population. Review and analysis of clinical, survey, financial, demographic, and/or encounter data as it applies to the performance outcomes, quality of care, utilization of services, or quality of service to members, providers, or the population are examined prior to the design and implementation of PIP activities. PIPs may span a course of three years in which barriers are identified, baseline data and target are examined, discussed with subject matter experts, interventions are identified and applied and remeasured for effectiveness quarterly at a minimum. Regular submissions and discussion to the internal and external stakeholders such as EQRO and AHCA will ensure activities are monitored and meet ongoing requirements.

The health plan PIP design, implementation and monitoring follows a project management and quality improvement standardized approaches such as Plan, Do, Study, and Act (PDSA).

6. Medical Management Program Components

Ambulatory Management

The scope of such programs includes wellness and prevention, as well as continuous monitoring of outpatient approaches to achieve optimal outcomes. Health and case management, ancillary services, and diagnostic services are considered types of ambulatory management. Other processes include the use of preventive guidelines, clinical practice guidelines, and monitoring compliance with the effectiveness of the ambulatory components of clinical guidelines.

Care Management Programs

The Care Management programs are delegated to Evolent Health and brings various programs to meet the needs of the health plan Medicaid population.

Complex and Condition Care Program (*see DM Complex and Condition Care Program Description*) was developed to systematically and comprehensively assess, monitor, measure, evaluate, and implement strategies to improve the quality of integrated care and healthcare services delivered to patients. The Program was designed to uphold and mirror the values of Evolent Health while administering the health plan benefits and services to improve the treatment outcomes and care experience of patients. A productive relationship between physician, clinical team, and patient is key to better health care outcomes, safer care, and a better care experience for the patient.

The Program is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Evidence-based medicine and a team approach is used to:

- Empower patients
- Support behavior modification
- Reduce incidence of complications
- Improve physical functioning
- Improve emotional well-being
- Support the physician/patient relationship
- Emphasize and reinforce use of clinical practice guidelines

The Transitions Care Program targets hospitalized patients deemed to be at risk for complications post-discharge. This program facilitates connection between hospital staff and the PCP care team, focusing on interventions aimed at preparing the patient and care giver for the transition to home by starting the discharge process upon admission. These interventions include but are not limited to: medication review supported by a dedicated clinical pharmacist, patient education with teach-back, a written discharge plan, confirmation that adequate caregiver support and resources are available, scheduling follow-up appointments including a PCP visit post discharge, and a referral to the complex care management program as needed.

The Catastrophic Care Program (*see Catastrophic Care Program Description for detail*) promotes continuity and coordination of care and facilitates the use of appropriate clinical services and community resources across the continuum of care for the following types of members:

- catastrophic illness
- members with complex medical needs, as evidenced by claims data, hospital discharge data, health assessment survey results, emergency room visits, pharmacy data,

utilization management processes, or as referred by the member, caregiver or practitioners.

Services are coordinated for members with complex or multiple conditions. Established criteria assist to identify members needing complex case management versus general case management and these members are managed according to established protocols.

The health plan will take appropriate initiatives to address the needs of Florida Medicaid enrollees. The health plan aims to improve coordination and continuity of care made possible by an enhanced team consisting of nurses, social workers, dieticians, pharmacists and community workers. The team members collaborate to support the member's preventive health and behavioral health needs along with any social issues or other barriers that may contribute to their use of unplanned care or other avoidable services.

Continuity and Coordination of Care and Services

Continuity and coordination of care are critical to verifying members are receiving the proper care in an appropriate setting. In addition, where continuity and coordination exist, there is less chance of medication or treatment errors. Continuity and coordination of care is monitored using a combination of claims data, medical record chart reviews and survey of practitioners. The specific issues chosen for evaluation are referenced in the current year's work plan.

Health Assessment Survey

A health risk assessment is provided to members as a means of managing members' health proactively. Based on results, members are provided with recommendations to improve health, or targeted referrals may be made to disease management and case management to assist members in their care and service needs.

Utilization Management

The utilization management (UM) process encompasses the following program components: after hours service, prior authorization, concurrent review, ambulatory review, retrospective (post-service) review, and discharge planning. All approved services must be medically necessary. The clinical decision process begins when a request for authorization of service or clinical information is received. Request types may include authorization of specialty services, skilled/rehabilitative services, outpatient services, ancillary services, scheduled inpatient services, and/or notification of emergent/urgent inpatient services. The process is complete when the requesting practitioner and member have been notified of the determination and any required letters have been processed.

Inpatient Management

Inpatient facilities include acute inpatient hospital, acute inpatient rehabilitation, and skilled nursing facilities. Appropriate utilization of inpatient admissions is managed in partnership with participating facilities. Interaction includes the exchange of data through reporting and frequent meetings with the facility.

Acute care facilities routinely report their inpatient admissions to the UM Department. Onsite review may be conducted at the top volume facilities. The remaining facilities report their admissions telephonically on a daily basis. Cases are reviewed against established criteria (InterQual) and guidelines. A physician reviews cases that may be inappropriate for admission after appropriate clinical information is obtained.

Participating facilities are aware of administrative requirements to inform the UM Department of planned or unplanned admissions. Registered nurses telephonically review admissions and continued stays to acute care, skilled, and rehabilitation facilities against established criteria and guidelines. When appropriate, members are referred for discharge planning or care management based on specific diagnoses or events identified during the review process.

Medical Review

The UM staff support activities across the continuum of care to affect optimal outcomes, achieve continuity of care, support appropriate services, and manage care within member benefits.

The primary function of the UM staff is to facilitate efficient resource utilization, and review and verify medical appropriateness and necessity for members whose needs are represented in the following categories:

- pre-certification /prior authorization of services
- out-of-network services
- transition of care
- admission and concurrent review
- retrospective review
- discharge planning

Staff reviews clinical information against established criteria (InterQual) to determine medical necessity and appropriateness for requested medical services. These would include Medicare medical coverage guidelines, internal medical policies and community standards to each case.
The member’s specific benefit package is also taken into consideration.

Medical necessity criteria are selected or developed and approved by the UM Committee and presented to QIC with input from participating physicians. When developing criteria, the following are taken into consideration: approval from an appropriate regulatory body, input

from participating specialists, and support by published scientific evidence. Criteria and medical policies are reviewed annually against current industry standards and any applicable revisions are made and approved by the UM Committee.

When applying criteria to a request for services the following information is taken into consideration: age, comorbidities, complications, progress of treatment, psychosocial situation, home environment, as well as the availability and ability of the local health care system to provide for the member's medical needs. Information is obtained from the member's medical record, treating practitioners, and/or the member or member representative. If the documentation supplied is insufficient or requires clarification, the review staff may contact the treating practitioner for additional clinical information.

Utilization reports are prepared on a regular basis to communicate, to internal management and participating practitioners, the information needed to impact and effect better utilization of health care services.

Definition of Medical Necessity

1. The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability.
2. The service or benefit will, or is reasonably expected to, reduce or ameliorate, the physical, mental, or developmental effects of an illness, condition, injury, or disability.
3. The service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

Appropriate Utilization

Poor quality of care can be the result of either under or over-utilization of services and is appropriately addressed jointly by the Quality Improvement and Utilization Management departments. (42 CFR 438.330(b)(3)) Monitoring of under-utilization is integral to the health management programs and specifically relative to services that assess the current state of the member's clinical condition such as medication refills and routine testing. Over-utilization is assessed in the ambulatory setting through a review and analysis of diagnostic, laboratory, and pharmacy services, and in the inpatient setting through review of compliance with guidelines for admission and appropriateness of discharge planning. Occurrences of "never events" and hospital acquired conditions are monitored and managed as a potential quality of care case. Results are trended for improvement opportunities.

Behavioral Health

The management of behavioral health is integrated with quality and utilization management. Since individuals receive behavioral health services in a number of settings, it is important to assess the quality of care in these settings and to implement changes in processes where

improvement opportunities exist. Behavioral health treatment is monitored for effectiveness/outcomes, continuity between the inpatient and outpatient setting, and with the primary care practitioner. Continuity and coordination of care between the behavioral health practitioner and medical practitioner, and follow-up after hospitalization for mental illness or substance abuse are monitored through medical record reviews and HEDIS monitoring. The findings are analyzed and presented to the QIC at least annually.

A behavioral health practitioner is involved in the behavioral health management program and processes. Integration between programs and utilization of services, member assessments, triage and referral processes and on-going care plans are conducted by behavioral health nurses. A behavioral health practitioner is responsible for supervision, oversight and evaluation of behavioral health aspects of the program.

Utilization Management Processes

The following are the administrative responsibilities of Utilization Management:

- administer utilization management activities in accordance with the UM program description
- verify that qualified medical personnel supervise all review decisions
- guarantee that a physician conducts medical appropriateness review of any denial
- assure adherence to standards for timely completion of utilization management requests
- assure adherence of timely responses to members and practitioners for all utilization management decisions
- provide to members and practitioners clearly documented reasons for the denials and an explanation of the appeal process
- identify the criteria used in making the denial
- monitor and assess over- and under- utilization of services
- perform oversight of delegated services

7. QI Plan Integration with Other Functional Areas

The Quality Improvement department interfaces on an ongoing basis with other functional areas.

Quality Improvement and Utilization Management

The integration between Quality Improvement relates to:

- potential quality of care and patient safety issues
- member complaints, grievances and appeals
- practitioner complaints and appeals
- member and practitioner satisfaction
- referrals to care management
- preventive services
- development of clinical interventions for members and practitioners

Pharmacy Services

The interface with Pharmacy Services relates to:

- over- and under- utilization
- appropriateness of prescribing patterns
- recipient restriction process
- member safety and continuity of care issues
- medication treatment management monitors

Network Management

The interface with Network Management and Provider Relations relates to:

- practitioner performance reporting
- network adequacy
- communication of identified problems through office visits
- provider and practitioner education needs
- communication of information for credentialing and re-credentialing processes
- practitioner satisfaction
- potential quality of care and patient safety issues

Member/Practitioner Services

The interface with Member/Practitioner Services relates to:

- member complaints, grievances, and appeals
- practitioner/provider complaints
- quality service initiatives, including member satisfaction

Claims

The interface with Claims relates to:

- analysis of claims processing related to member complaints
- quality service initiatives

Communications

The interface with Communications relates to:

- practitioner and member mailings, including Website materials
- assessment of member understanding of health plan materials, including member Web-based information and the provider/practitioner directory
- communicates the annual quality plan and results

8. Member Rights and Responsibilities

Members must have a clear understanding of both their rights and responsibilities when seeking health care services. The health plan reviews and, if appropriate, revises the Rights and Responsibilities on an annual basis and distributes to members, practitioners, and providers.

Confidentiality

Policies and procedures are available to protect the confidentiality of member information and records. These policies apply to all individuals that access member information. The policies and procedures specifically address:

- the health plan and any delegate's use and disclosure of member protected health information (PHI) appropriately in order to protect member privacy
- access to confidential information on a "need to know basis" with disclosure of the minimum information needed
- the maintenance and retention of medical records (both original information and documentation used for utilization management, care management and quality assessment)
- rights for members to access their PHI, including requesting restrictions on, amendments to and accountings of disclosures of their medical information
- protecting the identity of the member, practitioner, or provider by encrypting all aggregated and individual data reported as a component of the QI Plan process
- protecting the content of all meeting minutes and internal communications (including electronic documents) by clearly identifying these documents as confidential and by maintaining such documents securely and by shredding such documents if disposal is indicated

A Compliance Officer is designated to be responsible for the development and implementation of processes for member privacy. In addition, agreements require that all contracted practitioners and providers comply with appropriate policies and procedures to preserve patient confidentiality. Health plan operations are in compliance with HIPAA regulations.

Member Satisfaction

A certified CMS vendor is used to administer the ***Consumer Assessment of Healthcare Providers and Systems*** (CAHPS™) survey to a statistically valid sample of members. Survey responses provide insight into the members' experience with the health plan and health care delivery system.

Additional surveys may be conducted to determine satisfaction specifically related to care management programs. The results of the surveys, which are shared with both members and practitioners, allow the health plan to evaluate the effectiveness of programs and interventions and provide focus for targeted quality initiatives.

Member Inquiries, Complaints, Grievances and Appeals

Inquiry Tracking

Any oral or written request to the health plan without an expression of dissatisfaction (e.g., a request for information or action by a member) is tracked and trended as an Inquiry. A mechanism is provided for members to express and resolve disagreements concerning services, claims, benefits, participating practitioners and providers and administrative contract policies. Every effort is made to resolve the member's complaint at the Member Services Department level.

Complaints, Grievances and Appeals

The health plan has a process for the resolution of member disputes and responding to members' requests to reconsider a decision they find unacceptable regarding their care and service. Documentation includes the substance of the appeal, investigation of the concern and an appropriate response based on the substance of the appeal.

All members receive information on the procedures governing complaints, grievances and appeals. All complaints, grievances, and appeals are logged, and the investigation and outcome recorded in a database with detailed categories identifying the type of issue. Policies and procedures comply with applicable State and/or CMS guidelines for grievance, appeals, and expedited appeals. The processes are monitored for compliance with State, CMS, and/or Department of Labor (DOL) regulations and internal policies related to resolution time and member communication. Member complaints, grievances and appeals are tracked and trended and used to identify potential opportunities for improvement.

Quality of Care Concerns

Potential quality of care concerns initiated by a member, provider or health plan staff, are tracked and investigated. The process involves receipt and logging the potential quality of care case, issuing acknowledgement letter to complainant, request for medical records, clinical review by a physician, including a like-specialty physician (when warranted) and sent for peer review when appropriate. All quality of care cases are closed within 90 calendar days from complaint receipt per AHCA requirements. All quality of care issues, whether confirmed or negated, are filed in the individual practitioner's quality file and are queried upon re-credentialing. When poor quality of care is detected, follow-up actions are agreed upon and monitored. Monitoring of "never events" and hospital serious adverse events are considered potential quality of care events.

9. Practitioner Selection and Retention

Credentialing and Re-credentialing

The health plan maintains an accurate and timely credentialing and re-credentialing process for network practitioners and monitors credentialing activities to assess adherence to the

processes outlined in the health plan's policies. Information related to a physician's quality of service is integrated into the re-credentialing process through a file review.

Access and Availability

Standards for geographic availability of primary care physicians and specialists have been established. At least one evaluation of the geographic availability is performed annually. The results of the assessment are the basis for work plans to improve practitioner availability when the standards are not met.

The health plan utilizes the CAHPS ™ survey to measure compliance with established appointment access standards. Measurement occurs at least annually, when survey membership criteria is met, for the Medicare Advantage population.

Practitioner Satisfaction

The health plan measures practitioner satisfaction through an annual survey. Results of the survey are reviewed and analyzed by Network Management and the QIC for improvement opportunities and to evaluate effectiveness of interventions implemented as follow-up to the previous year's survey. Results may be shared through practitioner communications.

10. External Accountability

Regulatory Compliance

The QI program is designed to comply with all applicable CMS and State contractual requirements. State and federal regulations specific to quality and utilization are monitored. The QIC is made aware of changes to the quality improvement program and annual work plans when modifications must be made to accommodate the regulations. The Board of Directors is ultimately accountable for assuring applicable state and federal HMO/managed care organization laws and regulations are met.

Healthcare Effectiveness Data and Information Set (HEDIS) Data Collection and Reporting

The health plan utilizes a NCQA certified auditor (Healthy People) and NCQA certified software vendor (Change Healthcare) to administer HEDIS. Audited HEDIS reports are produced annually. Medical record documentation may be used to augment the administrative data used for the reports (hybrid data collection).

Trended HEDIS data are analyzed and areas for improvement are identified. Results on HEDIS measures may drive health plan quality improvement design and activities.

11. Resource Allocation

Data Sources

Quality improvement processes are data driven. The health plan utilizes a variety of data sources to monitor, analyze and evaluate the QI Plan activities and reporting of performance measures. These sources include but are not limited to:

- Claims data
- Encounter data
- Pharmacy data
- Member complaints, grievances and appeals
- Practitioner/provider complaints and appeals
- Member satisfaction surveys
- Practitioner/provider satisfaction surveys
- Laboratory data
- Vision data
- State Registries
- HEDIS scores
- Statistical, epidemiological and demographic member information
- Medical record information / EMR
- Utilization review data
- Authorization and denial data
- Enrollment and disenrollment data
- Behavioral health information
- Care management information
- Service monitors
- Health risk assessments

Data Systems

The following data systems are utilized to support the QI Plan. Information systems and software are evaluated and upgraded on an ongoing basis in order to verify the availability of accurate, secure, timely, complete and credible data and information per AHCA requirements. These systems include, but are not limited to, the:

- Claims system
- Credentialing database
- Care management documentation system
- Complaints and grievances database
- Data repository
- Automated call system
- Pharmacy documentation system
- Predictive modeling tools

Staff Resources and Training

The following individuals and their appropriate staff are available for quality improvement Plan activities.

- Chief Medical Officer
- Director, Pharmacy
- Managing Director, Clinical Operations
- Director, Utilization Management
- Director, Quality Improvement
- Network Practitioners, as applicable

The adequate resource allocation is critical to the success of the QI Plan. Staffing, systems, data sources, reporting mechanisms and software are evaluated on an ongoing basis to verify the availability of resources to identify, initiate and complete quality improvement initiatives.

The QI Plan and members that participate in QI activities with the oversight and guidance from the QI Director and input from subject matter experts follows quality improvement standardized approaches such as Plan, Do, Study, and Act (PDSA). This also includes the initial training, discussion, selection and implementation of performance indicators as well as performance improvement activities. The QI Department in collaboration with other departments such as Compliance shall guide and provide training about quality which includes at a minimum protocol developed by CMS regarding quality[2]. The proper staff availability and training ensures compliance with AHCA requirements.

12. Review and Evaluation

The QI Plan is supplemented by an annual work plan which incorporates dates and responsibilities with the program objectives. The progress toward these goals is presented to the QIC throughout the year for review, recommendation, and approval, where appropriate.

At the close of each year, a comprehensive evaluation of the program is developed and presented to the QIC and to the Board of Directors for review, evaluation, and approval. The evaluation includes a description of completed and ongoing QI activities and trending of measures to assess quality and safety of clinical care and quality of service. Additionally, the analysis provides an overall effectiveness of the QI program with respect to adequacy of resources, QI Committee structure, practitioner participation and leadership involvement, and need to restructure or change the QI program for the subsequent year. This evaluation serves as the foundation for the development of a work plan for new and continued activities for the following year.

[2] https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

13. Conflict of Interest

Health plan employees, as well as members of the Quality Improvement Committees and associated committees, are required to sign a confidentiality statement as well properly use and safeguard confidential information used in the committee. The committee members and participants to the QI activities are also required to identify and resolve potential conflicts of interest.

In addition, committee participants are to disclose actual or potential situations concerning issues under review in which a participant or the committee as a whole has a direct or indirect interest in the outcome or has two separate and distinct duties. Health plan Compliance is responsible for monitoring the compliance with federal, state, and local laws and regulations governing use and disclosure of PHI. The Compliance also helps evaluate and respond to requests for use and disclosure of PHI and monitor internal processes for compliance with use and disclosure requirements.