Quality Improvement Program

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Contents

Introduction 2
Cox HealthPlans Mission Statement 2
Goals and Objectives 2
Scope 3
Annual Evaluation of QI Program 4
Committee Reporting Structure 4
Performance Indicators 9
Benchmarking 10
Credentialing 10
Network Adequacy 10
Medical Management 10
Health Risk Assessment (HRA) 11
Health Education and Wellness Promotion 12
Member Satisfaction 12
Provider Satisfaction 13
Risk Management 13
Peer Review 13
Quality Improvement Initiatives 12

Introduction

Cox HealthPlans (CHP) is a non-profit affiliate of CoxHealth, an ISO 9001 accredited health system, that provides insurance solutions for members across Southwest Missouri. Started in 1995, CHP is the only locally based health insurance company in the Ozarks. Cox HealthPlans offers fee for service plans to small and large commercial groups and individuals through a Preferred Provider Organization (PPO) and an Exclusive Provider Organization (EPO), in addition to selling individual plans on the Marketplace exchange with an Exclusive Provider Organization (EPO) plan. In collaboration with CoxHealth, CHP also offers a Medicare Advantage plan, a Health Maintenance Organization (HMO) plan with a Medicare contract, that is available in seven counties in southwest Missouri.

The Quality Improvement (QI) Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service for CHP plan members. The program also sets forth a structured approach for conducting delegation oversight and monitoring compliance with State of Missouri and Federal Marketplace requirements, and compliance with Centers for Medicare & Medicaid Services (CMS) requirements for Medicare Advantage plans. The program focuses on identifying and implementing opportunities for improving operational processes as well as quality of care, health outcomes and satisfaction of members and practitioners/providers.

QI Program information and activities will be shared regularly with CHP employees, members, and providers through newsletters, website posting, flyers, and other forms of communication as needed.

Cox HealthPlans Mission Statement

To support health improvement in the communities we serve by offering competitive insurance products based on quality outcomes and evidence-based healthcare.

Goals and Objectives

The QI Program is designed to optimize the quality of the health care to members, while maintaining cost effective utilization of health care resources. This is accomplished by working closely with CoxHealth to actively pursue opportunities for improvement through systematic monitoring and evaluation of services.

The QI Program goals are to:

- Provide timely access to high-quality healthcare for all members through a safe, cost-effective, health care delivery system;
- Systematically monitor and evaluate the quality and appropriateness of health care and services;
- Pursue opportunities to improve health care, services and safety; and
- Maintain ongoing AAAHC accreditation.

To achieve these goals, the QI program focuses on the following objectives:

- Establish and maintain member rights and responsibilities and ensure members are treated with respect, consideration, and dignity;
- Ensure members have access/availability to qualified health care practitioners and providers;
- Adopt, promote and monitor evidence based clinical and preventive health guidelines;

- Ensure appropriate utilization of services;
- Ensure the provider network and health programs are designed to meet the needs of members, including cultural and linguistic considerations;
- Promote diversity, equity, inclusion, and accessibility for the membership, including the provision of accessible documentation to meet the needs of members.
- Make available case and disease management services to members with chronic conditions and complex health care needs;
- Regularly review and analyze member and provider data for demographic information and care needs;
- Promote health education and wellness among CHP members;
- Conduct health risk appraisals (HRAs) and incorporate the results into the development of member resources and disease management programs;
- Monitor and benchmark clinical and service performance indicators and work with delegates to improve care;
- Incorporate peer review activities in credentialing and recredentialing;
- Conduct ongoing monitoring of provider network regarding quality, sanctions and licensure issues;
- Investigate and ensure timely response to all complaints, grievances and appeals and analyze trends that need to be addressed;
- Provide oversight and ongoing monitoring of all delegated activities;
- Evaluate the effectiveness of quality improvement programs;
- Communicate results from quality improvement activities with members, providers and employees;
- Ensure adequate resources are dedicated to quality improvement activities; and
- Support the Medicare Advantage line of business by monitoring compliance with CMS requirements for Medicare Advantage plans.

Scope

The QI program encompasses a wide range of clinical and service quality initiatives affecting members, providers, as well as internal stakeholders throughout CHP and CoxHealth. Key areas of focus include:

- Access and availability of network providers
- Behavioral Health Care and Service
- Complaint, appeal and grievance management
- Continuity, coordination, and transition of care
- Credentialing/Re-credentialing
- Peer review
- Delegation oversight (oversight of entities to which CHP delegates selected functions)
- Health Education and Wellness
- Health Risk Appraisal
- Medical records review and provider facility site reviews
- Member rights and responsibilities
- Member/Provider satisfaction
- Patient safety

- Utilization management of inpatient and outpatient services
- QI initiatives addressing specific focus areas
- Care Coordination and Care management
- Risk Management

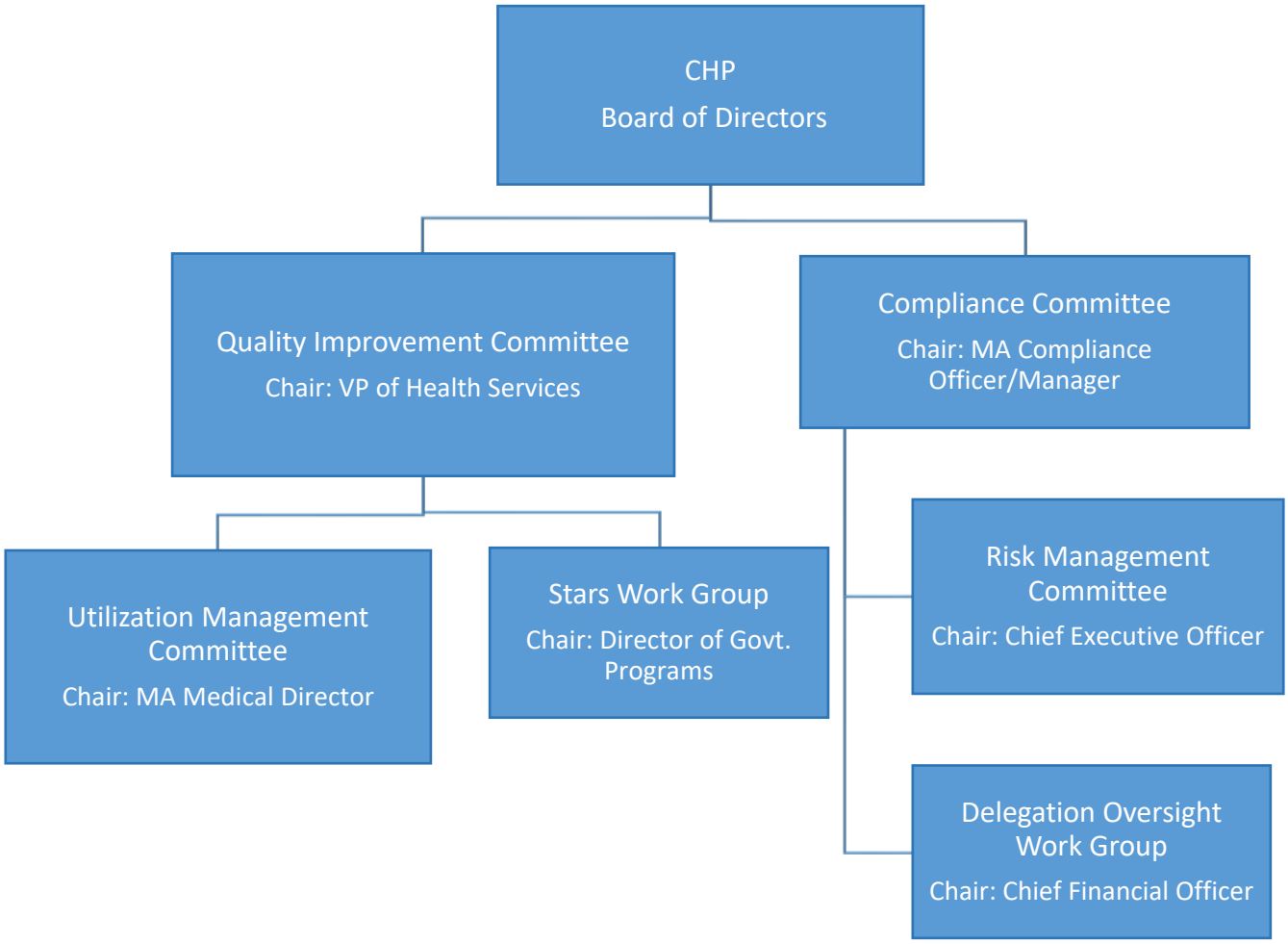
Annual Evaluation of QI Program

The QI Program will be evaluated annually for overall effectiveness. The evaluation will include a systematic review of each component of the program, incorporating the data collected throughout the year through audits, surveys, and HEDIS measures.

Committee Reporting Structure

The CHP Committee reporting structure is diagrammed and described below.

Quality Improvement Committee Structure



Other Work Groups and Committees:

These working groups and committees share information as necessary with the committees in the above committee reporting structure.

Department Head – CHP senior leadership and department directors meet monthly to review high-level summary of the previous board meeting, company financials, department specific dashboards, operational and strategic initiatives, employee development, and other current topics.

Enterprise Risk Management (ERM) – An internal working group of CHP senior leadership and department directors that meet throughout the year to review and analyze the company's existing ERM document. The group also works to identify and pursue any new risk categories.

Delegation Oversight – An internal working group that oversees CHP delegates, including review and discussion of pre-delegation audits, updates, and annual delegate oversight reviews.

Risk Adjustment – A working group tasked with monitoring risk adjustment tracking and reporting with an emphasis on the Medicare Advantage line of business.

Stars – A working group of CHP and CoxHealth staff that meets to discuss and analyze CMS Star Ratings information and Medicare Advantage plan performance, and make recommendations for improvement.

Savings Opportunities Group – An internal cross-functional working group within CHP that meets to discuss, analyze, and implement various saving opportunities within CHP.

Financial Analysis – An internal group of health plan senior leaders that meet to review various items such as financial performance, reserves, and provider discounts.

Regulatory – An internal working group of CHP senior leadership, department directors and frontline staff that meet throughout the year to discuss federal and state changes and work through implementation of new regulations, guidance, and laws as they apply to CHP.

Benefits Committee – An internal working group comprised of CHP senior leadership and department directors who meet throughout the year to discuss member benefits that have been reported through member services, provider services, or through grievances and appeals. The committee reviews and analyzes the information for any necessary changes to plan benefits or configurations.

Product Development – An internal working group tasked with evaluation of existing products offered by CHP and development of new products for the market.

IT Steering Committee (ITSC) – An internal working group that oversees the information technology coding priorities of CHP.

Board of Directors

Cox HealthPlans has an independent Board of Directors (governing body) comprised of business leaders throughout southwest Missouri, CoxHealth CEO, and CoxHealth physician leaders. The Board of

Directors is responsible for the operation and performance of the health plan and for oversight of the QIC and Compliance Committee.

Quality Improvement Committee (QIC)

The QIC assists the Board of Directors in overseeing and ensuring the quality of clinical care, patient safety, and customer service provided to members by CHP and its delegate(s).

The QIC's responsibilities include:

- Developing and recommending to the Board of Directors and management a Quality Improvement Program with annual work plans and improvement targets aligned with CHP's long-range plans, AAAHC accreditation requirements, CMS requirements for Medicare Advantage plans, and federal requirements for marketplace QHPs.
- Developing and recommending to the Board of Directors and management necessary AAAHC accreditation-related policies and standards.
- Overseeing compliance with AAAHC accreditation standards.
- Making recommendations to the Board of Directors and delegates on all matters related to the AAAHC accreditation standards and CMS, state, and federal requirements, to include quality of care, patient safety and customer service and plan performance goals.

The QIC meets at least four times a year, or when necessary at the call of the QIC chair. Delegate representatives, among others, may be invited to attend QIC meetings. Agendas for and minutes of the meetings shall be prepared and retained for at least six years.

QIC members may include:

- VP of Health Services
- CHP Medical Director
- Medical Department Manager
- QI and Accreditation Manager
- Director of Member and Provider Services
- Director of Claims
- CHP President
- CHP Chief Financial Officer (CFO)
- CHP Board Member
- Participating network provider
- Behavioral health practitioner
- Care Management representative from CoxHealth
- An administrative support person

Utilization Management Committee

The UM Committee is responsible for ensuring that practitioner, institutional, ancillary, and therapeutic services are properly utilized and to ensure that these services are available, accessible, medically appropriate, and cost effective. The UM Committee meets at least quarterly to:

- Review the UM Program and UM policies
- Review the clinical criteria used to make UM decisions

- Adopt, promote, and monitor provider adherence to preventive health and clinical practice guidelines
- Review new medical technology and make determinations for individual consideration or inclusion in the benefit program
- Perform oversight of CHP's Pharmacy Benefit Manager (PBM)
- Perform oversight of delegated UM functions, both behavioral health and medical delegation
- Review reports on potential fraud and abuse and determine actions
- Evaluate reports on practitioner and member satisfaction with the UM process
- Evaluate reports related to members in care management to include disease management and complex care management
- Evaluate the use and cost of services provided to members through utilization reports

The UM Committee members may include:

- CHP Medical Director
- Network physician
- Behavioral Health Practitioner
- VP of Health Services
- Medical Department Coordinator
- Medical Department Manager
- QI and Accreditation Manager
- Director of Claims

Compliance Committee

CHP's Compliance Committee oversees the Compliance Program, including Medicare compliance. The Compliance Officer/Manager chairs the Compliance Committee. The Compliance Committee is accountable to, and must provide regular compliance reports to, CHP's senior-most leader and Board of Directors. Reports on the status of the Compliance Program are usually reported through the chairperson of the Committee.

The Compliance Committee's responsibilities include:

- Developing strategies to promote compliance and the detection of any potential violations
- Reviewing and approving compliance and FWA training, and ensuring that training and education are effective and appropriately completed
- Assisting with the creation and implementation of the compliance risk assessment and of the compliance monitoring and auditing work plan
- Assisting in the creation, implementation and monitoring of effective corrective actions
- Developing innovative ways to implement appropriate corrective and preventative action
- Reviewing effectiveness of the system of internal controls designed to ensure compliance with Medicare regulations in daily operations
- Supporting the compliance officer's needs for sufficient staff and resources to carry out his/her duties
- Ensuring that CHP has appropriate, up-to-date compliance policies and procedures

- Ensuring that CHP has a system for employees and FDRs to ask compliance questions and report potential instances of Medicare program noncompliance and potential FWA confidentially or anonymously (if desired) without fear of retaliation
- Ensuring that CHP has a method for enrollees to report potential FWA
- Reviewing and addressing reports of monitoring and auditing of areas in which CHP is at risk for program noncompliance or potential FWA and ensuring that corrective action plans are implemented and monitored for effectiveness
- Providing regular and ad hoc reports on the status of compliance with recommendations to CHP's Board of Directors.

Compliance Committee members may include:

- CHP's Compliance Officer/Manager
- QI and Accreditation Manager
- VP of Health Services
- Medical Department Manager
- CHP Medical Director
- Director of Member and Provider Services
- MA Grievances and Appeals representative
- Chief Information Officer (CIO)
- CHP President
- CoxHealth's Corporate Compliance Officer

Risk Management Committee

CHP has a Risk Management program that addresses the safety and welfare of members and employees, and establishes policies and systems for identifying, reporting, analyzing and preventing adverse incidents. CHP works collaboratively with CoxHealth on risk management activities. The Risk Management Committee reviews incident reports and identifies opportunities to improve systems and education for employees, providers and members to reduce the risk of adverse incidents. The Risk Management Committee reports to the Compliance Committee.

Risk Management Committee members may include:

- CHP President
- QI and Accreditation Manager
- Director of Claims
- Underwriting Manager
- Director of Member/Provider Services
- Director of Enrollment
- VP of Health Services

Delegation Oversight Workgroup

The Delegation Oversight Workgroup directs ongoing delegation oversight for delegated entities and reports to the Compliance Committee. Results from pre-delegation audits are also reviewed by the

workgroup prior to contracting with new delegates. The workgroup receives reports from delegated entities and conducts audits and file reviews to ensure delegated entities are meeting CHP contract and AAAHC accreditation standards. The workgroup reports annual delegation review audit reports to the Compliance Committee and makes recommendations for corrective action, if needed. The delegation oversight process includes:

- Pre-delegation review and audits for potential new delegates prior to initiating delegation
- Review of delegation contracts to ensure contracts meet AAAHC requirements
- Periodic assessments to ensure the delegated entity has the capacity to perform the delegated services
- Annual or more frequent reviews to ensure services are provided in accordance with terms of the delegation agreement. The review includes review of policies and procedures, reports, performance measures, file review, and onsite reviews.
- Implementation of corrective measures for the delegated entity when necessary

The Delegation Oversight workgroup members may include:

- VP of Health Services
- QI and Accreditation Manager
- Director/Manager of Marketing
- Director of Claims
- Director of Accounting & Finance
- CHP Chief Information Officer (CIO)
- CHP Chief Financial Officer (CFO)

Performance Indicators

CHP monitors a variety of clinical and service performance measures and indicators, including:

- Call center telephone answering service and call abandonment rates
- Timeliness of claims payment
- Complaints and appeals rates
- Grievances rates
- Inpatient, pharmacy, and ambulatory utilization rates
- Population health participation rates
- Preventive Care clinical measures
- Clinical outcomes measures
- Behavioral Health measures
- Member satisfaction survey results, including CAHPS results
- Provider satisfaction survey results
- CMS Star Quality Ratings
- US Health and Human Services (HHS) required measures for Qualified Health Plans (QHP) on the federal exchange Marketplace under the Affordable Care Act, including:
    - Quality Rating System (QRS) measures
    - Enrollee Satisfaction Survey (ESS) results

CHP reports HEDIS-like measures from the CoxHealth EMR for non-Marketplace lines of business.

CHP establishes goals for performance measures, monitors results to goals and benchmarks and identifies improvement opportunities.

Benchmarking

CHP participates in a number of benchmarking activities, monitoring its internal trends and comparisons with CoxHealth regional benchmarks, including:

- Internal benchmarking of performance measures over time
- Benchmarking of selected measures against CoxHealth results
- Internal and external benchmarking activities include performance indicators based on systematic review of appropriate data sets, data collection that is consistent in relation to the selected performance measures, relevance and validity to local, state, and nationally published data, appropriate measures of performance indicators, and sustained performance improvement over time.
- External benchmarking activities for the CHP Marketplace plan for QSR and ESS results are reported and compared with national HHS benchmark. CHP will also use these benchmarks to compare against HEDIS-like measures for non-Marketplace plans.

Benchmarking results are reported to CHP employees, providers, and the Board of Directors.

Credentialing

CHP conducts delegation oversight of all credentialing. CHP reviews delegate credentialing policies and procedures, quarterly credentialing reports and Committee minutes, and conducts annual credentialing file review to monitor compliance with AAAHC standards.

Network Adequacy

CHP establishes access and availability standards, communicates standards to providers, and monitors to identify and address network gaps and deficiencies. Activities include conducting population analysis to determine member needs, evaluating geo-access reports, reviewing access complaints, and reviewing member and provider satisfaction survey results. CHP and CoxHealth Network work together to address any gaps in the provider network.

Medical Management

The Cox HealthPlan (CHP) Medical Management Program is designed to partner with members to help them improve their health while utilizing appropriate medical services. CHP and CoxHealth provide members with the knowledge and information needed to make informed care decisions that will maximize plan benefits and ultimately result in higher level of quality. This partnership allows the combining of medical claims, pharmacy claims, health records and enrollment data with the health system's clinical resources, creating a comprehensive approach to identification, outreach and targeted care for our members. Unlike other standard medical management programs that only use claims data, our program integrates and coordinates all health system resources for our members. All Cox HealthPlans members are eligible for medical management.

As part of medical management, CHP partners with CoxHealth to offer a variety of case and chronic condition management resources in coordination and collaboration with the Population Health Services

Organization (PHSO), which helps connect members to specialty providers and services, as well as offers classes, support groups, and health education resources.

CoxHealth offers classes and support groups, including:

- *Diabetes Self-Management Education* is provided through a nationally recognized American Diabetes Association accredited program utilizing a multi-disciplinary approach
- *Diabetes Support Group* provides an opportunity for clients diagnosed with diabetes and their family members to receive extra support and education
- *Living a Healthy Life with Diabetes* is a six-week workshop for anyone diagnosed with diabetes or pre-diabetes
- *Living a Healthy Life with Chronic Pain* is a six-week workshop for anyone who lives with chronic pain
- *Feel Better Now* is a six-week program for anyone with a chronic health condition
- *Explain Pain* provides self-management techniques to help manage and improve chronic pain
- *Advance Care Planning Workshop* helps clients take the first steps in completing an advance directive
- *My Path to a Nicotine Free Future* teaches the benefits of quitting, how to cope with urges and stress, and why staying quit is so challenging
- *Freedom from Nicotine Support Group* provides an opportunity for clients to interact with others in a similar situation

CoxHealth also offers a variety of health education resources, including:

- Clinics and specialists supporting *Allergy and Asthma*
- *Bridge to Health program* supporting heart-health lifestyle, such as proper diet, taking necessary medication, listening to your body and exercise.
- *Heart Failure Clinic* is staffed by a nurse practitioner and gives patients tools to manage their disease
- *Nutrition services* include medical nutrition therapy, outpatient nutrition, healthy food assistance, cancer nutrition, cooking classes, fitness center, and sports medicine
- *Peripheral Artery Disease Rehabilitation* offers education and support to make healthy changes to reduce the risk of having a heart attack or stroke
- *Pulmonary Rehabilitation* offers respiratory treatments and pulmonary diagnostic testing
- *Senior Advantage* offers classes, information, and assistance for patients 50-plus
- *Education for patients* includes a variety of online and educational videos and access to comprehensive libraries of Patient Channel and HeartCare Channel videos.

Health Risk Assessment (HRA)

CHP offers members a Health Risk Assessment (HRA) questionnaire online through a survey vendor. The HRA questionnaire is designed to connect members to wellness resources that will be helpful to them based on their responses. Information from completed HRAs is also aggregated and analyzed to help evaluate wellness and chronic condition programs.

Health Education and Wellness Promotion

A variety of Health Education and Wellness programs are offered to members. Many programs, member resources and tools are available through CHP's affiliate CoxHealth, including:

- *Childbirth classes*
- *Breastfeeding basics*
- *Infant Safety & CPR*
- *Exercise from Home*

CoxHealth also offers patients and the community health fairs, health screenings, and specific wellness events. Examples include:

- Wellness for Warriors is a program designed for active military, veterans, law enforcement, first responders, and their families
- CARDIAC Kids offers cardiovascular risk screenings for school age children in select rural schools
- Committed to Kids, the intervention arm of CARDIAC Kids, provides education focused on healthy food choices and physical activity to high-risk families
- CARE Mobile is a pediatric clinic on wheels

CHP also promotes the following online resources:

- The victim center: https://www.thevictimcenter.org/resources/
- Alcoholics anonymous: https://aaswmo.org/
- Alternatives, Inc. (alcohol and substance abuse- also counseling for anger management/mental health): https://www.missourialternatives.com/
- NAMI Southwest Missouri (mental health): https://namiswmo.org/
- CDC Healthy Schools: https://www.cdc.gov/healthyschools/multimedia/video.htm
- CDC Self-Management Education: https://www.cdc.gov/learnmorefeelbetter/videos/index.htm
- CDC Healthy Living: https://www.cdc.gov/HealthyLiving/

Member Satisfaction

CHP assesses member satisfaction with commercial plans through its member satisfaction survey. Results from the survey, along with analysis of complaints and appeals, are used to identify areas of opportunity to improve member satisfaction in areas such as quality of care, continuity of care, and care coordination. CHP's CMS-approved survey vendor will administer the Enrollee Satisfaction Survey (ESS) for CHP's Marketplace plan and administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for the Medicare Advantage plan. Results from these surveys, along with analysis of complaints and appeals, are used to identify areas of opportunity to improve member satisfaction in areas such as quality and continuity care, and care coordination. CHP maintains a strong internal focus on understanding the results of the survey to improve member experience of care and services, and to drive Star ratings performance. Member satisfaction results are communicated to members, providers and plan employees.

Provider Satisfaction

CHP fields an annual Provider Satisfaction survey to evaluate provider satisfaction with CHP and identify opportunities for improvement in areas such as quality of care, continuity of care, and care coordination. Results are shared with CHP committees and together they develop action steps to improve provider satisfaction. Provider satisfaction results are shared with network providers and CHP employees.

Risk Management

CHP has a Risk Management Program that addresses the safety and welfare of members and employees, and establishes policies and systems for identifying, reporting, analyzing and preventing adverse incidents. CHP works collaboratively with CoxHealth on risk management activities.

Peer Review

Peer review is an ongoing process that reviews care delivery and decision-making. CHP conducts peer review of providers as necessary and conducts peer review of internal utilization decisions made by physicians and utilization review coordinators in a process called inter-rater reliability. The Medical Department Director coordinates the process of peer review. Recommendations are made regarding appropriate action to correct deficiencies and monitoring of corrective action is performed.

On an ongoing basis, monitoring of practitioner or other provider care activities is conducted to determine medical necessity and appropriateness of care delivery. Cases for peer review may be identified through prior authorization for care delivery (e.g., pharmacy, inpatient care, and outpatient procedures), quality of care referrals, risk management cases, member complaints/grievances, and/or medical record documentation review.

Cases for inter-rater reliability studies are randomly selected on at least an annual basis from physician reviewer and utilization review coordinator UM decisions made within CHP. Files of peer review activities are maintained and used in the recredentialing process.

Quality Improvement Initiatives

CHP will have at least two formal Quality Improvement (QI) Initiatives each year. The Initiatives will meet all the requirements of AAAHC accreditation, Chapter 9G. The QI Initiatives will include a process to assess and monitor their performance utilizing qualitative and quantitative data collection methods. QI initiatives will be assessed to determine effectiveness and sustainability of improvement at least annually. Performance and improvement outcomes, including quality of care delivered to members, provider performance trends, member and provider satisfaction, member complaints and grievances, or any other Quality Improvement Plan focus area, are included in subsequent QI Initiatives and accounted for in policy revision and the determination of scope of services provided to members.