2024 Simpra Advantage Quality Improvement (QI) Program Description

QIC Approval: 02.09.2024
Board of Directors Approval: 02.20.2024
Updated 2.29.2024

SimpraAdvantage
Alabama's Healthplan

Contents

I. Introduction

The Simpra Advantage (Simpra) Health Plans Quality Improvement Program is a coordinated and comprehensive program designed to monitor, assess and improve the quality and appropriateness of care and services provided to our Special Needs Plan (SNP) members. We accomplish this by creating an infrastructure and processes that promote high quality outcomes and service. This document serves as a summary description of the Quality Improvement Program.

The Quality Improvement Program is revised as needed and reviewed at least annually. It is available for review by the various regulatory and accreditation entities upon request. It is also made available to our members and network providers.

II. Mission Statement

The mission of Simpra's Quality Improvement (QI) Program is to provide an effective, system-wide, measurable approach to continuously monitoring, evaluating, and improving access, quality of care and services for enrolled members and to work with providers to ensure a quality health care experience for enrolled members using a cost-effective and efficient method. The mission creates the foundation for organizational QI and includes:

- Quality assurance and performance improvement activities using the Plan-Do-Study-Act (PDSA) quality improvement model to guide day-to-day operations and decisions;
- Involvement from all business partners, departments, and services;
- A comprehensive approach regarding systems of care, management practices, and business practices;
- Decisions based on data, which are collected in a systematic format in alignment with our infrastructure.

III. Purpose

The purpose of the Quality Improvement (QI) Program is to ensure we have the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis.

The QI Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcomes of care and services delivered to our Special Needs Plan Members. In addition, it is designed to provide mechanisms that continuously pursue opportunities for improvement and problem resolution. Our QI Program includes all elements of the Centers for Medicare & Medicaid Services (CMS) Health Plan Management System (HPMS) template and is written to ensure compliance with Medicare Managed Care Manual Chapter 5 and 16b.

IV. Scope of Program

The scope of the QI Program includes monitoring and identifying opportunities for improvement of physical, behavioral health and pharmacy care and services. The services are assessed in various forums either weekly, monthly, quarterly, or annually, as appropriate. This is accomplished by partnering with

providers and other stakeholders to address performance improvement initiatives and corrective actions that are targeted at continuously improving quality of clinical and administrative services. This QI Program covers all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.

The QI Program is designed to address the potential physical, behavioral and pharmacy healthcare- related issues faced by Members. There is additional emphasis on the most vulnerable Members at a high risk for condition exacerbation, potentially avoidable hospitalizations, and complications from high-risk medications and polypharmacy.

A formal evaluation of the QI Program is performed annually and provides guidance for changes to the in the following year and may include the following:

- Analysis of cultural and linguistic needs of the population and clinical needs of members with complex health needs
- Monitoring/review of delegated activities
- Monitoring/review of provider accessibility and availability
- Monitoring/review of Member satisfaction/grievances
- Monitoring/review of Member safety
- Monitoring/review of continuity and coordination of care
- Measurement and improvement monitoring of the SNP model of care
- Analysis of the Chronic Care Improvement Program (CCIP)
- Collection and reporting of Medicare Advantage and SNP HEDIS® measures[1]
- Collection and reporting of CMS Display measures
- Collection and reporting of CMS Star measures
- Participation and analysis of the Medicare HOS and CAHPS survey results, if required[2]
- Credentialing and recredentialing
- Provider Peer Review oversight
- Adoption of clinical practice guidelines
- Adoption of Utilization Management guidelines
- Monitoring and analysis of under and over utilization
- Monitoring and analysis of adverse outcomes/sentinel events
- Collection and reporting of Part C Reporting Elements
- Collection and reporting of Part D Medication Management data

V. Program Governance and Staffing

Governing Body

The governing body is the Board of Directors (BOD) which is responsible for the establishment and oversight of the QI Program. The Chief Executive Officer, Chief Medical Officer and the Quality Improvement Committee are assigned responsibility for the implementation of the QI Program. The Chief

[1] Medicare Managed Care Manual Chapter 5, Section 30.1
[2] Medicare Managed Care Manual Chapter 5, Section 30.2; 30.3

Medical Officer provides clinical oversight for all QI activities and chairs the Quality Improvement Committee (QIC). The QIC reviews and provides oversight of the QI Program.

The Board of Directors is knowledgeable about the content and operation of the QI program and must exercise reasonable oversight with respect to the implementation and effectiveness of the QI program. QI activities are reported to the Board of Directors annually.

Staffing

A. Chief Medical Officer

The Chief Medical Officer (CMO) is a physician and holds a current license to practice medicine with the State Medical Board. The CMO is responsible for the implementation of all QI Program activities. The CMO chairs the QIC and works in conjunction with other designated team members to develop, implement and evaluate the QI Program. Responsibilities include, but are not limited to, the following:

- Provide clinical leadership for Plan-wide quality program through active participation in development and oversight of the implementation of the Quality Program, Annual Assessment, Annual Quality Project Work Plan;
- Establish processes to ensure that clinical decisions are rendered by qualified medical or behavioral health personnel, unhindered by fiscal or administrative management;
- Establish processes to ensure that the medical care provided meets the community standards for acceptable medical care;
- Establish processes to ensure that medical protocols and rules of conduct for plan medical personnel are followed;
- Developing and implementing medical policy;
- Actively participating in the functioning and resolution of grievance procedures;
- Providing support and clinical guidance to the program and to all providers in the network;
- Establish processes to ensure that the QI, Utilization Management (UM), Operations, and Provider Services departments interface appropriately to maximize opportunities for QI activities;
- Overseeing the formulation and modification of comprehensive policies and procedures that support the QI operations;
- Reviewing clinical grievances and Potential Quality Issues (PQI) and directing corrective actions to be taken, including peer review, if required;
- Directing health education and credentialing activities; and
- Assisting with review and analysis of data including but not limited to HEDIS® and QI program studies.

B. Compliance Officer

Responsible for establishing and implementing an effective system for routine monitoring and identification of compliance risks. Responsibilities include, but are not limited to:

- Serving as the primary CMS compliance contact with accountability for implementing processes to support an effective Compliance Program to help ensure against non-compliance and Fraud, Waste and Abuse (FWA).
- Performing ongoing assessment of regulatory risks to the company and clearly communicating results at the executive leadership level, including the Board of Directors.
- Collaborating with colleagues and business leaders in the development of compliant processes and required documentation as evidence of compliance and related activities.
- Reviewing the monitoring and auditing of processes performed by First-Tier and Downstream Entities and ensure the completion of corrective actions, as required.
- Providing ongoing oversight, direction, and management of the Plan's Compliance partners, including mentoring and development of individual team members.
- Representing the Compliance Program on committees and ad hoc teams, as appropriate.

C. Medical Director and Vice President of Clinical Quality

The Medical Director and Vice President of Clinical Quality oversees clinical quality and care management. This position assists the CMO on all clinical aspects of the program, including member clinical care, quality improvement, model of care implementation, utilization management, provider credentialing, and ongoing program development and improvement. Responsibilities include:

- Participate in implementation of the Quality Program, Annual Assessment of the Quality Program, an Annual Quality Work Plan and committee activities that support the quality program.
- Assist with development, review, and analysis of HEDIS and QI program studies.
- Participate in development of education content and implementation for Registered Nurses and Nurse Practitioners on care management, best practices, model of care implementation and clinical content.
- Review clinical grievances, Potential Quality Issues (PQI), and Quality of Care Issues.
- Oversee provider education regarding pharmacy, hospital utilization, quality improvement and responsible health care expenditures to improve clinical outcomes.
- Provide current medical expertise and direction for clinical policies and programs.

D. Director of Quality Improvement

The QI Director oversees the administrative day-to-day operations of the QI Department and is responsible for the execution and oversight of QI activities. Additional responsibilities include but are not limited to:

- In collaboration with the Plan Medical Director, developing and/or revising annually, the QI program and work plan and presenting for review and approval;
- Developing and/or revising QI policies and procedures annually;
- Implementing processes to ensure that quality trends and patterns are monitored, quality issues are identified, and corrective action plans are developed;
- Implementing processes to ensure that staff collect, monitor and act on data and report identified trends to the Plan Medical Director and Quality Improvement Committee;
- Implementing processes to ensure that QI activity including HEDIS®, Star Ratings, QI

Program studies (CCIPs), PQI reviews are conducted appropriately;

- Identify and implement measures and analysis to address health equity and reduce disparity gaps.
- Implementing processes to help ensure Member and Provider Satisfaction Surveys are conducted annually;
- Interfacing with all internal departments to ensure compliance to the QI Program and policies and procedures;
- Assuring compliance with quality improvement requirements of accrediting and regulatory agencies, as required.

E. QI Nurse

The QI Nurse provides support to the Plan and QIC and interfaces with other departments on day-to-day QI processes and issues. Additional responsibilities include but are not limited to:

- Performing statistical analysis relevant to QI functions and goals, including development of the annual QI evaluation;
- Provide direction on performance improvement activities to support improvement in quality of care based on result of various data points including the Model of Care, HEDIS®, Star Ratings, Display Measures, CCIP, PQIs, Member Satisfaction;
- Interface with the Plan Medical Director(s) on Clinical Quality meetings and QIC preparation;
- Conduct quality of care reviews; report activity to the QIC and collaborate with Plan Medical Director, as needed;
- Assist with sub-committee (i.e., EAC) meeting preparation and facilitation.

F. HEDIS Nurse Manger

The HEDIS Nurse Manager is the Subject Matter Expert (SME) for HEDIS/Stars measures and processes. He/she will manage, coordinate and monitor quality improvement and organizational projects from inception including HEDIS measures, Star ratings and CCIP to identify opportunities for improvement, monitor the success initiatives, track improvement, and provide a set of measurement standards. Responsibilities include:

- Development and oversight of Quality Improvement Projects and metrics related to HEDIS/Stars;
- Education of internal staff and external clients on HEDIS/Stars requirements;
- Develop and maintain a detailed HEDIS/Star project plan to include milestones, tasks, and target dates;
- Monitor project deliverables to ensure adherence to standards including operations documentation;
- Support the project life cycle including requirements gathering, creation of project plans, schedules, roadmaps;
- Support HEDIS audit process, and facilitate project execution, deployment and closure.
- Maintain detailed project documentation including meeting minutes, action items, issues lists and risk management plans;
- Manage and maintain relationships with vendors in support of HEDIS/Stars submission.

G. Other Staff and Resources

Additional staff and resources are available to collaborate on performance improvement and conduct statistical and data analysis sufficient to establish quality controls and improvement projects. The staff includes but is not limited to:

- Primary Care Physician (PCP)/NFist (a PCP specializing in the care of nursing home patients)
- Advance Practice Providers/Nurse Practitioners
- Data Analysts
- Network Service Specialists
- Other supporting clinical and administrative staff
- Interdepartmental support (UM, Operations, and Pharmacy)

VI. Committee Reporting Structure

Quality Improvement Committee

Description

The Quality Improvement Committee (QIC) is established by the authority of the Board of Directors as a standing committee and is charged with the development, oversight, guidance and coordination of all QI activities and the responsibility an effective QI Program. The QIC monitors provisions of care, identifies problems, recommends performance improvement initiatives, and guides the education of providers to improve health care outcomes and quality of service. The QIC is also responsible for UM activities as outlined in the UM Program Description. The QIC scope includes, but is not limited to, the following:

- Directing QI activity throughout the organization with a focus on improving processes to meet member and provider needs;
- Working to ensure provider participation in the QI program through planning, design, implementation and review[3];
- Annually reviewing and approving the QI Program, Work Plan, and Annual Evaluation;
- Reviewing and approving QI policies and procedures, guidelines, and protocols;
- Developing a measurable Chronic Care Improvement Program (CCIP) for each plan benefit package;
- Developing relevant subcommittees or workgroups for designated activities and overseeing progress;
- Responsibility for evaluating and giving recommendations concerning audit results, satisfaction surveys, HEDIS®, CMS Display and Star Measure performance, health equity and other QI Program activities, including CCIPs;
- Responsibility for ensuring member access, member safety, continuity and coordination of care, and overall performance of the Model of Care;
- Oversight of provisions of care including over and underutilization of medical, behavioral health and pharmacy services;

[3] Medicare Managed Care Manual Chapter 5 section 2

Reporting

The Quality Improvement Committee shall submit a summary report of quality activities and actions for review and approval to the Board of Directors annually.

Composition

The Chief Medical Officer is the chair and shall provide clinical guidance and oversight of the Committee. The QI Director provides administrative support for the meetings. Primary responsibilities include, but are not limited to:

- Directing the Committee meetings;
- Reporting Committee activities to the Board;
- Acting on behalf of the committee for issues that arise between meetings;
- Ensuring all appropriate QI activity and reports are presented to the committee;
- Facilitating committee involvement in review, evaluation and follow up of data presented;
- Ensuring there is a separation between medical and financial decision making.

Membership

Membership is assigned and will include representatives from the following:

- Medical Director
- Clinical Leads
- Compliance
- Quality Improvement
- Utilization Management
- Clinical Care Coordination
- Pharmacy Operations
- Member Services
- Network
- Operations
- Other members appointed at the discretion of the Chairperson

Quorum and Voting

A quorum consists of a minimum of five participants, three of the five must be Director level and above. Voting members will be Director level staff and above. Approval of actions is by a majority vote. Representatives and other guests may attend the meetings upon invitation.

Meeting

The QIC meets bimonthly but can meet more frequently if circumstances require or to accomplish the committee's objectives. In between meetings, members are expected to oversee relevant metrics and day to day activity structured to support continuous improvement in the Quality Improvement Program and escalate any significant variances to the CMO, Medical Director, QI Director or Compliance Committee, as applicable. The CMO may act on the Committee's behalf on issues that arise between meetings.

Confidentiality and Conflict of Interest

All committee members and participants will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement upon hire. Activities and minutes of the Committee are for the sole and confidential use of the Health Plan and are protected by State and Federal laws and the Health Insurance Portability and Accountability Act (HIPAA).

Recording of Meeting and Dissemination of Action

- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- All minutes are contemporaneous, dated, Committee approved and electronically finalized and reflect all committee decisions made.
- Meeting minutes and all documentation used by the Committee are the sole property of the Health Plan and are strictly confidential.
- The minutes are recorded in a nationally recommended format. All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are maintained in the QI Department.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

Credentialing and Clinical Peer Committee

Description

The Committee will be responsible for monitoring credentialing, re-credentialing, peer review, and clinical practice guidelines. The Credentialing and Clinical Peer Committee's scope includes, but is not limited to, the following:

- Oversight of all initial credentialing of new organizations and providers
- Evaluate newly trained health care professionals who have completed all appropriate training and education within the last 12 months and determine if an initial credentialing period of up to 60 days is permittable.
- Oversight of the re-credentialing of existing organizations and providers
- Review of providers and organizations with an identified or potential deficiency in their credentials
- Providing final approval or denial on provider credentialing decisions
- Providing consultation in the development of Credentialing policies
- Providing consultation in the development and/or adoption of Medical Necessity, Clinical Practice and New Technology guidelines and policy.
- Providing consultation on the approval of delegated organizations
- Reviewing provider appeal requests on adverse determinations
- Considers performance indicators such as those collected through the Quality Improvement (QI) program, Utilization Management (UM) reviews, customer grievances, and customer satisfaction surveys as applicable for recredentialing decisions.

Monitoring occurs in between credentialing cycles and includes ongoing monitoring of licensure sanctions; Medicare/Medicaid sanctions and exclusions (Office of Inspector General - OIG); CMS Opt Out and the

System for Award Management (SAM) which is the Official U.S. Government system that consolidated the capabilities of CCR/FedReg (Central Contractor Registration - will include FedReg), ORCA (Online Representations and Certifications Application), and EPLS (Excluded Parties List System) exclusions. The results of the ongoing monitoring are reported monthly to the Credentialing Committee for review and action as applicable.

Reporting

The Credentialing and Clinical Peer Committee shall provide a report to the Quality Improvement Committee quarterly. Provider network updates are reported to regulatory agencies as per contract requirements.

Membership

The Chief Medical Officer shall chair the committee. Committee members are appointed on an annual basis or as vacancies arise and may be staggered to protect the continuity of the committee functions. Representatives of CMS, or other appropriate State agencies may attend upon request.

As deemed necessary and appropriate, the Committee may invite other members of the Company's management team and such other persons necessary for the decision-making process.

Quorum and Voting

Only physician members can vote. A quorum consists of a minimum of 2 committee members plus a Chair. All approval of actions is by a majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. Non-Physician members of the Credentialing Review Committee may not vote but shall attend the meetings and provide support to the deliberations. In the event that the Credentialing Committee is unable to constitute a quorum for voting purposes because of conflicts of interest, alternative committee member (s) will be selected as needed, at the discretion of the Chairperson.

Meetings

The Credentialing and Clinical Peer Committee meets on a monthly basis. The committee can add an ad hoc/urgent committee meeting in situations where it is deemed necessary by the committee members.

Confidentiality and Conflict of Interest

All committee members and participants, including network providers, consultants, and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement upon hire. All members of the Credentialing and Clinical Peer Committee meetings annually sign a Confidentiality Statement that is kept on file.

Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the Credentialing Clinical Peer Committee are for the sole and confidential use of the Health Plan and are protected by State and Federal laws and the Health Insurance Portability and Accountability Act (HIPAA).

Recording of Meeting and Dissemination of Action

The Committee Secretary shall take written minutes of the meetings and shall provide copies of the minutes to the Committee Chair.

Notification letters will be sent to organizations and providers on final credentialing decisions within 30 calendar days of Committee decision date. Copies of notification letters shall be stored with the provider file and shall be made available to Committee members upon request.

Utilization Management/Appeals Committee

Description

The Utilization Management/Appeals Committee (UMAC) is responsible to the Quality Improvement Committee and Board of Directors for implementation of the UM program. Issues identified during the utilization review process as a potential quality variance will be forwarded to the Simpra Quality Department for evaluation and intervention, if warranted. The UMAC is accountable for monitoring, assessing, and influencing the appropriateness and efficiency of care across the continuum.

Reporting

The UMAC will report to the Quality Improvement Committee quarterly.

UMAC Structure

The UMAC consists of the Chief Medical Officer, who serves as the Chairperson, a physician who is independent of Associated Care Ventures |Simpra Advantage Plan, and at least one member from each major clinical department as appointed by the Chairperson of the UMAC.

The Chairperson oversees the Committee activities and reports findings to the Quality Improvement Committee. Committee member appointments are reviewed on an annual basis. The members of the UMAC include:

- Chairperson, Chief Medical Officer
- Medical Directors
- Independent Physician
- Director, Utilization Management
- Director of Care Management
- Director of Pharmacy
- Chief Compliance Officer
- Director, Appeals & Grievance
- Other, administrative or clinical personnel as deemed appropriate by the Chairperson

Meetings

The UMAC meets on a quarterly basis; there is a minimum of four (4) meetings held per year. The meetings will consist of two segments:
The first segment includes all members and focuses on utilization reports (approval and denial volumes, high utilization and low utilization trends, acute lengths of stay, acute admissions per thousand and observation services per thousand, turnaround time), general business, utilization management programs and provider/member surveys. The second segment of the meeting will occur if there are quality or other issues related to utilization review. Issues specifically related to medical review, appeals and other processes within the UM department will be addressed.

Voting

A quorum consists of 6 committee members. Approval of actions is by a majority vote by a quorum of voting members.

Delegation Vendor Oversight Committee (DVOC)

Purpose

The purpose of the Associated Care Ventures/Simpra Advantage (ACV/Simpra) Delegation & Vendor Oversight Committee (DVOC or 'the Committee') is to assist the Plan's Compliance Program in maintaining oversight of its contracted vendors, including First-Tier, Downstream, and Related Entities (FDRs) to ensure they perform in compliance with regulatory requirements and the expectations of ACV/Simpra when providing services to our members.

ACV/Simpra has business relationships with entities that are under contract with the Plan to perform certain functions that otherwise would be the responsibility of the organization to perform, including management and provision of services. The DVOC is responsible for overseeing ACV/Simpra delegated relationships to ensure consistent quality and adherence with the Centers for Medicare and Medicaid Services (CMS) regulatory requirements and ACV/Simpra expectations.

However, regardless of any relationships with entities, vendors, contractors, subcontractors, and FDRs, ACV/Simpra maintains ultimate responsibility for services provided to our members, the terms of the contract, and fulfillment of all terms and conditions of its contract with CMS.

Authority

As the DVOC deems appropriate, the Committee may form and/or delegate authority to subcommittees and may also conduct or authorize investigations into matters within its scope of responsibility.

Committee Responsibilities

DVOC responsibilities include:

- Perform comprehensive audits prior to formal delegation of any function of our business, including services provided to members, to ensure each vendor has the ability to fulfill the delegated obligation.
- Oversight of ongoing performance monitoring and annual auditing to ensure compliance with the regulatory requirements and ACV/Simpra expectations regarding the delegated functions, as well as to enhance activities to identify, detect, and prevent instances of non-compliance and Fraud, Waste, and Abuse (FWA).
- Continually monitor the vendor to ensure they maintain the capability to fulfill delegation obligations through review of their programs, policies, procedures, and service delivery.
- Engage the use of Corrective Action Plans (CAPs) to track remediation of identified gaps or deficiencies.
- Provide guidance as appropriate to business owners that have direct ownership of delegated vendor relationships.

Committee Membership

Membership will include representatives from the following ACV/Simpra operational areas:

- Compliance Leadership (Chairperson)
- Claims
- Enrollment
- Call Center
- Pharmacy
- Utilization Management
- Care Management
- Business Development
- Quality
- Provider Data Management
- Network Operations
- Other members appointed at the discretion of the Chairperson.

Reporting Structure

The DVOC will report to the Plan's Compliance Committee with a dotted line to the Quality Improvement Committee (QIC) at least quarterly.

Meetings and Procedures

Meetings

The DVOC maintains rules of procedure that are consistent with the bylaws of the Plan, the Compliance Program Description, the Standards of Conduct, and this Charter. The DVOC shall meet as often as it determines, but not less frequently than quarterly.

The DVOC may request that directors, officers, or employees of ACV/Simpra, its FDRs, or other persons whose advice and counsel are sought by the DVOC, attend any meeting of the DVOC to provide such pertinent information as the DVOC requests. All Committee members are expected to attend each meeting, in person or via teleconference.

Quorum and Voting

A quorum consists of a majority of Committee membership with at least one representative from the department(s)s responsible for the vendor(s) being reviewed. Approval of actions is by a majority vote. Representatives and other guests may attend the meetings upon invitation.

Confidentiality and Conflict of Interest

All DVOC members and participants will maintain the ACV/Simpra standards of ethics and confidentiality regarding both patient information and proprietary information. All ACV/Simpra employees are required to sign a Confidentiality Statement upon hire. Activities and minutes of the DVOC are for the sole and confidential use of ACV/Simpra and are protected by State and Federal laws and the Health Insurance Portability and Accountability Act (HIPAA).

Recording of Meetings and Dissemination of Actions

The following applies to each scheduled DVOC meeting:

- A written agenda will be used for each DVOC meeting.

- Meeting minutes:
  - will be comprehensive, timely, show indicators, recommendations, follow-up, and evaluation of activities,
  - are contemporaneous, dated, Committee-approved and electronically finalized and reflect Committee decisions made,
  - are recorded in a nationally recommended format. All unresolved issue/action items are tracked in the minutes until resolved, and
  - are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.
- Meeting minutes and all documentation used by the Committee are:
  - the sole property of ACV/Simpra and are strictly confidential, and
  - are maintained in the QI Department.

The Committee shall review and reassess the adequacy of this Charter annually. The Committee shall also oversee an annual assessment of the Plan's Compliance Program and report the results to the Governing Body.

Enrollee Advisory Committee (EAC)

Description

The Simpra Quality Improvement Committee has established the Enrollee Advisory Committee (EAC) to provide a formal method for enrollees' voices to be included in Simpra decision-making process and to provide insight and recommendations to help improve the overall enrollee experience. EAC feedback will be integral in identifying barriers to care and initiating best practices to improve access and health equity for underserved populations.

Regulations

CMS regulations § 422.107(f) require Medicare Advantage (MA)organization offering a D-SNP benefit must establish one or more enrollee advisory committees to solicit direct input on enrollee experiences. The establishment and maintenance of the enrollee advisory committee is a valuable beneficiary protection to ensure that enrollee feedback is heard by managed care plans and to help identify and address barriers to high-quality, coordinated care for dually eligible individuals.

Reporting

The EAC shall submit a summary report of recommendations, follow-up and review to the QIC.

Composition

The Quality Director is the chair and shall provide guidance, administrative support and oversight of the Committee. Primary responsibilities include, but are not limited to:

- Facilitating the Committee meetings;
- Reporting Committee activities to the QIC;
- Acting on behalf of the committee for issues that arise between meetings;
- Ensuring all appropriate activity and reports are presented to the committee;
- Facilitating committee review, evaluation and follow up of data/reports presented;

Membership
The Enrollee Advisory Committee will include a reasonably representative sample of the population enrolled in the D-SNP or other individuals representing those enrollees. Membership will also include representatives from the Simpra Departments:

- Medical Director
- Clinical Leads
- Compliance
- Quality Improvement
- Pharmacy Operations
- Member Services
- Network
- Operations
- Other members appointed at the discretion of the Chairperson.

Quorum and Voting
A quorum consists of a minimum of four participants including at least one member. Committee decisions require approval by a majority of the assembled quorum. Representatives and other guests may attend the meetings upon invitation.

Meetings
The EAC meetings will be an inclusive environment focused on shared communications which will allow us to integrate the voice of the customer into ACV/Simpra processes. The EAC will meet at least three times a year.

Recording of Meeting and Dissemination of Action

- A written agenda will be used for each meeting.
- Minutes are kept for each meeting and are submitted in a timely manner to the QIC.
- Meeting minutes and all documentation used by the Committee are the sole property of Simpra Advantage Health Plan and are strictly confidential.

Confidentiality
All committee members and participants will maintain the standards of ethics and confidentiality regarding both enrollee and proprietary information. Simpra staff are required to sign a Confidentiality Statement upon hire. At the beginning of each meeting members agree to maintain confidentiality of all items reviewed and discussed. Activities and minutes of the Committee are for the sole and confidential use of the Health Plan and are protected by State and Federal laws and the Health Insurance Portability and Accountability Act (HIPAA).

Vulnerable Member Review Committee (VMRC)- NEW 2024 COMMITTEE

Program Description/Charter added following review and approval at the 2.29.2024 VMRC meeting.

Description
The Vulnerable Members Review Committee (VMRC) is established by the authority of the Quality Improvement Committee as a standing committee and is charged with review of matters concerning or relating to the quality of care delivered to members and efforts to advance the quality of medical care provided. The Committee will identify activities to ensure member care is safe, effective, patient centered, efficient, timely and equitable.

The Committee provides guidance regarding compliance with professionally recognized standards of care, advancements of the field of clinical quality and safety, applicable federal/state laws and

regulations and Simpra Advantage policies.

The Committee identifies issues and addresses barriers to care. The Committee may initiate inquiries, investigations and make recommendations for improvements. The Committee will monitor the progress of reviewed members for improvement progress.

This Committee will also serve as the forum for completion of required medical record reviews for quality of care and clinical practice guidelines.

Committee responsibilities include:

- Review of referred or flagged cases for clinical appropriateness and quality of care.
- Identifying and addressing the needs of members who are identified as vulnerable (high risk, high frailty score, multiple admissions, etc.).
- Providing support and oversight to improve care of most vulnerable members.
- Reviewing adverse incidents and root cause analyses; if appropriate, recommend corrective action.
- Monitoring summary reports of quality and patient safety activities for potential trends and prospective review.

Reporting

The VMRC shall submit a quarterly summary report of aggregate data/activities and actions to the QIC.

Composition

The Chief Medical Officer and VP of Clinical Quality co-chair the committee and shall provide clinical guidance and oversight of the Committee. Administrative support, preparation, documentation, and coordination of the meetings is provided by the Quality Nurse.

Membership

Membership will include representatives from the following:

- Medical Director(s)
- Clinical Leads
- Quality Improvement
- Utilization Management
- RN Care Coordinators
- Pharmacy Operations
- VP Nursing Facility Relations
- Other members will be invited at the discretion of the Chairperson.

Meetings

The VMRC meets monthly but can meet more frequently if circumstances require or to accomplish the committee's objectives. Meeting minutes are taken for each meeting and provided the following month for review and approval. A quorum representing a majority of the members must be present to conduct business.

Confidentiality and Conflict of Interest

All committee members and participants will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement upon hire. Activities and minutes of the Committee are for the sole and confidential use of the Health Plan and are protected by State and Federal laws and the Health Insurance Portability and Accountability Act (HIPAA).

VII. Access to Providers

In creating and developing the delivery system of providers, the Health Plan will take into consideration assessed special and cultural needs and preferences of our Members. Within the service area, the Health Plan maintains a network of contracted physicians to meet access standards. Accessibility of services is measured by the timeliness of appointments for routine, urgent and emergency care. On-site Nursing Home-based primary care will be provided by the Health Plan's NFist physicians and Nurse Practitioners. Specialty physicians will provide services in the nursing home when possible. Appropriate transportation will be provided, as necessary. Each provider/practitioner must, at a minimum, meet the following standards of access and availability for all Health Plan Members as outlined in the Provider Manual.

VIII. QI Process

Continuous Quality Improvement

Simpra utilizes a continuous quality improvement (CQI) process to identify opportunities to improve both the quality of care and quality of service for Members. The Health Plan adopts and

maintains clinical guidelines, criteria, quality screens, as required by CMS[4], and other standards against which quality of care, access, and service can be measured and improved upon using a Plan, Do, Study, Act (PDSA) method.

The Continuous QI (CQI) process will be utilized when an opportunity for improvement is identified through monitoring of either quality of care or quality of service indicators. The steps in the CQI process will be documented; results and action plans for improvement will be presented to the QI Committee (QIC) for review and approval. These steps will include:

- Determination of the relevance of the issue to the population;
- Evaluation of baseline measure(s);
- Analysis to identify an opportunity for improvement;
- Analysis to identify possible root cause or barriers;
- Planning and implementation of actions to eliminate possible root causes or barriers;
- Evaluation of performance and effectiveness of the interventions by quantitative and qualitative remeasurement after implementing actions;
- Analysis to determine how actions impacted performance; and
- Continued re-measurement to determine whether improvements are sustained.

Proposed action plans will be approved by the QIC allowing the impacted departments to move forward with implementation. Subsequent to committee review, an improvement action plan such as a Quality or Process Improvement Project will be developed and implemented. This improvement action plan will contain a description of necessary corrective actions as well as timeframes for implementing the actions and evaluating the outcomes. Specific corrective actions and established timeframes for correction will depend on the type of data or process being addressed.

[4] Medicare Managed Care Manual Chapter 5, Section 20

The CQI process collects, analyzes, and integrates data necessary to implement all QI Projects. Additionally, the QI Program provides mechanisms and processes for ensuring oversight of Plan services. It ensures alignment of member safety activities with organizational goals to provide high quality health care and services to our Members and helps determine if the Quality Program effectively addresses the specific needs of our Members.

Simpra has established a process for annual formal evaluation of the impact and effectiveness of the QI program and a process for correction of all problems that are identified through internal surveillance, complaints, or other mechanisms.

QI Projects are written in a recognized written format, which assures we evaluate the intervention completely. QI Projects must meet guidelines for preventive care standards. The guidelines include Advisory Committee on Immunizations Practices, U. S. Preventive Services Task Force and all other nationally recognized practice guidelines, as appropriate.

When an improvement opportunity is identified and selected, we will employ the PDSA (Plan, Do, Study, Act) methodology of QI to identify barriers to improvement, identify appropriate interventions, and to analyze the effectiveness of the interventions employed to achieve improvements in the results for the targeted performance measure.

Standards of Practice

The standards of practice used as criteria, measures, indicators, protocols, practice guidelines, review standards or benchmarks in the QI process are based on professionally recognized standards. Sources for standards include but not limited to:

- National and local medical professional associations;
- Local professionally recognized practices;
- Review of applicable medical literature;
- Available medical knowledge.

Standards are used to evaluate quality of care of Providers and are incorporated into policies and procedures. Thresholds and targets derived from these standards/norms and accepted will be:

- Measurable;
- Achievable;
- Consistent with national/community standards;
- Consistent with requirements of regulatory agencies and legal guidelines;
- Valuable to the assessment of quality or the potential improvement of quality for our Member population.

Standards are communicated to Providers in a systematic manner that may include:

- Health Plan Provider Manual;
- Website;
- Clinical meetings;
- Notices or Newsletters.

Health Information System

Simpra utilizes data from our care management system, as well as customer service, enrollment, claims, and utilization management systems. This data allows us to manage patient care and to assess and improve health care quality and outcomes as well as to process prior authorization requests, case-manage, provide educational materials, track and trend appeals and grievances, document Member and provider inquiries, and track customer service performance statistics. The system is maintained and utilized by the Information Technology team, applying HIPAA standards at all times to validate and protect Member's health information.

Data can be collected to quantify performance against targeted baselines, benchmarks, thresholds or indicators, analyzed and integrated. The quality review of data occurs through departmental reports on a daily, weekly, monthly, quarterly, bi-annual and annual basis. Corrective action plans are reviewed and documented as needed, with implementation of system enhancements as identified to resolve quality processing items. Findings are reported to the QI Committee (QIC).

Member Satisfaction

1. Grievance and Appeals Process

Simpra has an established complaint, appeals, and grievances system, in accordance with CMS requirements, for the resolution of grievances and appeals initiated by Members or providers concerning health care services. The process ensures that Members have access to full and fair filing processes and that they receive ample assistance if needed.

Simpra's policies and procedures are based on Medicare and Medicaid regulations including Title 42 Code of Federal Regulations (CFR) Part 438, Subpart F; 42 CFR 422, subp. M; 42 CFR 423, subp. M; Medicare Managed Care Manual, Chapter 13; and Medicare Prescription Drug Benefit Manual, Chapters 5, 6 and 18. Simpra will monitor the CMS Health Plan Management System (HPMS).

2. Member Satisfaction Surveys

Simpra will monitor feedback and responses from Member satisfaction surveys to identify and pursue opportunities to improve Member satisfaction and the processes which impact satisfaction. Results are presented to the Quality Improvement Committee for recommendations and interventions. We use internal benchmarking to compare performance year over year. This helps guide decisions about future projects, improvement opportunities, and program development.

Chronic Care Improvement Program (CCIP) [5]

The Chronic Care Improvement Program (CCIP) focuses on effective management of chronic conditions unique to the population we serve. Simpra will have a written CCIP outlining why the selected chronic condition was chosen, the planned interventions, the goals, and how progress will be measured, and the overall anticipated outcome.

All eligible Members have an annual health risk assessment completed and an individualized care plan developed that will guide in the selection of the chronic condition to address. Additionally, identification can occur through data sources such as hospital inpatient/discharge/ER claims, lab result data,

[5] Medicare Managed Care Manual Chapter 5 Section 20.1

pharmaceutical claims data, outpatient data, MDS, nursing facility data, outpatient claims and encounter data. Data is assessed for specific diagnosis and procedure codes (ICD-10, CPT, HCPCS and NDC) including (but not limited to) the following conditions:

- Hypertension
- Asthma and/or COPD
- Diabetes
- Heart Failure
- Dementia

The Quality Improvement Committee will review and approve the CCIP topic. The CCIP will be conducted over a three-year period and will be based on the Plan – Do – Study – Act (PDSA) quality improvement model. The QI Department evaluates the outcomes of the CCIP with the utilization of measurable analysis and post-intervention studies.

Clinical Practice Guidelines and UM Criteria

Simpra adopts nationally recognized Clinical Practice Guidelines (CPGs), such as U. S. Preventive Services Task Force Standards; The Society for Post-Acute and Long-Term Care Medicine (AMDA); and the American Diabetic Association which are submitted to the Credentialing Committee for discussion and recommendations. All clinical practice guidelines are approved through the Credentialing Committee every other year, or more frequently if substantive changes are noted.

Adherence to Clinical Practice Guidelines is monitored using a variety of methods and is outlined in the Policy.

The UM Department uses nationally developed and accepted review criteria and locally developed medical coverage policies to assist the clinical reviewer in determining appropriate health care for specific clinical circumstances. This may include, but is not limited to, decisions involving pre-authorization inpatient review, level of care, discharge planning and retrospective review. Clinical Review Criteria are developed through a formal process and are based on authoritative sources, including clinical, peer-reviewed literature and expert consensus and consider local practice patterns and Plan benefit designs as well as nationally and regionally accepted standards.

All Clinical Guidelines and Criteria are reviewed annually and approved by the Credentialing Committee. Providers will be educated on guidelines and criteria.

Peer Review

Peer review is conducted in any situation where peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific provider or to review aspects of care, behavior or practice, as may be deemed inappropriate. The Chief Medical Officer is responsible for authorizing the referral of cases for peer review. All peer review consultants (including members of the Credentialing Committee) are duly licensed professionals in active practice.

At least one consultant will be a provider with the same or similar specialty training as the provider whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty. The Chief Medical Officer can send cases out for a specialty review and consultation to be used for the peer review process. The Chief Medical Officer will confirm that the peer review consultants have

the necessary experience and qualifications for the review at hand.

Continuity and Care Coordination

The QI Program ensures the continuity and coordination of care that Members receive. Multiple tools are used to oversee aspects of documentation including but not limited to:

- Medical Record reviews;
- Healthcare Effectiveness Data and Information Set (HEDIS®);
- Model of Care Metrics;
- Plan Metrics;
- Pharmacy Metrics.

This collaborative information is tracked and analyzed to identify opportunities for improvement. When a Provider discontinues a contract with the Health Plan, the Member can continue with that Provider for care for the remainder of active treatment or 90 days, whichever is shorter.

Member Safety

The QI Program has a risk management/member safety component which identifies supports and facilitates member safety throughout our network operations. We evaluate multiple aspects of the patient care process, such as hospital safety, health education, partnering nursing facility safety, drug utilization safety, potential quality issues, and Appeal and Grievances.

Programs are in place through our Pharmacy Department to identify Members who are on medications that are contraindicated (such as drug interactions) or when warnings have been issued. All Members receive a comprehensive medication review and reconciliation during initial assessment and with each follow up to identify issues related to patient safety, drug to drug interactions and drug-disease interactions.

The Member's grievance system has codes identified to track grievances relating to safety issues. Simpra strives to include patient safety specific education in our intervention and program mailings and have educational material available to Members through multiple sources. Our Provider Manual documents specific patient safety issues and policies.

The protection of each Member's health, safety, and well-being is of paramount importance, and we are committed to ensuring that every staff member that comes in contact with the Members are held to the highest standards of professionalism, integrity, and service.

Potential Quality Issues (PQI)

A major component of the QI Program is the identification and review of potential quality issues and the implementation of appropriate corrective action to address confirmed quality of care issues.

A PQI is a deviation or suspected deviation from expected Provider performance, or clinical care or outcome of care that cannot be determined to be justified without additional review. Such issues will be categorized to allow for tracking and trending.

The QI Department has adopted a system of severity levels to be applied to any and all potential quality of care and service issues and actual quality of care and service issues. Any severity level that reveals a quality-of-care issue rated 3 or above is required to have Medical Director review to determine appropriate actions.

Sentinel/Adverse Events

The QI Process reviews sentinel events to monitor important aspects of care, accessibility, and service.

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof to a Member.

Simpra will identify and respond appropriately to all sentinel events occurring within the facility or associated with services that the facility provides. Appropriate response includes:

- Conducting a timely, thorough, and credible root cause analysis;
- Developing an action plan designed to implement improvement to reduce risk;
- Implementing the improvements and;
- Monitoring the effectiveness of those improvements.

Quality Metrics

Simpra actively takes part in reporting to support oversight of multiple measures in accordance with CMS and other regulatory standards. The measures include but are not limited to:

- Healthcare Effectiveness Data and Information Set (HEDIS®);
- CMS Star Measures;
- CMS Display Measures;
- Model of Care Metrics;
- Part C Metrics;
- Part D Metrics.
- The QI Department collects data through multiple sources:
    - Claims and encounter data;
    - Medical record review;
    - Proactive Measure Review;
    - Specialized software program that runs each measure proactively during the measurement year.

Member listings of services that have not been captured and profile reports with peer comparisons are provided to primary care providers in an effort to ensure member's care is appropriate and complete.

Every measure is compared to National benchmarks (if a benchmark is not available, a goal is established) and a quantitative analysis will detail the plan's performance against prior performance, the plan goal and benchmark. Measures that do not meet minimum performance levels or have a significant drop-in rate may have a performance improvement plan developed.

All outcome monitoring and analysis is reported to the QI Committee (QIC) and/or the appropriate subcommittee and is also reviewed by clinical leadership. The frequency at which quality measures are monitored is dependent upon the measures and type of data used to monitor performance. Monitoring of the quality measures may be done monthly, quarterly, bi- annually and annually. For example, final audited HEDIS® measures are collected and reported annually whereas measures assessing over- and under-utilization may be monitored monthly or quarterly.

QI Organization (BFCC-QIO)

CMS contracts with a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) to fulfill provisions in Title XI of the Social Security Act as amended by the Peer review Improvement Act of 1982.

These provisions relate to improving the quality of care for SNP Medicare Members, protecting the integrity of the SNP Medicare Trust Fund by ensuring that payments for services are reasonable and medically necessary and protecting Members by addressing care related complaints and other Member issues.

Simpra will adhere to the reporting requirement set forth by CMS through the BFCC-QIO.

Practitioner/Provider Performance Data

To ensure compliance with regulatory standards, Practitioners and Providers must comply with Simpra's policies and procedures and allow the use of their performance data (i.e., HEDIS®, clinical performance data).

Auditing and Oversight

Simpra conducts QI audits, studies, and programs to assess quality of service to our Members, including monitoring both the quality of care delivered to Members and the documentation of such care including adherence to the model of care, safety issues, clinical and/or preventive guideline compliance, continuity and coordination of care, over- and under- utilization of services, confidentiality practices and inclusion of Members' input into treatment plan decisions. The review process allows for identification of the provider's level of compliance with contractual and regulatory standards achieved in the maintenance of Member records. We use multiple tools to oversee aspects of documentation including but not limited to:

- Medical Record reviews;
- Healthcare Effectiveness Data and Information Set (HEDIS®);
- Model of Care Metrics;
- Plan Metrics;
- Pharmacy Metrics;
- Credentialing Information.

Primary Care Physicians and Advanced Practice Providers who are responsible for the Model of Care receive information on their performance throughout the year. We conduct provider training as needed to facilitate greater compliance in future assessments. If, upon review, a provider's overall results fall below the specific metric goal, additional review will be conducted and a Corrective Action Plan (CAP) may be implemented, if needed. Results are reported to the Quality Improvement Committee. If a provider is placed on a CAP, the information will be reported to the Credentialing and Clinical Peer Committee for oversight.

Interventions and Follow-Up for Clinical Issues

The QI Department will recommend opportunities to improve the delivery and quality of care through the design and implementation of QI interventions. Wherever possible, these interventions will be designed to achieve systemic or procedural improvements affecting multiple Members, Providers or services. Such interventions may include but are not limited to:

- Providing feedback to providers to inform them of gaps in care or specific findings of QI reviews

pertaining to the provider in question;

- Providing health promotion and health education programs to inform Members of ways to improve their health or their use of the health care delivery system;
- Modifying administrative processes to improve quality of care, accessibility and service. These processes may include, but are not limited to, customer services, UM and case management activities, preventive services and health education;
- Modifying the provider network, including adding providers, as indicated, to improve accessibility;
- Taking disciplinary action against providers;
- Providing information to Members in their primary "threshold" languages.

Corrective Action Plan

When conducting any activity that reveals any opportunity for improvement, Simpra will develop a performance improvement initiative. Corrective Action Plans will be developed, as required.

Dissemination of Information

QI activities are presented and reviewed by the Quality Improvement Committee and may include but are not limited to:

- Model of Care audits;
- Sentinel events;
- CCIPs;
- Performance Improvement Initiatives;
- Policies and Procedures;
- Delegation audit results;
- Model of Care;
- Facility Star Ratings;
- Satisfaction survey results;
- UM trends;
- QI Program, Work Plan, Annual Evaluation and Quarterly Reports;
- HEDIS® and other quality metric data;
- Star Rating trends;
- Regulatory information.

Results of QI activities are communicated to members and providers, and may include:

- Correspondence with the Provider showing individual results and a comparison to the group;
- Correspondence with the Providers showing results and comparisons to the network;
- Regularly scheduled conference calls with Advanced Plan Practitioners;
- Member and Provider newsletters and website;
- Provider Manual.

The QI Program Description and performance results are made available to all providers and Members upon request. Members and providers are notified of the availability through the Member Handbook and Provider Manual.

Each department has representation on the Quality Improvement Committee and receives information on a regular basis.

The QI program progress is available for CMS review as requested.

Quality Outreach and Provider Participation[6]

The Quality Program will have the responsibility of providing information to nursing facilities, Advanced Plan Practitioners and primary care physicians (PCP) so that they may be aware of the Quality Improvement Program and goals and to encourage participation in activities to improve care. A key component of the Quality Program is to develop strong and collaborative relationships with these providers through outreach efforts. Outreach will emphasize the provider's role with the Model of Care, HCC Diagnosis coding, HEDIS®, Star Ratings, CMS Display measures, and any other key focus areas as identified by CMS and HHS.[7]

Staff engage with Providers to offer education on the following:

- Improving access to quality care for Members;
- Limiting barriers to care for Members;
- Provider Portal;
- HEDIS®, Star Ratings, CMS Display measures and pertinent CMS and HHS identified quality initiatives;
- Improving documentation practices;
- Improving identification of Members who have not been seen or have gaps in care;
- Identifying opportunities to limit barriers between the provider and the Plan;
- Clinical care resources and Member referral instructions;
- Collaboration on the collection of important diagnosis and service information.

The Quality Outreach Program sustainability is attributed to the following two factors:

- Ensuring that providers understand the requirements. The better providers understand the measures, the higher probability of reaching an improvement over time.
- Outreach staff become a permanent resource to nursing facilities.

Serving Members with Complex Needs

Model of Care

1. **Description** – The Model of Care (MOC) provides a description of the SNP population that Simpra serves. This description helps us target the population and identify those specific specialized needs, so resources and services are available to those who need them.
2. **Measurable Goals** – The MOC has detailed specific measurable goals that address access to care, coordination of care, transition of care, preventive health, utilization and health outcomes.
3. **Staff Structure** – Each department is involved in supporting and/or directly participating in the MOC. An organization chart with an emphasis on MOC responsibilities is attached to the MOC.
4. **Interdisciplinary Care Team (ICT)** – The composition of the ICT will be individualized according to the Member's clinical and psychosocial needs, which is detailed in the MOC.

[6] Medicare Managed Care Manual Chapter 5 section 20
[7] CMS Managed Care Manual Chapter 5, Section 20, item 4.

5. **Provider Network and Clinical Practice Guidelines** – The provider network is continually assessed to identify additional specialized needs of the SNP population and gaps in coverage. Actions are taken to ensure appropriate medical providers, mental health providers, acute and post-acute facilities and other ancillary organizations necessary to provide care to the SNP population.
6. **Training** –Staff are trained on the MOC, which includes but is not limited to all aspects of care management and clinical guidelines. Provider's staff is also provided training on the scope, functions and requirements of the MOC.
7. **Health Risk Assessments** – The Health Risk Assessment Tool is designed to capture self-reported health status information along with demographic information, and past medical and social history. The tool helps identify medical, functional, cognitive, psychosocial, and mental health needs and potential gaps in care. The Health Risk Assessment is designed to be completed within 30 minutes and contains geriatric-specific, evidence-based assessments.
8. **Individualized Care Plans** – The Individualized Care Plan is the long-term, longitudinal care plan incorporating specific health goals, treatments, services, and interventions required to meet the Member's current health conditions and improve the overall quality of the Member's health. Based on the results of the HRAT, the post-HRA visit timeframe is set and practitioners take HRA responses into account, along with results of a physical examination and other available health information, to decide if the member's care and treatment plan should be updated. An Individualized Care Plan is generated for each member.
9. **Care Coordination** – Care transition protocols are incorporated to provide an integrated, proactive approach to safely transition members between levels of care and across care settings.
10. **Communication** – The MOC document describes the structure of communications which are supportive of performing the MOC components.
11. **Performance and Health Outcomes** – The QI Department works with all departments involved in the MOC to collect and analyze the data captured during the process. This data is reported to staff necessary to conduct care management. Reports are provided to committees and the Board of Directors. The QI department will provide health outcomes analysis to all stakeholders.

IX. Effectiveness of the QI Program

Measurable Goals

Outcome measures that account for performance in clinical, administrative, cost of care and member safety are defined for the program and incorporate goals and internal or external benchmarks. Section 4 of the Model of Care and the Plan specific CCIP outlines clearly stated and measurable benchmarks and goals.

Benchmarks are set based on Plan performance compared to other comparable SNP Plans.

Goals are outlined below and may include:

- Top tier (4 or 5) Star Ratings for CMS Star Measures;
- NCQA National percentiles for SNP HEDIS Measures or a 5% improvement over prior year;

- National Averages for CMS Display and Patient Safety Measures.

The Quality Improvement Committee oversees progress toward meeting goals and performance benchmarks.

QI Calendar/Work Plans

The QI Work Plan/Calendar are developed annually outlining QI activities for the year. The Work Plan will include all activities not completed during the previous year, unless identified in the annual evaluations as issues that are no longer relevant or feasible to pursue.

The Work Plan is reviewed by the Chief Medical Officer and submitted to the QIC and Board of Directors for review and comment.

The QI Work Plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements and identified areas for improvement.

Measuring Effectiveness of Care Management Programs

Care Management Programs, such as Model of Care, CCIPs, HEDIS®, grievances and PQIs, are measured on a consistent basis to demonstrate effectiveness of the interventions established. These measurements are established through the QIC and Credentialing and Clinical Peer Committee and specific timeframes for re-measurement and methodology vary.

Measurements and studies are presented to the QIC and the Board of Directors and are summarized in the annual evaluations. Quarterly reports are an evaluation of the progress of the QI activities, as outlined in the Work Plan, and are submitted to the QIC for review and comment each quarter.

Quarterly Reports

Quarterly reports are an evaluation of the progress of the QI activities, as outlined in the Work Plan, and are submitted to the QIC each quarter.

Annual Plan Evaluation[8]

A formal evaluation of the impact and effectiveness of the QI Program is performed each year. QI activities, as defined by the QI Work Plan, will be evaluated annually to measure performance for the year and to assist in revising the QI Program and preparing the following year's Work Plan. The evaluations are reviewed and approved by the Chief Medical Officer and QIC and submitted to the Board of Directors.

X. Resources and Interdepartmental Interface

Pharmacy Department

The Pharmacy Department and QI Department work collaboratively on disease management, medication compliance, utilization management, patient safety, medication therapy management, and study projects.

Utilization Management (UM) Department

The UM Department frequently identifies potential risk management and quality of care issues and health education needs through care management, inpatient review, utilization review, referrals, and post-acute management.

[8] Medicare Managed Care Manual Chapter 5, Section 20

Member Services Department

When a Member Services representative identifies a potential quality of care issue from a Member it is forwarded to the Grievance Department for resolution. The Grievance Department will involve Quality Nurses in the review of clinical issues. Member Services records all incoming calls by specific indicators for tracking, trending and reporting.

Credentialing Department

QI information is provided to the Credentialing Department for inclusion in the credentialing/recredentialing process. The QI Department provides the Credentialing Department with any corrective action plans related to PQI reviews, as appropriate. The QI Director works with the Credentialing Department to ensure peer review cases, as directed by the Chief Medical Officer, are reviewed by the Credentialing and Clinical Peer Committee for review and action.

Network Operations Department

The Network Operations Department assists the QI Department in obtaining QI information from and disseminating information to providers. In addition, the Network Operations Department:

- Serves as a liaison between the QI Department and providers to facilitate education and compliance with approved Health Plan's standards, policies and procedures;
- Assists the QI Department with providers who do not comply with requests from the QI Department;
- Ensures contracted ancillary providers and facilities meet regulatory requirements.

Claims Department

The QI Department utilizes claims data to help in identifying targeted populations for CCIPs, quality initiatives and to identify potential quality of care issues and sentinel diagnoses.

Health Informatics Department

The QI Department works collaboratively with the Health Informatics Department to collect, analyze and integrate data into our QI process. The QI Department works with Health Informatics to ensure that data is accurate and complete. Specialized and standardized reports are generated through the Informatics Department so data elements can be continuously monitored. Through this department data is maintained for regulatory agency review. The data is also used to conduct an annual review of the overall QI Program. Data being submitted from outside vendors or being sent out of our organization goes through the Informatics department and the Information Systems Department to ensure all HIPAA regulations are being met. No file containing member specific information is sent out of the QI Department without meeting all HIPAA requirements.

XI. Part C – Reporting Elements

Simpra utilizes the Medicare Part C and D Plan Reporting Requirements and Technical Specifications Documents along with associated guidance (CMS User Group Calls, HPMS memos, NCQA documentation, State/Federal regulations, etc.) to develop reporting protocols that clearly identify the required data elements and corresponding source data. The Informatics team develops these protocols in collaboration with the business owner so that the information reported accurately represents the required measure. The structured protocols ensure consistency and reproducibility of the information that is reported. Additionally, as per CMS guidance, Simpra will engage the services of a third-party entity to perform data validation.

The QI Committee and the Compliance Committee are responsible for reviewing the results of the Part C and D Plan Reports and identifying trends or issues that require intervention. Action items identified by the Committees will be carried out by the appropriate teams. Minutes of the committees reflect recommendations and actions generated by review of the Part C Reports.

XII. Part D – Medication Therapy Management

Simpra provides a Medication Therapy Management Program (MTMP). Pharmacists and other providers utilize pharmacy claims data to identify Members who meet the program criteria (e.g., multiple chronic diseases, multiple Part D medications, pharmacy costs above an MTM cost threshold, or opioid overutilization).

MTMP components include interventions for both Members and prescribers, annual comprehensive medication reviews (CMR) with written summaries, and quarterly targeted medication reviews (TMR) with follow-up interventions. For Members who have cognitive impairment, MTMP providers will include caregivers, health care proxies, or legal guardians.

Medication profiles associated with these Members are reviewed to identify opportunities to improve the pharmaceutical regimen and align the regiment with the Member's goals and wishes in addition to the care teams. Examples of the clinical observations include, but are not limited to, identification of duplicate therapy, harmful drug-drug interactions, inappropriate dosing, ensuring that the drug regimen is consistent with national treatment guidelines, etc. Clinical recommendations are based on nationally recognized protocols and guidelines approved by the Credentialing and Clinical Peer Committee.

The pharmacist provides their observations and treatment modification recommendations to the Member's primary care provider. Provider response to the recommendations is tracked by monitoring responses returned to the Health Plan and information obtained from prescription claims data. Additionally, for high-risk situations, the MTMP providers may contact the provider by phone and will monitor the resolution. If the high-risk issue is not resolved, the matter is reported to the Chief Medical Officer for peer-to-peer discussion. By actively engaging the Member in understanding the appropriate use of their medication, MTMP outcomes may be further enhanced.

Data associated with the MTMP is obtained directly from the MTMP database and pharmacy claims data. The Pharmacy Director is responsible for evaluating the accuracy of the data and providing overall program oversight in collaboration with the Plan's clinical pharmacists. The MTMP activity and outcomes are presented to the QIC. The Committee is responsible for reviewing the program's effectiveness and identifying program modifications or issues and trends that require action.

XIII. Confidentiality and Conflict of Interest

All information related to the QI process is considered confidential. All QI data and information, inclusive of but not limited to, minutes, reports, letters, correspondence, and reviews are housed in a designated, secured area in the QI Department. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

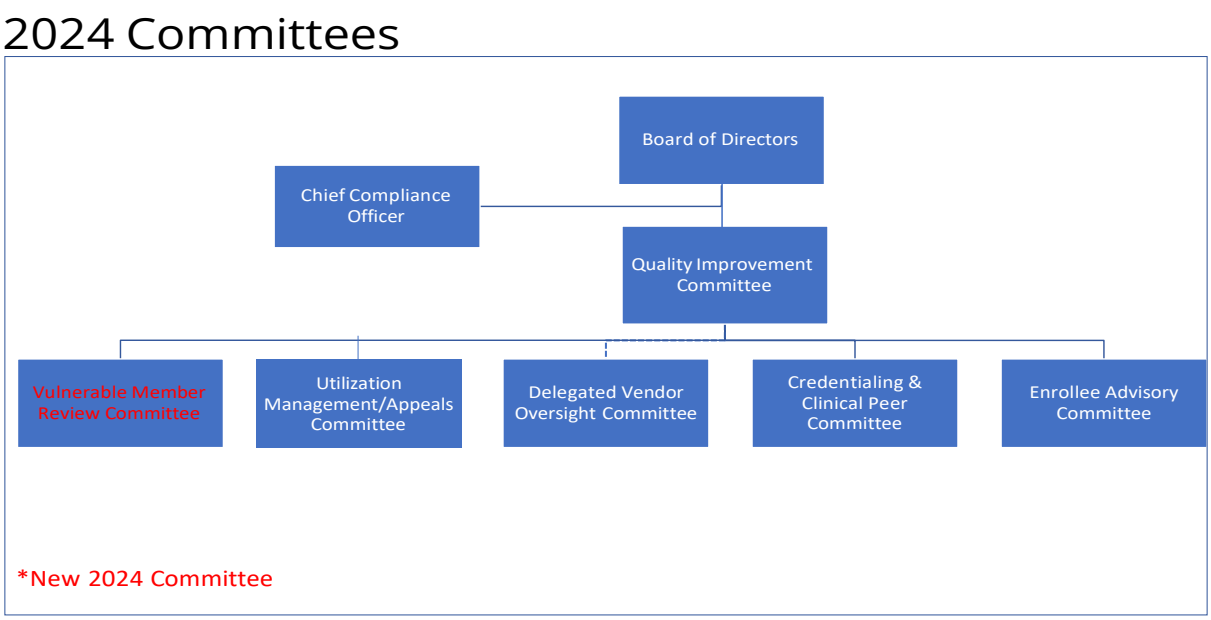
All QI activities including correspondence, documentation and files are protected by State and Federal laws and the Health Information Portability and Accountability Act (HIPAA) for patient's confidentiality. All persons attending the Quality Improvement Committee will review confidentiality standards annually.

All persons attending the Credentialing and Clinical Peer Committee or its related committee meetings will sign a Confidentiality Statement and Conflict of Interest Statement annually and will be maintained in the Compliance Department. No persons shall be involved in the review process of QI issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated. There is a separation of medical/financial decision making and all committee members, committee chair and Chief Medical Officer sign a statement of this understanding.

All Simpra staff are required to sign a Confidentiality Agreement upon employment. Only designated employees by the nature of their position will have access to Member health information as outlined in the policies and procedures.

Appendix A

2024 Simpra Quality Improvement Committee structure



Updated 1.2024

Simpra Advantage Quality Improvement Committee Program Documents

The **Quality Improvement Committee** has reviewed and approved updates to the 2024 Quality Improvement Program Description on:

Program Approval:

Clare I. Hays MD

02.21.2024

Clare Hays, MD, CMD
Chief Medical Officer
QIC Chairperson

Date

Karen Lumpkin, MS, JD, CPHQ

02.21.2024

Karen Lumpkin, MS, JD, CPHQ
Director, Quality

Date