Policy and Procedure No: QM 101.5	**Revision No: 5**
Division: Care Management	
Department: Quality Management	
Title: PHP Quality Improvement Program	
Effective Date: 12/1/2010	
Supersedes Policy No: 95004, QM 101.0, QM 101.1, QM 101.2, QM 1.2, QM 101.2, QM 101.3, QM 101.4	
Reviewed/Revised by: Sandra Holzner	**Review/Revision Date: 12/10/2025**
Approving Committee: Quality Management Committee	**Date: 12/11/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

The Quality Management Department oversees the development and implementation of the Quality Improvement (QI) Program. The Quality Improvement Program establishes a systematic methodology to monitor clinical and service performance, identify opportunities for improvement, and implement corrective action plans to enhance quality of care and member experience. This policy aligns with CMS Managed Care Manual Chapter 5 requirements for Quality Improvement Programs.

Policy:

1. The Executive Oversight Committee (EOC) Board of Directors is ultimately accountable for the quality of care and services provided to members but delegates oversight to the EOC.

2. The Quality Improvement program includes, but is not limited to, the following elements:

    a. Quality Improvement and Health Equity Committee (QIHEC);

    b. Annual Quality Improvement Program Description and Work Plan;

    c. Annual Program Evaluation;

    d. Quarterly Updates of Quality Improvement Work Plan;

    e. Quality improvement projects, including projects that are required by CMS;

    f. Submission of HEDIS®, CAHPS®, and HOS results, and other performance measures per Federal regulations and contracts.

Procedure:

1. Quality Improvement and Health Equity Committee (QIHEC):

    a. The QIHEC provides summary reports quarterly and annually to the EOC of the Board of Directors.

    b. The EOC of the Board of Directors reviews and approves the Quality Improvement Program.

    c. The QIHEC is chaired by the Medical Director and the Health Equity Officer. The co-chairs of QIHEC ensure that the Quality Improvement Program is adequate to monitor the full

scope of clinical services rendered, that identified problems are resolved and corrective actions are initiated when necessary and appropriate and that fiscal management does not influence medical decisions.

d. The QIHEC is comprised of members with varied backgrounds to provide a full range of expertise in clinical practice, behavior health, health administration, public health including community providers, and the Health Equity Officer.

e. The QIHEC reviews and approves the Quality Improvement Program Description, Work Plan and Quality Improvement Program Evaluation annually.

f. The QIHEC oversees the effectiveness of Quality Improvement programs.

g. The QIHEC reviews highlights of the Quality Improvement activities quarterly and identifies opportunities for improvement.

h. The QIHEC prioritizes improvement opportunities and design strategies if needed. The QIHEC oversees strategy implementation and measure success.

i. The Committee reviews Quality of Care issues so that medical decisions are based on best practice guidelines and not influenced by fiscal and administrative management.

j. The Quality Improvement and Health Equity Committee meets at least four times per year.

k. The following subcommittees report to the QIHEC at least four times per year:

   i. Utilization Management Committee (UMC)

   ii. Member Provider Committee (MPC)

   iii. Credentialing and Peer Review Committee (CPRC)

   iv. Member Advisory Committee (MAC)

l. Receives feedback and suggestions from MAC liaison and supports initiatives to implement suggestions.

m. Oversees the completion of all Federal and State regulations for Quality Improvement, Quality Improvement contract deliverables and accreditation standards.

n. Communicates Quality Improvement activities and outcomes to all members, providers and staff via numerous channels including but not limited to newsletters, blast fax, telephone calls, meeting presentations, special events, etc.

2. The Quality Improvement Program Description and Work Plan:

   a. Delineates a systematic process for quality improvement that monitors and evaluates the quality and appropriateness of care and services rendered;

   b. Identifies quality improvement methodology and quality improvement indicators;

   c. Incorporate information from the following departments: Member services, appeals and

grievances, care coordination, utilization management; credentialing, provider relations, claims, and pharmacy.

3. The annual evaluation of the Quality Improvement program includes:

    a. Assessment of progress in implementation of Quality Improvement strategies and the effectiveness of the program;

    b. Assessment of timely completion of projects;

    c. Determine effectiveness of project and identify potential areas of improvement;

    d. Recommendations for needed changes in program strategy or administration.

4. The Health Plan solicits Providers to participate in the development and implementation of quality improvement initiatives.

5. The Information Technology Department maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement the Quality Improvement program.

6. AHF develops, implements and submits quality/performance improvement projects per CMS and State requirements and External Accountable Organizations.

7. The Quality Management Department reports audited HEDIS® and CAHPS® results annually to Centers for Medicare & Medicaid Services.

8. The Quality Management Department facilitates any Star Ratings requirements or initiatives such as HOS and validation review.

Definitions:

1. Healthcare Effectiveness Data and Information Set (HEDIS®): A widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.
2. Consumer Assessment of Healthcare Providers and Systems (CAHPS®): A patient's perspective of care survey, administered annually, in which a sample of members from provider organizations (e.g., MAOs, PDPs, PFFS) are asked for their perspectives of care that allow meaningful and objective comparisons between providers on domains that are important to consumers; create incentives for providers to improve their quality of care through public reporting of survey results; and enhance public accountability in health care by increasing the transparency of the quality of the care provided in return for the public investment.
3. Health Outcomes Survey (HOS): The first outcomes measure used in the Medicare program. It is a longitudinal, self-administered survey that uses a health status measure, the VR-12, to assess both physical and mental functioning. A sample of members from each MAO health plan is surveyed. Two years later these same members are surveyed again in order to evaluate changes in health status.

Monitoring:

1. The Quality Management Department submits its current year's Program Description and Work Plan and may submit an Executive Summary of Accomplishments of previous year's QM Activities

with the QI Program Evaluation & Assessment to the Quality Improvement and Health Equity Committee for review and approval by the first quarter.

2. Once approved by QIHEC, the Quality Management Department submits these same documents to the EOC of the Board of Directors for review and approval.
3. The Quality Management Department updates its documents according to feedback and recommendations provided by the EOC of the Board of Directors.
4. This policy is reviewed, updated if necessary and approved by the QIHEC at least annually.

References:

1. Centers for Medicare & Medicaid Services Managed Care Manual, Chapter 5 – Quality Improvement Program