2019 Quality Improvement Program Description Overview

Introduction

Eon/Clear Spring's Quality Improvement (QI) program guides the company's activities to improve care and treatment for the member's we serve. The program aligns with the company's vision which supports continuous quality of care, access to care in a safe, culturally sensitive manner and to be in compliance with State contractual and federal requirements and guidelines.

Purpose

The QI program monitors, evaluates the appropriateness of member's care, ensure professional standards of care, and identifies areas for improvement.

The Plan develops quality objectives each year as outlined in our annual Quality Improvement Program Description, which documents the scope, structure and function of the QI program. We also evaluate the Plan's success in achieving our annual QI program goals each year and document the results in our Quality and Utilization Program Evaluations.

Scope

The QI program's scope includes all of Eon/Clear Spring's many plans across the following states: Colorado, Illinois, Virginia, South Carolina, and North Carolina.

- Medicare HMO
- Medicare PPO
- Special Needs Plan (SNP)
- Special Needs Chronic Plan (C-SNP)
- Medicare/Medicaid dual – eligible plan

Goals and Objectives

The QI program has the following goals and objectives:

- Provide effective customer service for members, physicians and other health care providers
- Identify and resolve issues related to member access and availability of services
- Improve the overall quality of life of members through personalized Case Management initiatives
- Monitor coordination and integration of member care across practitioner and provider sites
- Assist members with complex needs and multiple chronic conditions achieve optimal health outcomes

- Provide mechanism by whereby members, physicians and other health care providers can express concern to the Plan regarding care and services
- Ensure that participating practitioners/providers who provide care to our members are fully credentialed
- The Plan supports activities such as Risk Management, Compliance, Peer Review, Utilization Management and other required programs
- Institute a Member Safety program and initiatives
- Promote activities that result in better communication across departments, improve services for members, physicians and associates
- Mechanism by which members, physicians and other health care providers can express concerns regarding care and services

Ongoing Quality Improvement Services

Eon/Clear Springs has programs that focus on health and wellness. Through the Case Management program, the Plan helps members identify and manage their current conditions that may lead to possible future issues with health, work to ensure that care is delivered in a safely and efficiently, help in the management of chronic disease and complex health conditions and prevent future diseases by emphasizing preventive screening.

Some of the program Eon/Clear Spring uses in an effort to improve the quality of care member receive are:

Program Activities

Part of the QI program activities is the ongoing monitoring for quality of care. Emphasis is placed upon identifying high risk services, acute and chronic care, preventive care and other delivery settings. Initiatives of the QI program may include but not limited to:

- Member safety through the implementation of a Member Safety program
- Clinical measurement, preventive health initiatives and monitoring
- Provider qualifications and performance
- Pharmacy management
- Special Needs Plans member improvement initiatives through dedicated models of care (MOC)
- Continuity and coordination of care and services
- Quality Improvement Projects (QIPs) and Chronic Care Improvement Program (CCIP)
- Member and provider satisfaction
- Service and availability
- Over and underutilization of services
- Culturally and linguistic appropriate services
- Population Health Management

Member Safety Program

Eon/Clear Springs is committed to building a safer environment for our members by working in collaboration with network providers. The Plan focuses on four key areas:

- Reduction of 30 day readmissions
- Prevention of falls
- Monitoring appropriate medication use
- Adverse member outcomes

The program uses claims information and case reviews to identify opportunities for improvement in each of the four areas.

Clinical measurement, Preventive Health initiatives and Monitoring

In order to gauge the effectiveness of clinical and preventive health initiatives, the Plan uses the Health Care Effectiveness and Data Information Set (HEDIS) measures which are developed and maintained by the National Committee for Quality Assurance (NCQA).

The Plan will establish a baseline and set annual goals to meet and/or exceed NCQA benchmarks in each of the following measurable HEDIS domains:

- Prevention and Screening
- Respiratory Conditions
- Cardiovascular Conditions
- Diabetes
- Musculoskeletal Conditions
- Behavioral Health
- Medication Management
- Overuse/Appropriateness
- Access/Availability of Care
- Utilization and Risk Adjustment

Provider Qualifications and Performance

The Plan's network providers qualifications is the primary objective of the credentialing and re-credentialing processes to ensure that participating providers are in compliance with the Plan's credentialing standards. Selection and retention of participating providers is an important aspect of the QI program.

The Plans performs ongoing provider monitoring to ensure quality and safety of care between credentialing cycles. The Plan monitors member complaints, adverse outcomes and quality of care concerns involving participating network providers.

Pharmacy Management

The Plan follows the Medication Therapy Management (MTM) program to ensure that it promotes clinically appropriate, safe and cost-effective drug therapies. This program requires evaluation for

safety and efficacy when developing formularies, procedures to ensure appropriate drug class review and inclusion and a regular review of drug policies.

Our internal Pharmacy Data Analyst and Pharmacist, analyze member's pharmacy data to identify those members with polypharmacy, potential drug reactions, inappropriate use of medications usage, the presence of controlled substance and voluntary drug recalls.

Special Needs Plans (SNP) Model of Care (MOC)

The Plan's MOC for all contracts has received the 3 year approval by the National Committee for Quality Assurance (NCQA). Case Management initiatives for the SNP membership are delineated with the MOC.
The QI program provides oversight of the effectiveness of the MOC through the following:

- Analysis of number of completed, incomplete Health Appraisals (HAs) in order to assess outreach efforts
- Analysis of Chronic Conditions based on member self-reporting through the HA and claims data
- Analysis of Preventive Health based on member's response to the Health Appraisal and claims data
- Analysis of Quality's adverse outcome report in order to identify areas were potential adverse outcome have occurred

The Case management department addresses the needs of members through the following:

- Assist members with the coordination of care and services
- Improve member's health outcome
- Empower members via education of chronic conditions in order to attain the established goals
- Establish a plan of care and treatment that is consistent with the values, beliefs and wishes of the member
- Evaluate the plan of care according to the member's needs and changes in member's health status
- Provides follow up post discharge assessment

Continuity and Coordination of Care and Services

Through the Plan's Model of Care (MOC) evaluation, Case Management (CM) initiatives, analyzes of data, the Plan is able to identify areas where opportunities exist to improve continuity and coordination of care between settings of care and transitions of care from one provider to another.
Case Management post discharge initiatives focuses on the individual member needs for assistance post-acute inpatient stay to outpatient settings, need for intervention by clinical personnel (nurses), care coordination, social services and pharmacists. The MOC and the Case Management program emphasizes the importance of post discharge calls in improving continuity and coordination of care for the members.

The plan collects and analyzes data from various delivery sites and through each disease process. The data is used to determine where opportunities exist to improve the coordination of care and transitions of care from one provider to another.

Examples include:

- Coordinating home health care services
- Increasing the understanding of discharge plans and instructions
- Reconciliation of current medications to those post discharge
- Enhancing the communication between primary care physician and specialist
- Expediting the communication of a negative member outcome to primary care physicians.

Quality Improvement Projects (QIPs)

The Center for Medicare and Medicaid Services (CMS) requires the implementation of QIPs as part of their Quality Improvement (QI) program under federal regulations of the Medicare Managed Care Manual for each contract.

The QIP focus area is to improve member's health outcomes and/or enrollee satisfaction, address one or more of the CMS Quality Strategy Goals, and be conducted over a three-year period. The goals of the QIP are to:

- Support the CMS Quality Strategy Goals
- Facilitate development of targeted goals, specific interventions and quantifiable measurable outcomes
- Guard against potential health disparities; and
- Produce best practices

As a Plan, CMS provides us with flexibility to identify an area that supports goals listed above and serves the needs of the members.

The opportunity exists with this QIP to improvement health outcomes through enhanced notification of the Plan's providers and nurses when members have an Emergency Department (ED) visit in order to provide follow-up. The new "Follow-up after ED Visit for People with High-Risk Multiple Chronic Conditions" HEDIS measure will be the results metric that will be monitored over the three year study in order to access the effectiveness of the QIP.

Chronic Care Improvement Program (CCIP)

CMS also requires the implementation of CCIPs as part of the mandated Quality Improvement (QI) program under the federal regulations.

CCIP focus area is to promote effective management of chronic disease, improve care and members' health outcomes with chronic conditions. Program to be conducted over a 3 year period. Effective management of chronic disease is expected to slow disease progression, prevent complications and development of comorbidities, reduce preventable emergency room (ER) visits and inpatient stays, improve quality of life and save cost.

The Plan has selected Diabetes as the chronic condition. The interventions implemented will be through Case Management initiatives and provider participation. The expected outcomes are:

- Improve member compliance with A1C testing (HEDIS-CDC measure)
- Improvement in the control of blood pressure controls (HEDIS-CDC measure)

- Improvement in diabetic retinopathy screenings (HEDIS-CDC measure)

The Plan is expected to attest each year that both QIPs and CCIPs are in progress for each Medicare Advantage and SNP contract. Each study must contain an analysis of the outcomes and interventions data collected, as well as barriers to meeting goals, plans to reduce barriers, best practice and lessons learned.

Member and Provider Satisfaction

The monitoring, evaluating, and improvement of member satisfaction is a vital component of the QI program. This is accomplished through the use of surveys, as well as through the aggregation, trending and analysis of member complaint data.

The Consumer Assessment of Health Plan Study (CAHPS) – the Survey is administered, annually. The survey's goal is to evaluate the experience members have had with the Plan and our participating providers. The Plan will contract with a qualified, Agency approved, NCQA certified vendor to conduct the annual enrollee satisfaction survey required.

The Plan will conduct an annual Provider Satisfaction to assess the providers' satisfaction with various aspects of the Plan's program including Utilization Management and Case Management.

Survey results data will be compiled, analyzed in order to identify areas for improvement. Results are reported to the Quality Improvement Committee and are made available to participating providers, upon request.

Service and Availability

The Plan assess member satisfaction with services through internal call center metrics, member complaints, member grievances, identified quality of care concern related to access/availability, claims and satisfaction survey reviews. The Plan continuously monitors these service indicators and determines appropriate action to address concerns and needed improvements.

Over and Underutilization of Services

The Plan monitors over and underutilization of services through the Utilization Management and Case Management. The Plan reviews and monitors provider performance through utilization management reports, data and analyses for: prospective, concurrent, retrospective reviews, authorizations/certifications, denials, ER services, and inpatient data.

The Plan uses MCG clinical guideline criteria and standards, National Coverage determinations and Local Medicare Review policies to determine medical appropriateness and medical necessity as applicable to UM functions.

Culturally and Linguistic Appropriate Services

A goal of the Plan is to ensure that members have access to culturally and linguistically appropriate services, ensuring that all services delivered to members are tailored to members' needs.

The Plan has implemented a Culturally Competency Program. At a minimum annually, evaluate the needs and availability of language services within the network; implement interventions when improvement opportunities are identified. The program evaluates the cultural competence of the Plan's staff and participating providers.

Population Health Management

The Plan uses a variety of systems that deliver actionable data to providers for use in improving their patients' health and wellness.

Conclusion

The Plan is committed to creating solutions that engage customers in health and health care with better outcomes and lower cost with an over-all goal to help people achieve lifelong well-being.

Quality Improvement reporting of activities by all areas within the company continues to focus on evaluation of effectiveness of interventions, learning from past responses and sharing of best practices. This includes a move from operational metrics to outcome metrics where possible.

The Plan will:

- Evaluate progress to goals, evaluate barriers, evaluate effectiveness of interventions and implement changes as needed with a focus on outcomes
- Evaluate compliance to regulations through internal monitoring of processes
- Evaluate future expansion resource requirements, define responsibilities for all requirements and continually assess for possible efficiencies
- Evaluate QI program structure for any needed changes to address new business or new regulations
- Works towards achieving accreditation from a nationally recognized accrediting body.