2020 Quality Program

Health Alliance Plan (HAP) is a nonprofit health plan based in Detroit, Michigan. HAP is a subsidiary of Henry Ford Health System (HFHS), one of the nation's major comprehensive health systems. Founded in 1915, Henry Ford Health System (HFHS) is a non-profit, vertically integrated, mixed-model managed-care organization, and serves the primary and specialty health care needs of residents in southeastern Michigan, including Detroit and its surrounding metropolitan area. HAP has more than four decades of leadership in providing customers with access to quality health care coverage. HAP and its subsidiaries serve more than 533,155 members and serves companies of all sizes from large national groups to small groups through an expansive product portfolio including: HMO, PPO, EPO, ASO, self-funded, Medicare Advantage HMO, Medicaid, and MMP plans with prescription drug coverage, experience rated and fully insured products and HSA compatible high deductible health plans with online consumer tools. Leased provider network services are available through HAP's subsidiary, Preferred Health Plan. HAP's HMO product is comprised of a commercial HMO, Medicare Advantage HMO and Medicare complementary products. We are affiliated with numerous primary care physicians and specialists. HAP holds contracts with hospitals throughout southeast Michigan and maintains contracts with 700 ancillary providers (such as nursing homes, mental health facilities, optical shops, laboratories, DME providers, ambulance services, and pharmacy chains). The Henry Ford Medical Group (HFMG) is HAP's largest single provider group, caring for approximately 33 percent of the total membership.

HAP's origins date back to the 1960s. Community Health Association (CHA), the first incarnation of what is now HAP, was founded by UAW President Walter Reuther and began operating as Michigan's first nonprofit, prepaid group practice. CHA was renamed Metro Health Plan in 1972. As the call for managed health care grew, business, labor and health care leaders consolidated MHP into Health Alliance Plan. HAP was licensed as an HMO in 1979. HAP became the managed care component of what is now known as the Henry Ford Health System in 1986, providing our members with access to the HFHS provider network and its world-class teaching hospital. (PHP became a wholly owned subsidiary of HAP as part of this affiliation.) In 1988 HAP acquired Independence Health Plan, bringing with it approximately 74,000 members. In 1996, HAP assumed operational management of AHLIC. In March 2001, HAP purchased the HMO and POS product lines of SelectCare, Inc.

Alliance Health and Life Insurance Company (AHLIC) became operational in 1996 as an insurance company licensed by the State of Michigan. AHLIC offers EPA, POS and PPO products that are fully insured, and experience rated. AHLIC's license is state-wide and its products are primarily sold to employer groups with 50 to 250 eligible employees. Presently, most groups are in the southeast Michigan market. HAP administers all functions for the AHL PPO product, including but not limited to claims, member services and medical management.

HAP Empowered Plan
HAP Empowered is a separate, wholly owned subsidiary of HAP that serves approximately 4,171 Medicaid/Medicare enrollees. HAP Empowered Health Plan is invested in giving quality, low cost care to Michigan residents. Medicaid coverage is provided through HAP Empowered Health Plan and the Healthy Michigan Plan. During 2018, consolidation efforts were underway for all departments. HAP and HAP Empowered integration continued to leverage people and process for better outcomes for our members,

providers, and employees with more effective utilization management that integrates care management, behavioral health, disease management and Long-Term Support Services. Effective January 1, 2019, HAP Midwest Health Plan was rebranded HAP Empowered.

ASR Health Benefits
ASR Health Benefits is a full-service Third-Party Administrator in Grand Rapids, Michigan. The HAP-ASR affiliation with majority interest ownership offers competitive options for employers and health and welfare funds seeking to self-fund their health benefit costs, through Administrative Services Only (ASO) plans with a statewide network solution.

Trusted Health Plan Acquisition
HAP acquired Trusted HP – Michigan, a Medicaid plan headquartered in Detroit. This acquisition will expand our Medicaid footprint, allowing us to serve Trusted's existing members in Wayne, Oakland and Macomb counties and to once again offer Medicaid products in this all-important Region 10.

Mission
The Health Alliance Plan (HAP) Quality Program aims to assure that safe, effective, patient centered, timely, efficient, and equitable clinical care and services are provided to Commercial, HMO, PPO, ASO, Alliance Health and Life (AHL), and Medicare Advantage beneficiaries. The entire document applies to both Medicare and non-Medicare enrollees. HAP seeks to demonstrate value and improve quality through the elimination of over, under, and misuse of services. The Quality Program focuses on coordinating activities for continuous quality improvement of clinical care and safety (including general medical and behavioral health care) and of services across HAP's delivery system by:
- improving the health status of our members
- identifying and reducing healthcare disparities
- identifying organizational opportunities for improvement
- implementing interventions to improve the safety, quality, availability and accessibility of, and member satisfaction with, care and services
- promoting members' health, through health promotion, disease prevention, and condition management through targeted interventions and health fairs
- through partnerships with physicians and office staff
- assisting in the development of informed members engaged in healthy behaviors and active self-management
- measuring, assessing, and/or coordinating the following:
  - evidence-based clinical quality
  - patient safety
  - practitioner availability and accessibility
  - member and practitioner satisfaction
  - supporting the continued development of proactive practitioner practices

Quality Management (QM) works collaboratively with other departments and stakeholders to support and help achieve administrative, clinical, and service quality improvements, to assure appropriate utilization and to enhance continuity of care for HAP's Commercial, PPO, and Medicare Advantage beneficiaries.

History

A. Program

The Quality Program has been a primary focus of Health Alliance Plan since its founding. The program has been regularly evaluated and updated. The HAP Board of Directors approved HAP's original Quality Assurance Program document on May 10, 1988. HAP's Quality Assurance Program was renamed the Quality Management Program in 1991 and was renamed the Quality Program in 2005 to reflect plan-wide involvement. HAP's Quality Assurance Committee was created with the original Quality Assurance Program in May 1988 and has been meeting regularly since that time. The Quality Assurance Committee was renamed the Quality Management Committee in 1991 and renamed the Quality Improvement Council (QIC) in 2001. HAP has conducted an annual evaluation of the Quality Program since 1991. In October 2012, the committee was renamed Clinical Quality Management Committee to emphasize the clinical focus of the committee's activities.

B. Subcommittees

Initially the CQMC had subcommittees addressing Credentialing and Peer Review activities. A significant revision in committee structure took place in 2001 with several new subcommittees or committee reporting relationships established. New subcommittees included the following: Member Experience (ME), Hospital Quality/Patient Safety Committee, Appeals and Grievance. Reporting relationships were formalized with the Medical Management Oversight Committee and the Pharmacy Oversight Committee. Additionally, the Clinical Quality Management Committee receives periodic updates from the Corporate Compliance Committee.

C. NCQA

HAP's commitment to public accountability for the quality program has been demonstrated through our involvement with the National Committee for Quality Assurance's (NCQA) accreditation and HEDIS programs. HAP's HMO was awarded its initial NCQA Accreditation in 1993. HAP currently has accreditation for the Commercial HMO and Medicare, Alliance Health & Life PPO, and Medicaid products.

D. Scope

HAP has a proud, long-standing commitment to quality improvement initiatives that encompass the full spectrum of care and services provided by HAP. The Quality Program is dedicated to fulfilling that commitment by working with the physician and provider community to establish evidence-based clinical guidelines and service standards. The guidelines and measures are used to develop tools to provide feedback to patients and physicians to encourage improvement. The Quality Program applies to members enrolled through Commercial, PPO, ASO Self-Funded, Medicaid, MMP, and Medicare Advantage products in HAP and its subsidiaries. The Clinical Quality Management Committee (CQMC) approves the program's annual goals and objectives from which health plan staff develops the Annual Quality Program Work Plan.

Specific clinical quality initiatives within the Quality Program and Annual Work Plan are categorized by quality of clinical care and service, safety of clinical care and member experience. The following groups are responsible for quality management, but participation varies based on the intensity and scope of the efforts in that area. These priorities may be subject to change during the year based on new information and/or changing regulatory, accreditation, and/or purchaser needs:

- Coordinated Behavioral Health Management (CBHM), HAP's behavioral health department, provides coordination of all aspects of behavioral health care for our members by our highly trained member call center and our seasoned Master level clinicians. CBHM has a member engagement program designed to assist our members in obtaining the best quality of care and quality of life. Member engagement touch-points include: receiving communications about medication adherence, education and coaching about their emotional will being, coordination of care and transitional guidance through all levels of their behavioral health care. CBHM Managed Care Specialist collaborate with behavioral health practitioners to coordinate care and encourage compliance with clinical practice guidelines. The CBHM Managed Care Specialist work in collaboration with HAP's Medical Care Management team to provider telephonic behavioral health consultations when requested. The CBHM team also investigate and resolve quality of care complaints in accordance with the Quality Program, with problem cases being referred to HAP's Peer Review Committee.

- Medication Therapy Management Program: HAP's Medication Therapy Management (MTM) Program enrolls Medicare beneficiaries who are high risk for medication errors as identified by consuming multiple medications and having three or more comorbidities . The MTM Program is patient-centric, thereby including all disease states. The goal of our MTM Program is to ensure medication regimens provide optimal therapeutic outcomes through integration of the patient's personal health care goals with evidence-based medicine in collaboration with the patient's physician(s). Our MTM Program indirectly reduces medication errors by ensuring our program's objectives address the three most common causes for preventable Adverse Drug Events: Failure to monitor medication therapy adequately, prescribing stage errors (e.g. wrong drug/wrong therapeutic choice, wrong dose, etc.) and patient non-adherence to medication therapy. Patients found eligible for the program and who do not decline enrollment are given a telephonic appointment with a specially trained clinical pharmacist at the patient's preferred date and time. A Pharmacist reviews medications and retrievable medical data prior to calling patient. The Clinical Pharmacist will formulate a medication treatment plan that will encourage adherence to drug regimen and assure the highest quality of care is being provided with the most cost-effective approach by incorporating the patient's personal healthcare goals with evidence base medicine. The pharmacist will discuss the patient case with the patient's physician telephonically or in-person. In collaboration with patient's physicians, pharmacist will develop and implement the new regimen. Pharmacist will counsel patient on new medication regimen and ePrescribe/call in any medication changes to the patient's preferred pharmacy. Each time the patient receives a Comprehensive Medication Review, the beneficiary and physicians will be mailed a cover letter, medication action plan and updated personal medication list that meets CMS's requirements. All patients enrolled into our MTM program receive at least one follow-up call to assure the previously rendered MTM services meet medication-related outcomes: a) Improved effectiveness, b) Improved safety, c) Improved adherence, and/or) d) Lower drug costs. Patient's not attaining set medication-related goals have additional medication changes made in collaboration with the patient and patient's physician. In addition, each patient that does not decline the MTM services receives a quarterly letter providing education on drug adherence; the letter is personalized to provide specific education on diabetes, blood pressure and/or cholesterol drugs. To further improve drug adherence, each quarter the patient's physician also receives a letter listing all the medications his/her patient has filled using a HAP prescription card, along with the dates of fill and associated amounts filled on those dates. For our MMP members, case managers annually introduce MTM services to all of our MMP members and for

MMP members that agree to the service a referral is made to our clinical pharmacy team. In addition to MMP annual referrals and Medicare specific eligibility requirements, HAP Case Managers can refer other members requiring medication management to our clinical pharmacy team to render MTM services.

- Quality Improvement: Quality improvement is a program designed to objectively and systematically monitor and evaluate the appropriateness of clinical and non-clinical member care and services. Through measurement, analysis and intervention, distinct areas of opportunity are defined. Quality Improvement seeks to identify the causes of suboptimal performance/outcomes and targets interventions to address the identified causes. Quality improvement programs include community collaborations (weight management), health equity, population health, practitioner accessibility and member education related to prevention, provider profiling, targeted member reminders, physician and member incentives, and guideline implementation activities.

- Population Health Management, Health Promotion & Preventive Care: Health promotion programs include guideline implementation activities and general or targeted practitioner and/or patient education (i.e., office posters, member outreach initiatives, health events, and educational mailings).

- Evidence-based Medicine: Practice Guideline implementation programs include clinical practice and preventive service guidelines, regular monitoring for practitioner performance and member education (i.e., information available on the web and in newsletters).

- Quality and Safety: HAP focuses quality and safety initiatives on   improving the care and services provided to HAP members. The quality and safety initiative outcomes for HAP members are promoted through consumer, provider, and physician education, information, collaboration, quality contracting, and recognition. The initiatives may incorporate hospital performance metrics, analysis, and research findings that align with corporate strategies. A multidisciplinary Committee collaborates to research data, interpret findings and determine new opportunities for improved member safety that align with corporate strategic objectives. This Committee assists in providing hospital performance reports mined from publicly posted performance data such as the MHA. Additionally, the Committee facilitates the monitoring, analysis and reporting of certain preventable medical errors that occur during hospitalizations as regulated by Centers for Medicaid and Medicare Services (CMS). The preventable medical errors have been identified and labeled "never events" because they never should happen in a hospital or could be prevented. CMS has established a list of fourteen (14) specific hospital acquired conditions (HAC) that hospitals are required to report to health plans and are subject to non-payment. . The Committee facilitates identification, tracking and trending of these conditions through claims and payment data where potential patient safety issues exist. The Committee maintains an on-going multidisciplinary workgroup to ensure HAP preparedness for emergent health situations that are congruent with the Henry Ford Health System. This includes serving as a liaison between the Henry Ford Health System Resuscitation Advisory Council (RAC) and HAP to ensure that workplace safety measures are reported and aligned.   Moreover, the Committee coordinates publication of current information on the HAP web-site quarterly for employee safety awareness and education.

- The Healthcare and Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. This information is reported annually to the National Committee for Quality Assurance (NCQA) and is used to compare health plans on a local and national scale. HAP continually reviews these results for all applicable product lines to focus its efforts on improving care to its members. Contributing to these efforts is a series of initiatives driven by three basic strategies designed to promote and support performance improvement. These strategies are:
    1. Outreach initiatives to improve member engagement and self-management of chronic conditions
    2. Provider group collaboration, data sharing, and outreach initiatives to improve practice-site delivery of health care to members
    3. Data quality initiatives to improve the timeliness, accuracy and completeness of data used to measure performance and to provide prospective alerts to members and physicians regarding preventive and chronic care needs.

- Appeal and Grievance: The Appeal and Grievance Committee is a multi-disciplinary team responsible for adjudicating second-level appeal hearings in accordance to State and Federal regulatory requirements.

    Specifically, the committee will do the following:

    1. Review second-level appeals submitted for Commercial members.
    2. Vote on appeal outcomes.
    3. Act as a fiduciary to ensure compliance with HAP's contracts.

    4. Use member appeals as a barometer to gauge the necessity of ad hoc reviews of internal policies, processes and systems to ensure their appropriateness
    5. Perform other duties as deemed necessary by the committee chairperson

    Annual analysis of the appeals information reviewed by this Committee will be shared with the Clinical Quality Management Committee.

Objectives

The objectives of the HAP Quality Program are:
A. To assure and continually improve the value (member and practitioner satisfaction), quality, safety, availability, accessibility, appropriateness, and effectiveness of behavioral and medical health care services.

B. To enhance the health and well-being of the lives we touch through the use of appropriate data collection, sampling, validation, and analysis techniques to identify opportunities for improvement.

C. To establish areas of clinical priority, establish and update related preventive service and clinical practice guidelines in consultation with the Michigan Quality Improvement Consortium (MQIC)and affiliated practitioners, disseminate the guidelines, and promote and assure compliance with the guidelines.

D. To develop data-driven disease and condition management strategies to improve practitioner, provider, and member compliance with clinical guidelines and standards, thus enhancing members' health.

E. To engage in health promotion and education for practitioners, providers, and members in areas of clinical priority to enhance members' health and encourage active self-management.

F. To regularly evaluate HAP practitioner and provider qualifications and competence through credentialing and recredentialing programs, peer review activities, performance monitoring and investigation, targeted site visits, and quality improvement activities.

G. To participate in national and local initiatives to support transparency initiatives in the areas of quality, safety, utilization, access, and satisfaction.

H. To actively seek out and participate in national and local collaboratives and recognition programs to improve performance and achieve recognition as a quality leader.

I. To implement programs to enhance member and provider use of online tools

J. To identify and implement strategies to meet the needs of members with complex health needs including members with physical and mental disabilities, multiple chronic conditions and serious and persistent mental illness.

K. To implement programs which identify disparities in health and address cultural and linguistic needs of our membership

Complex Case Management (CCM), Transitional Case Management (TCM), and Population Health Management (PHM) Objectives

The HAP complex case management (CCM) program provides coordination of care and services to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

The goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with personalized goals, monitoring and follow-up.

The types of members who are managed in this program have the following general characteristics:
- The degree and complexity of their illness or condition is typically severe.
- The level of case management and care coordination necessary is typically intensive and/or
- The amount of resources required for member to regain optimal health or improved functionality is typically extensive.

The HAP Transition Case Management (TCM) program provides care transition assistance to members needing short-term help identifying and accessing health care services that are appropriate to their care needs. TCM facilitates member transition from the acute care setting to the rehabilitative or home-based setting.

The goal of TCM is to support clinically appropriate and resource efficient transitions to care settings and caregivers. These services help support discharge planning and prevent readmissions by connecting members to appropriate outpatient services, healthcare providers and community services. The TCM program also supports member and caregiver education aimed at enabling self-management. The activities involve identification of the member's discharge or transition needs, determination of available benefits and resources, development of a short-term case management plan and prioritized goals and interventions and monitoring of transition completion.

The types of members who are managed in this program have the following general characteristics:
- The member or the discharge type carries increased risk for readmission.
- The event, illness or condition requires that the member be supported with step-down, rehabilitative or at-home services.
- The level of case management and care coordination necessary is typically short term and focused on addressing a set of specific issues.
- The amount of resources required for member to regain optimal health or improved functionality is expected to be lessening and the member is likely to become independent in their care.
- Programs to support case management initiatives include, but are not limited to:
  - Digital Strategy to enhance health coaching in the management of diabetes, heart failure, respiratory disease, and behavioral health.
  - Progeny
  - Aspire (Comfort & Palliative Care)
  - Mom's Meals
  - Adhere Health
  - Livongo (Diabetes Management)
  - Nations Hearing
  - Care Port (Realtime admission and discharge notifications)
  - WedMD

Structure
A. HAP Board of Directors (Governing Body)
The HAP Board of Directors is responsible for the quality of health services delivered to HAP members. The Clinical Quality Management Committee (CQMC) reports directly to the Board. The Board meets four times annually. The Alliance Health and Life (AHL) Board is empowered to act on behalf of the corporation to perform all acts that are permitted to be performed by corporations under Michigan Law. The Board is solely responsible for the quality program and structure of AHL. Currently, the Board is made up of the same individuals who serve on the HAP Board of Directors Executive Committee.

B. Physician Leadership

The Chief Medical Officer is responsible for oversight of the Quality Program and the Clinical Quality Management Committee. He/she is accountable to the HAP Board of Directors for the Quality Program and reports regularly to the Board and/or their Quality Committee on activities, progress, and outcomes of the quality program. A Vice President Quality, Care Management, & Outcomes is designated to work closely with the Director of Quality Management and Associate Vice President of Performance Improvement and Management in the implementation of the Quality Program. Duties of the Vice President Quality, Care Management, & Outcomes include but are not limited to Chair of the Clinical Quality Management Committee, participation on the Peer Review Committee, the Credentialing Committee, the Credentialing Oversight Committee, and ongoing consultative support for all Quality Program activities. Physician involvement in appropriate population health management and preventive health improvement programs is provided by designated Medical Directors assigned to individual project teams.

The Vice President Quality, Care Management, & Outcomes leads the review of alignment of the program interventions with evidence-based guidelines and provides ongoing consultative support for all Population Health Management preventive health programs.

The Medical Director for Behavioral Medicine is involved in all behavioral health aspects of the Quality Program. Duties of the Medical Director for Behavioral Medicine include but are not limited to participation on the CQMC, Credentialing Committee, Pharmacy and Therapeutics Committee, Coordinated Behavioral Health Management (CBHM) Quality and Utilization Improvement Committee, Clinical Quality Management Committee, Benefit Advisory Committee, and Chronic Care Advisory Committee as well as serving as clinical expert for the behavioral health Population Health Management project team. The CBHM Medical Director provides ongoing consultative support for all behavioral health quality activities, Population Health Management, preventive health programs, and utilization management.

C. HAP Clinical Quality Management Committee (CQMC) and Other Committees

The Vice President Quality, Care Management, & Outcomes chairs the Clinical Quality Management Committee. The CQMC includes practitioners from the HAP delivery system, research or administrative representatives of practitioner groups, HAP's Senior Medical Directors, and HAP senior staff. The CQMC evaluates and approves the Quality Program and Work Plan, annual evaluation, and monitors progress toward meeting program goals and objectives. The CQMC oversees patient safety, clinical, administrative, and service quality improvement throughout the plan; recommends policy decisions; and is accountable to the Board through its Quality Committee. Executive Summaries of CQMC outcomes are presented during the Board meetings. The CQMC is comprised of HFHS physicians, HAP network physicians, HAP Board members, HAP Senior Medical Directors, and representatives from Quality, Case Management, Utilization Management, Network Management, Credentialing, Pharmacy, Appeal & Grievance, Population Health Management, Coordinated Behavioral Health Management, and the Medicare division. The committee meets a minimum of 4 times per year and one virtual meeting.

D. Reporting Relationships and Resources

Significant staff resources are dedicated to quality management activities. Approximately 26 full-time equivalents reside in the quality management and credentialing departments (Appendix A). Additionally, the Health Alliance Plan Health and Network Management Division organizational chart demonstrates

reporting relationships (Appendix C) and the significant staff resources dedicated to quality management activities.

Several organizational committees or subcommittees are charged with functions linked to support the Quality Program. These committees and subcommittees provide reports to the CQMC as applicable, at least once a year and upon request.

CQMC Subcommittees:

Peer Review Committee (PRC)

Objective: The PRC evaluates, investigates and tracks any identified professional performance concerns of HAP affiliated providers. In accordance with HAP policies and accreditation standards, provider concerns may be identified via routine performance monitoring, internal or external referral sources or intentional quality of care reports or monitored patient safety events.

Membership:
- Vice President Quality, Care Management, & Outcomes
- Senior and Associate Medical Directors
- Quality Management Registered Nurse(s)
- Quality Management Leadership
- HAP-Affiliated physician(s)
- HAP Pharmacy Coordinator
- HAP Credentialing Manager

Chairperson: HAP Medical Director designated by Vice President Quality, Care Management, & Outcomes
Meeting Frequency: At a minimum four (4) times per year and up to twelve (12) times per year if necessary.

Credentialing Committee

Objective: The Credentials Committee reviews and evaluate the qualifications of each Applicant for initial credentialing and reappointment and makes recommendation for affiliation with HAP

Membership:
- Vice President Quality, Care Management, & Outcomes
- Associate Vice President Performance Improvement and Management
- Senior Medical Directors
- Credentialing Department
- Quality Management
- Provider Contracting
- Community physicians

Chairperson: Vice President Quality, Care Management, & Outcomes

Meeting Frequency: Meets at least 22 times per year

Member Experience Meeting (MEM)
Objective: Monitor member and provider satisfaction through external (CAHPS) and internal surveys. Review administrative and clinical services to identify opportunities for improvement and partner with internal and external stakeholders to improve performance in those areas.

Membership:
- Market Intelligence
- Member Experience
- Quality Management
- Coordinated Behavioral Health Management
- Clinical Care Management
- Customer Service
- Operations (Claims)
- Provider Plan Management
- Information Technology
- Other Departments

Chairperson: Senior Director, Performance Measurement & Improvement
Meeting Frequency: Eight (8) times a year

Quality & Safety Committee (QSC)
Objective: To monitor, evaluate, educate and report patient safety performance data and identify centers of excellence that support patient safety improvement efforts across the delivery system. The Committee goal is to promote the best outcomes and safest conditions for HAP beneficiaries while preventing extra payment for increased health care costs attributable to a HAC or SRAE.

Membership:
- Senior & Associate Medical Director(s)
- AVP, Performance Improvement & Mgt, Quality, Reporting, A&G, M&O
- Finance/Claims
- Quality Management
- Information Technology

Chairperson: HAP Medical Director designated by Vice President Quality, Care Management, & Outcomes
Meeting Frequency: Meets at least six (6) times per year.

Health Care Management Compliance Oversight Committee (HCM MOC)
Objective: The Health Care Management Compliance Oversight Committee (HCM COC) oversees and assures adherence to the CMS, NCQA, MDHHS, and MiHealthLink utilization management (UM) and case management (CM) standards. The Chair (Senior Medical Director) or designee

presents the HCMCOC Annual report to HAP's Clinical Quality Management Committee for review and approval annually.

HCM COC responsibilities include:
- Oversee and assure adherence to the CMS, NCQA, MDHHS, and MiHealthLink utilization management (UM) and case management (CM) standards.
- Monitor adherence to the UM and CM policies and procedures.
- Conduct audits of internal departments and delegates using the regulatory and accreditation UM and CM standards.
- Recommend corrective action when necessary based on audit outcomes.

The committee membership consists of:
- A Medical Director from Health Care Management
- A Medical Director from Behavioral Health
- Representation from:
    - Referral Management
    - Admission & Transfer Team
    - Pharmacy
    - Behavioral Health
    - Inpatient Rehabilitation and Skilled Services
    - Case Management
    - Compliance & Shared Services
    - Vendor Relationship Manager and Project Coordinators for Delegated Medical Management Entities, NCQA, and CMS
    - Guests (when their special expertise would prove beneficial to the decision-making process)

Chairperson: Senior Medical Director and Director of Program Optimization
Meeting Frequency: Meets at least 6 times per year

Ambulatory Pharmacy and Therapeutics (P&T) Committee
Objective: Optimizing the quality of drug therapy for HAP patients while controlling drug costs through the approval and availability of efficacious, safe and cost-effective medications

Additional Responsibilities:
- Approves the HAP Oncology P&T Sub-Committee formulary decisions
- Approve P&T related policies and procedures
- Works cooperatively with other system committees to identify opportunities to enhance ambulatory drug therapy and integrate formulary and drug use evaluation with condition management and wellness programs

Membership:
- Physician representatives from HAP contracted networks
- HAP Medical Directors
- Geriatric Physician
- Geriatric Pharmacist

Chairperson: HFHS Physician with P&T experience
Meeting Frequency: Bi-monthly

HAP Oncology Pharmacy and Therapeutics (P&T) Sub-Committee
Objective: Optimizing the quality of oncology-related drug therapy for HAP patients while controlling drug costs through the approval and availability of efficacious, safe and cost-effective medications

Additional Responsibilities:
- Provides support for development of cost/value drug treatment algorithms
- Works cooperatively with other system committees to identify opportunities to enhance ambulatory drug therapy and integrate formulary and drug use evaluation with condition management and wellness programs

Membership:
- Oncologist and Hematologist representatives from HAP contracted networks

Chairperson: HFHS Oncologist or Hematologist with strong relationships with HFHS and non-HFHS oncologists and hematologists
Meeting Frequency: Quarterly

Appeal and Grievance Committee

Objective: The Appeal and Grievance Committee will focus on the following five core areas to establish a process in which the needs of HAP's customers are not only heard but examined and acted upon when appropriate:

- Act as Fiduciary: Ensure that appeal outcomes are consistent for all members
- Capture Member Voice: Listen to the issues that members present to be aware of current issues impacting HAP's consumer experience
- Examine Policies: Determine if internal policies warrant further review to better meet consumer needs
- Examine Systems: Determine when internal system configurations need to be examined
- Service as Liaison: Serve as a liaison between the member and employer group. For self-funded plans the committee will escalate trends to the employer group and make recommendations when situations warrant

Membership:

The core committee membership will consist of appointed representatives from internal HAP functional departments. Committee members must be free from any relationship that may interfere or appear to interfere with the exercise of their independent judgment in carrying out their committee responsibilities. Any dispute regarding conflict of interest regarding a member should be referred to the committee chairperson.

Hearings require participation of at least two committee voting members. However, the preferred minimum number of voters is three. Additional subject matter experts may also participate in hearings as non-voting members.

Members will be appointed to the committee on an annual basis. Each year, a request will be sent to the vice president (VP) of each area asking for appointed representatives. Each VP may appoint: him/herself, a manager/director, or choose to have multiple leaders from that area participate so that joint responsibility is shared throughout a calendar year.

In addition, potential ad hoc members of the committee may include, but are not limited to: Benefit Configuration/Information Technology, Compliance, Payment Integrity, Provider Contracting, Provider Operations and Provider Services. Ad hoc members are key representatives that may be invited to the meetings, based on the scope of the issue under discussion, and will serve as subject matter experts (SMEs).

Committee members are requested to attend as many meetings as possible to ensure that multiple disciplines are involved in decision making.

Unlisted SMEs can be invited by any participating member of the A&G Committee. When this occurs, the committee member will give the facilitator advance notice in order to ensure that appropriate meeting materials are sent to attendees in advance. SMEs will be invited to share their expertise regarding a specific matter.

If, at any time, a committee member determines that he/she is unable to complete the term of his/her annual appointment, that member should send written notice to the committee chair, thirty days prior to the requested separation date, with an explanation of why he/she needs to discontinue service. That notice should provide the date when his/her support will end as well as the name(s) of the person(s) who will serve as alternates for that member for the remainder of the term (whenever possible).

Chairperson: Vice President Quality, Care Management, & Outcomes
Meeting Frequency: Weekly

Additional forums utilized to exchange ideas and obtain input for the HAP Quality Program include the Henry Ford Health System Corporate Quality Committee, HAP Corporate Leadership Council, Network Medical Directors' Committee, and HAP's Corporate Compliance Committee.

- The Henry Ford Health System, HAP's parent company, provides ongoing support for HAP's Quality Program. The Henry Ford Health System Quality Forum consists of senior administrative, nursing, and physician leaders from the Henry Ford Medical Group, Henry Ford Hospital, Health Alliance Plan, Henry Ford Macomb Hospital, Henry Ford Macomb Hospital-Warren Campus, Henry Ford Wyandotte Hospital, Henry Ford Cottage Hospital, Henry Ford Behavioral Health Services, and Community Care Services. Additional representatives include the Henry Ford Health System Chief Quality Officer, the Henry Ford

Health System Vice-President of Planning and Performance Improvement, and other quality professionals supporting the Forum's improvement teams. The Quality Forum is responsible for identifying improvement opportunities, integrating improvement efforts across departments and business units, and tracking progress on System goals. Chaired by the Henry Ford Health System President and CEO, the Quality Forum reports its progress to the Henry Ford Health System Board of Trustees Quality Committee. The Forum meets monthly.

- The Collaborative Leadership Forum (CLF), comprised of HAP leaders AVP and above, meets quarterly to discuss high-level corporate strategy. In addition, monthly Leadership Huddles are held for all HAP leader's supervisor and above. These meetings are designed to share updates on ongoing and emerging initiatives and issues. There is an expectation that information shared at the Leadership Huddles will be cascaded to HAP staff with the outcome that front-line staff would receive key information regarding HAP at the appropriate time and level. To complement these meetings, a monthly internal e-blast called HAP Informed is emailed to all leaders that gives updates on HAP goals and strategies.

- The Network Medical Directors (NMD) Committee meets six times a year to discuss quality and utilization management data from their networks, exchange ideas about quality improvement projects, voice concerns on areas that need improvement, receive information on HAP developments and provide input on quality programs. Membership consists of community physicians and administrators, HAP Senior Medical Directors, and representatives from Case Management, Population Health Management, Provider Contracting, and Provider Relations.

- HAP's Corporate Compliance Committee fosters a culture of compliance by providing leadership, oversight, guidance and approval for the development, implementation and monitoring of HAP's Compliance Program. In addition, the Corporate Compliance Committee is responsible to provide guidance, direction and support to the Chief Compliance Officer with the implementation and enforcement of compliance policies and the Code of Conduct and with the resolution of compliance issues. The Corporate Compliance Committee will provide oversight to ongoing auditing and monitoring of the Compliance Program and will review the results of such auditing and monitoring. HAP is committed to conducting its business with honesty and integrity consistent with the highest standards of good business and professional ethics following all applicable laws, regulations, professional organization requirements and HAP policies and procedures.

E. **Quality Management (QM), Case Management (CM), Population Health Management (PHM), Coordinated Behavioral Health Management (CBHM), Medical & Business Informatics (MBI), Appeal and Grievance.**
Quality Management, Case Management, Population Health Management, and Coordinated Behavioral Health Management are responsible for developing, supporting, and/or implementing the HAP Quality Program and work plans. Responsibilities include but are not limited to:
- Staffing the CQMC and many of its subcommittees
- Performing quality assessment, measurement, evaluation, and improvement activities

- Supporting other HAP departments in clinical, service, and operational/administrative quality improvement activities
- Providing consultation and expertise regarding quality improvement, process improvement, and measurement techniques
- Providing guidance on and information to support identification of priority areas for improvement
- Partnering with Credentialing staff to provide oversight of delegated credentialing functions and performance monitoring activities
- Directing accreditation activities and providing support to other areas to meet accreditation standards

Automated systems are used to assist with the quality improvement processes. QM, CM, PHM, and CBHM rely upon data sources including: member complaint reports, survey results, medical records, CareRadius, utilization statistical reports, HEDIS results using MedMeasures, benefit manual, Power BI, Cactus, and Facets. We have transitioned the Health Management core platform from Clinical Care Management System (CCMS) to CareRadius/CareAffiliate from EXL.

Pegasystems (Pega):

Pegasystems Inc. is the leader in software for customer engagement and operational excellence. Pega's adaptive, cloud-architected software – built on its unified Pega Platform™ – empowers people to rapidly deploy and easily extend and change applications to meet strategic business needs. Interface between Pega and Care Radius is underway.

Power BI:

Power BI is a business analytics tool. It aims to provide interactive visualizations and business intelligence capabilities with an interface that allows end users the ability to create their own reports and dashboards.

F. Internal Collaboration
To support quality management across the delivery system, the QM staff work collaboratively with individuals and departments involved in research, patient safety, clinical assessment and quality improvement throughout the Henry Ford Health System. Within HAP, QM also works cooperatively with all departments to evaluate member and provider satisfaction; access to care and availability of practitioners; and to promote quality improvement, process improvement, patient safety, member education and provider education. A few examples are listed below:

Provider Development works to align HAP's delivery system in support of selected quality improvement efforts through negotiation of contracts and incentive programs incorporating quality goals and requiring cooperation with HAP initiatives. Also, aligning cultural, racial, linguistic and ethnic needs of membership with the network's capabilities.

Planning and Marketing Support interacts and partners with the purchaser community to assure HAP's quality initiatives address purchaser expectations.

Health Engagement addresses purchaser requests while supporting HAP's clinical quality improvement priorities.

Pharmacy Care Management participates on Population Health Management teams and other workgroups to provide expertise and assure alignment of clinical and pharmacy initiatives.

Credentialing ensures that affiliated practitioners and providers meet HAP credentialing standards through initial and recredentialing activities in alignment with regulatory and accreditation standards. Credentialing maintains accurate provider and practitioner data, and databases. Credentialing collaborates in local and national credentialing initiatives such as statewide credentialing applications to standardize processes.

CBHM's Quality and Utilization Improvement Committee (QUIC) Quarterly and Ad Hoc meetings are held with CBHM Administration, Medical Director, Project Manager, representatives of the CBHM Managed Care Specialist Staff, Behavioral Medicine Specialist, Primary Care Physician, and the Director/Designee of the Quality Management Department to review both quality and utilization management initiatives and improvement activities.

Standing agenda items include review of quality initiatives (including HEDIS), utilization management statistics, telephone access statistics, and case management response time to member requests for service. The committee regularly reviews all complaint, performance monitor, and quality indicator data. Complaints and performance monitors are investigated when specific thresholds are met.

G. External Collaboration
Health Alliance Plan strongly believes in a collaborative approach to quality improvement and health promotion in the community. Through collaboration we can learn from each other and apply best practices and develop a common message and set of priorities for physicians and the community. HAP staff actively participates in several external groups to support common efforts to improve the health of our members and community. These include Michigan Health & Hospital Association (MHA), Greater Detroit Area Health Council (GDAHC), Save Lives Save Dollars initiative, Michigan Quality Improvement Consortium, Michigan Association of Health Plans and their Foundation, Michigan Department of Health & Human Services, American Cancer Society Colorectal Awareness Network (CRAN), and Alliance of Community Health Plans.

H. Delegation
HAP delegates specific appropriate credentialing-related, pharmacy benefits management, behavioral health, and utilization management components of the quality program through formal agreements with affiliated institutions or groups. The responsibility for oversight and evaluation of delegated credentialing, pharmacy, and UM functions, to assure that policies, procedures, and performance metrics are comparable to non-delegated functions is managed by the CQMC subcommittees. Quality Management, Credentialing, Pharmacy, and the Medical Management Oversight Committee also assure that HAP maintains compliance with state and federal regulations and accrediting standards. Establishment of new delegated agreements involves participation of staff from the QM, Credentialing, Health and Network Management, Governance, and Legal and Regulatory Affairs departments.

Confidentiality

The confidentiality of member, provider and practitioner, and HAP business information is of utmost concern in conducting activities of the Quality Program. HAP maintains all relevant information in accordance with established HIPAA, regulatory, and accreditation standards. This includes storage, access, disposal and disclosure of the aforementioned information.

Program Review

The program description shall be reviewed and evaluated annually by the CQMC and the Board of Directors and revised or updated as necessary.

Standards for Medical Record Documentation

All member medical records in the physician office, health care center and other provider locations are stored and maintained according to HAP's medical record standards. These standards are incorporated into the applicable Quality Management medical record and facility standards. Medical record standards enhance quality through communication, coordination, and continuity of care and services, and promote efficient and effective treatment.

Culturally and Linguistically Diverse Membership

These goals are achieved through collaborative efforts and initiatives with Henry Ford Health System who has made significant strides in obtaining race, ethnicity, and language data directly from members. HAP's healthcare equity campaign is designed to improve the health status of our members through meeting regulatory requirements for capturing and reporting race and language data. Having this data would allow the ability to increase awareness of disparities in health care and develop population health management programs designed to identify and minimize the impact of disparities. Additional programs include literacy and language interpretation services.

Improving Services to HAP Medicare Members

Each year HAP sets goals for Medicare to improve our services to members. We submit annual Healthcare Effectiveness Data and Information Set (HEDIS) measures for quality reporting. HAP uses HEDIS results to track quality performance from year to year and to identify opportunities for improvement. Additionally, HAP annually measures member satisfaction using the Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey results for the Medicare population. The survey evaluates key satisfaction drivers including health plan performance and the members' experience with providers and access to care. The results are collected and analyzed annually and used to improve satisfaction among Medicare members. HAP also participates in the annual Health Outcomes Survey (HOS), which is used to evaluate the physical and mental health status and outcomes of our Medicare members, and to identify opportunities for improvement in programs and services, public reporting, and member health. HEDIS, CAHPS, and HOS initiatives are discussed at the Medicare Star Ratings work group, which is focused on improving health outcomes and satisfaction for the Medicare enrollees. HAP's goal is to achieve 4.5 out of 5 stars in the Medicare Star Rating Program. The work group meets regularly to track initiatives, discuss program progress, and identify opportunities to improve access to providers and services, quality of care, and member experience. Additional programs designed to improve the health and well-being of the lives

we touch include HAP's Case and Population Health Management programs and provider quality improvement education.

Centers for Medicare and Medicaid (CMS) Quality Improvement Program (QIP) and Chronic Care Improvement Program (CCIP)

HAP's Medicare Quality Program encompasses strategies to design programs that are population based, provide for identification of high-risk members with chronic conditions fter enrollment into nurse health coaching and case management, measure performance outcomes, and support systematic follow-up on the effectiveness of interventions. Additionally, the quality improvement projects address clinical and non-clinical activities and are based on measurable, evidence-based, achievable outcomes that are analyzed annually. The outcomes are reported to the Clinical Quality Management Committee (CQMC) and Board of Directors. CMS has requested that all Medicare Advantage Organizations (MAOs) develop and implement a CCIP focusing effective management of chronic disease. CMS has requested that health plans submit attestations in lieu of the actual program documents. However, health plans must be prepared to submit the programs at the request of CMS.

Social Determinants of Health (SDOH)

This Population Health Management initiative is designed to improve SDOH screening and referrals, decrease food insecurity, reduce homelessness, and embed SDOH and equity lens across the population.

Appendix A

Quality Resources	
Position	**Percentage FTE allocated to MCO QI**
Chief Medical Officer	.45
Vice President Quality, Care Management, &	.7
Medical Director for Utilization	.3
Medical Director of Behavioral Medicine	.425
AVP Performance Improvement & Management	1
Director Quality Management	1

Quality Resources	
Position	**Percentage FTE allocated to MCO QI**
Manager, Quality Management	1
Senior Project Coordinator	2
Clinical Quality Coordinator	1
RN Quality Management	2
QM Data Analyst	1
Quality Coordinator	1
Quality Analyst	1
Appeal Grievance Analyst	19
QM Accreditation Coordinator	1
Appeal Grievance Leads	2
Sr. Director Performance Improvement	1
Manager of HEDIS & Reporting	2
HEDIS Coordinator	3
HEDIS Medical Records Analyst	1

Appendix B

Committee Approval	
Committee	**Approval Date**
PPO Quality Committee	January 14, 2003
AHL Board of Directors	February 10, 2003
Quality Improvement Council	December 15, 2003
PPO Quality Committee	March 5, 2004
AHL Board of Directors	February 17, 2004
Quality Improvement Council	February 2, 2005
PPO Quality Committee	March 21, 2005
Quality Improvement Council	February 1, 2006
PPO Quality Committee	May 18, 2006
AHL Board of Directors	May 18, 2006
Quality Improvement Council	February 7, 2007
Quality Improvement Council	February 6, 2008
Quality Improvement Council	February 6, 2009
Quality Improvement Council	February 9, 2010
Quality Improvement Council	February 8, 2011
Quality Improvement Council	February 7, 2012

Committee Approval	
Committee	**Approval Date**
Clinical Quality Management Committee	February 5, 2013
Clinical Quality Management Committee	February 4, 2014
Clinical Quality Management Committee	February 6, 2015
Clinical Quality Management Committee	February 2, 2016
Clinical Quality Management Committee	February 7, 2017
Clinical Quality Management Committee	February 27, 2018
Clinical Quality Management Committee	February 12, 2019
Clinical Quality Management Committee	February 11, 2020