2022 Quality Program

OVERVIEW and BACKGROUND

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 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 products include a commercial HMO, Medicare Advantage HMO and Medicare complementary products. HAP is 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.

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 Health Plan is a separate, wholly owned subsidiary of HAP that serves approximately 28,622 Medicaid enrollees. HAP Empowered Health Plan is invested in giving high-quality, low-cost care to Michigan residents. HAP Empowered consists of the following Medicaid products:

- HAP Empowered Medicaid
  - Children's Special Health Care Services (CSHCS)
- HAP Empowered Healthy Michigan Plan
- HAP Empowered MI Health Link
- HAP Empowered Duals (HMO SNP)

MI Health Link, also known as the Medicare Medicaid Program (MMP), is a health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid, and live in specified counties in Michigan. MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care, all in a single program designed to meet individual member needs. HAP began the first year of the MMP demonstration project in 2015 and continues to serve the needs of the dual eligible population in Wayne and Macomb counties with continued participation in the project.

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.

Purpose

The purpose of the HAP Continuous Quality Improvement Program (CQIP) is to enhance the quality and safety of health care services provided to the members through its practitioners, providers, care coordinators, and other HAP staff members. It is designed to monitor and evaluate the appropriateness of clinical and non-clinical member care and services objectively and systematically. Through the continuous process of monitoring and evaluation, HAP examines the components of its managed care service and delivery system, identifies opportunities for improvement, and recommends changes to affect those improvements to act to correct problems revealed in quality improvement activities. After recommendations are implemented, a re-examination of affected components enables the plan to validate improvements by measuring service and delivery system enhancements.

The CQIP is approved by the HAP Board of Directors and is updated as necessary and reviewed annually at a minimum. The review includes a description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services, the trending of measures to assess performance, an analysis of whether there have been improvements in the quality of clinical care and the quality of service to members, and an evaluation of the overall effectiveness of the QI Program.

Practicing providers participate in the Clinical Quality Management Committee as well as the associated subcommittees. Members and providers who wish to learn more about the QI program can request information on a description of the QI program and a report on progress towards meeting QI goals. This information is also found on the website at hap.org.

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
- Identifying under underutilization and overutilization of services
    - Monitoring includes provider performance reports including provider and member specific details on underutilization and overutilization of services including but not limited to provider profiles consisting of HEDIS® gaps in care reports, utilization, and financial data.
- 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.

Quality Program History

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.

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 include the following: Customer Experience Committee (CEM), Hospital Quality/Patient Safety Committee, and Appeals and Grievance-Member Service Committee. Reporting relationships were formalized with the Medical Management Oversight Committee, the Pharmacy Oversight Committee, and the Corporate Compliance Committee.

Accreditation

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.

Scope

HAP has a 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, 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 touchpoints 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 Specialists work in collaboration with HAP's Medical Care Management team to provider telephonic behavioral health consultations when requested. The CBHM team also investigates and resolves 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).

- 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 calls/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.

- 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.

Support Processes

Many processes assist in the development and implementation of the goals set forth in the QAPI. Member services support occurs through the monitoring of customer calls and member transfers. All member inquiries, complaints and appeals are tracked and followed-up. To ensure the equitable distribution of health care services to the entire population including members of racial/ethnic minorities, those whose primary language is not English, those in rural areas, and those with disabilities the availability of practitioners and accessibility of services for all members are addressed through the network analysis, after-hours and wait time studies conducted on HAP contracted PCP providers. In addition, member newsletters are mailed to members throughout the year. The QAPI supports and addresses findings of compliance reviews (annual, onsite, and ad hoc) by MDHHS, external quality reviews, and statewide focus studies. Additional support processes include utilization management activities. These activities are recorded and reported on a continual basis. These monitoring activities include the monitoring of lengths of stays, number and types of services, and types of births and deliveries, under and over-utilization, and pharmacy issues. The utilization management program, evaluation, and other related activities are reported to the CQMC.

The Population Health team supports the QAPI by providing educational programs and materials for tobacco cessation, high-risk and routine pregnancy and to promote preventive care including well child visits and immunizations. Reminders are also sent to members for mammograms, pap smears, lead screening, immunizations, annual physicals, and well child/adolescent visits. The Population Health Management Department in conjunction with QM is responsible for submitting an annual report to MDHHS on health promotion and disease prevention programs; outreach, referral, and follow-up activities related to enrollee uptake and participation rates.

HAP completes a network analysis and a provider satisfaction survey annually. HAP also oversees the provider newsroom communications, provider education, and office staff education These activities are also integral processes that support the Quality Management Program. Access to the Provider Administrative Manuals, directories, and newsroom updates are available on the HAP website. These activities are reported to the CQMC.

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 member is at the center of the care planning process identifying their own choices, preferences and priorities. Through person-centered care planning, the member takes ownership of their care and becomes the active driver of their care. Once determined that a member has complex care needs and would benefit from case management services, the member receives a comprehensive evaluation of their physical and psychosocial function and well-being. Furthermore, all barriers that prevent participation and compliance are identified and addressed. 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.
- Multiple chronic illnesses
- Chronic illnesses that result in high utilization

- 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

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 address social determinants of health and cultural and linguistic needs of our membership.

ORGANIZATIONAL 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 Clinical Operations & Strategy is designated to work closely with the Director of Quality Management and Manager, Quality Management in the implementation of the Quality Program. Duties of the Vice President Clinical Operations and Strategy 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 Clinical Operations and Strategy 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, 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 Clinical Operations and Strategy 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 five times per year.

D. Reporting Relationships and Resources

Significant staff resources are dedicated to quality management activities. Approximately 20 full-time equivalents reside in the quality management department (Appendix A). 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.

Clinical Quality Management Committee: Subcommittees:

Peer Review Committee (PRC)

Objective: To evaluate and maintain oversight of the clinical and/or technical performance concerns of HAP affiliated providers. In accordance with HAP policies and accreditation standards, provider concerns may be identified via performance monitoring, potential or actual quality of care reports or patient safety reported events.

Membership:

- Vice President, Clinical Operations & Strategy
- Senior and Associate Medical Directors
- Registered Nurses (Quality Management Department)
- Quality Management

- HAP-Affiliated physician(s)

Chairperson: Vice President, Clinical Operations & Strategy/designated Medical Director
Meeting Frequency: Meets at least four (4) times per year and up to twelve times per year if necessary

Credentialing Committee

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

Membership:

- Vice President Provider Network Management
- Chair of the Credentialing Committee
- Senior Medical Directors
- Credentialing Department
- Quality Management
- Provider Contracting
- Community physicians

Chairperson: Vice President, Clinical Operations & Strategy/designated Medical Director
Meeting Frequency: Meets at least 22 times per year

Member Experience Meeting (ME)

Objective: to lead and facilitate service improvements that will contribute to enhancing the member and patient experience. This objective accomplished through review of customer input provided by research surveys and other relevant operational performance metrics to identify opportunities and support the implementation of interventions among responsible stakeholders.

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: Vice President, Customer Experience
Meeting Frequency: Six (6) times a year

During 2021, the committee redistributed the purpose of the Member Experience Committee into other existing standing meetings to reduce duplication of topics and attendees. MA and Commercial topics were distributed through the weekly Stars Committee meetings. Medicaid and MMP topics were also distributed through this committee along with the Medicaid and MMP monthly workgroup meetings. These groups

reviewed results from survey research and other data to evaluate member and provider satisfaction with HAP services and to identify opportunities for improvement.

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 Hospital Acquired Condition (HAC) or Serious Reportable Adverse Event (SRAE).

Membership:

- Senior Medical Director(s)
- Finance/Claims
- Quality Management
- Information Technology

Chairperson: HAP Medical Director designated by Vice President Clinical Operations and Strategy
Meeting Frequency: Meets at least six (6) times per year.

Health Care Management Compliance Oversight Committee (HCM COC)

Objective: The Health Care Management Compliance Oversight Committee (HCM COC) monitors compliance with National Committee for Quality Assurance (NCQA) and Medicare standards and, when applicable, with federal and state regulatory requirements. This is done for Health Alliance Plan and its subsidiaries (excluding ASR) and all product lines. It oversees compliance in Utilization Management, Coordinated Behavioral Health Management, Pharmacy, Case Management, and all Delegated Entities. The Chair (Senior Medical Director) or designee presents the HCM Program document to HAP's Clinical Quality Management Committee for review and approval annually.

HCM COC responsibilities include:

- To assure compliance with NCQA, CMS and other regulatory standards
- To approve pre-delegation assessments once they have been evaluated.
- To annually evaluate, update, and approve the Health Care Management Program and policies and procedures for HAP and its delegates.
- To initiate corrective action plans when applicable for internal and delegated Health Care Management issues.
- To annually review and evaluate Health Care Management policies.
- To review quarterly activity reports submitted by the delegates.
- To assure that clinical criteria is annually reviewed.
- To review Health Care Management audits for timeliness and appropriateness of approvals and denials.
- To assure that an annual inter-rater review is performed, and the results are evaluated and addressed.
- To ensure that HAP uses licensed health care professionals.

Membership:

- 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)
- Project Coordinators for:
    - Behavioral Health
    - Delegated Medical Management Entities
    - NCQA
    - CMS
- A representative from the delegated utilization management entity being reviewed (as needed)
- Guests (when their special expertise would prove beneficial to the decision-making process)

Chairperson: Senior Medical Director and Director Coordinated Behavioral Health Management
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
- Oversees the administration of the Michigan Medicaid Common Formulary, including products on the Single Preferred Drug List
- Adopts updates to the formulary and utilization management criteria, as established by the State's Medicaid P&T Committee and the Common Formulary Workgroup
- Provides feedback on drug utilization review (DUR) activities conducted internally and in conjunction with the pharmacy benefit manager (PBM)

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's Corporate Compliance Committee

Beginning January 1, 2022, the Corporate Compliance Committee (CCC) was retired and replaced by the Executive Quality and Compliance Committee (EQCC). The governance committee is supported by newly formed subcommittees that will report up through the EQCC.

The HAP Executive Quality and Compliance Committee is established to foster a culture of compliance by providing leadership, oversight and guidance for the development, implementation and monitoring of HAP's compliance and ethics programs and HAP's compliance policies and procedures. 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.

Additional Responsibilities:

- Serves to prevent violations of applicable laws, regulations, federal/state contract obligations, and professional organization requirements as well as supports and protects the rights of HAP members and other stakeholders.
- Proactively audits and monitors to identify violations of laws, regulations and applicable professional organization requirements and provides appropriate response, mitigation, and remediation to any such misconduct as soon as it is suspected or discovered.
- Encourages individuals to promptly report any conduct, ethics, or compliance concerns that they reasonably believe violates HAP's Code of Conduct, applicable laws and regulations, professional organization requirements, or HAP policy or procedure.
- Appropriately disciplines individual(s) who fail to follow the standards of the Code of Conduct or other legal requirements, who engage in unethical practices, or any individual who fails to take reasonable steps to identify, prevent, discontinue and report such failure(s) to follow the Code of Conduct or other legal requirements, or engagement in unethical practices.
- Develops, implements, monitors, and evaluates the sufficiency of appropriate corrective actions to ensure non-compliance or unethical practices will not be repeated.
- Creates a culture of compliance and ethics by, among other activities, establishing compliance and ethics training and awareness programs and supporting operational and functional areas in developing compliance processes, policies, and procedures.

HAP's Government Programs Compliance Officer is appointed by the Chief Compliance Office to chair the Committee. HAP's Chief Compliance Officer position as well as the Compliance Committee will not be subcontracted or delegated to a first tier or downstream entity.

HAP's Executive Quality and Compliance Committee is made up of Vice Presidents from different functional and operational areas representing diverse responsibilities.

Guests may attend Committee meetings on an as-needed basis. Individually, Executive Quality and Compliance Committee members are responsible to bring ethics and compliance issues to the Committee as appropriate and to promote a culture that encourages ethical conduct and a commitment to compliance with the law and HAP's Code of Conduct.

Chairperson: HAP's Chief Compliance Officer
Meeting Frequency: No less than four (4) times per year or as necessary

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:

- Function 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 fulfilling 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 participate 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 Clinical Operations and Strategy
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 and Network Medical Directors' 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 Hospitals, 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 Corporate Leadership Council (CLC) meets once a month. The meetings are designed to share updates on ongoing and emerging initiatives and issues. There is an expectation that information shared at CLC meetings will be cascaded to other leaders and to HAP staff with the outcome that front- line staff would receive key information regarding HAP and HAP at the appropriate time and level. Membership is comprised of plan-wide representation from HAP's senior leadership team.

- 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 and Provider Network.

Quality Management (QM), Case Management (CM), Population Health Management (PHM),Coordinated Behavioral Health Management (CBHM) and Medical Configuration & Reporting 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

Data collection, integration, analysis and ensuring accuracy and completeness

Data integration allows for member identification as well as assists with the determination and supporting of identified members' ongoing care needs. HAP may evaluate several integrated data sources to determine the appropriate risk stratification of members including those that offer predictive modeling to ensure that me members receive the appropriate support and interventions in the right setting at the right time including:

- **Facets**: Claims processing system
- **Pega**: Customer Service Call Center Software
- **Care Connect 360**: MDHHS website
- **EPIC**: Henry Ford Health Electronic Health Record (EHR)
    - Data is accessed by team members from the following teams via secure read only access:
        - Case Management
        - Utilization Management
        - Quality Management
        - Program Development
- **MiHIN (**Michigan Health Information Network): An ADT feed that HAP receives from the State of Michigan of HAP members who have had an admission or discharge from any hospital in Michigan. This feed also:
    - Sends immediate notification of all member utilization to HAP
    - Contains admissions and discharges from the following facilities:
        - Inpatient Hospitals
        - Skilled Nursing Facilities (SNFS)
        - Emergency Room Departments
- **Careport**: Software that interprets and cleanses MiHIN data directly from facility data. Provides an online tool that tracks member history through the continuum of care.
- **Laboratory Results**: Laboratory results are available for HAP via CarePort's HAP's ADT feed. This information is available in the patient summary and is shared with Case Management, as well as PCPs for post hospitalized members. The labs are included in the member summary/transitions of care record.
- **ACG Tool**: Tool developed by Johns Hopkins Healthcare combining the expertise of Johns Hopkins Hospital and Johns Hopkins University that is utilized to stratify HAP's population. The ACG tool transforms data from CareRadius (HAP's care management platform), Medical/Behavioral Claims, Pharmacy Claims, Laboratory results, Health Appraisal Results and Health services programs within the organization into analytics and reporting for use across the Population Health Management areas of focus.
- **Member Pharmacy Fills**: These are uploaded to CareRadius from the pharmacy claims processor (ExpressScripts [ESI]). This pharmacy information is then reviewed by case management, pharmacy, medical directors and utilization management staff. The pharmacy information is used to educate members on their medication changes and increase medication adherence. A comprehensive medication review is completed for members who are on high-risk medications, are prescribed 15 or more medications, and/or if medication reviews requested by members.
- **Health Risk Assessments**: Health Risk Assessments are completed for MMP, DSNP, and Medicaid Healthy Michigan Plan Members upon enrollment.

Below are additional systems/tools utilized to implement and support the QAPI:

Integrated Care Bridge: The Care Coordination framework for Michigan's integrated care program. Through the Care Bridge, the members of an members' Integrated Care Team (ICT) facilitate formal and informal services and supports in a member's person-centered care plan. The Care Bridge includes an electronic from the health plan care coordination platform which will support an Integrated Care Bridge Record to facilitate timely and effective information flow between the members of the ICT.

CareRadius: An important part of each care management program is the ability to share information electronically. CareRadius functions as both a care coordination platform and a communication mechanism that enables staff to see all the programs and services a member receives. CareRadius is designed with a member centric approach that allows each discipline to review other disciplines' documentation and updates. Tasking and other forms of communication within the platform complement face to face and email communication between staff members.

HEDIS®: The information from the data warehouse is used to populate the HEDIS® software used to produce the annual HEDIS® reports. An annual audit is conducted to ensure HAP is capturing all data required to produce accurate HEDIS® reports. HAP uses the HEDIS® tool each year as one of the ways to help make sure that our members are getting the preventive screening and services needed with the intent of keeping members healthy and/or assist in the identification of potential health problems early. The results of HEDIS® are discussed at the Clinical Quality Management Committee annually. The committee then reviews the information and makes recommendations on actions to improve care.

Annual review and actions

All components of the QAPI are data driven. Utilizing the reports from the systems outlined above, feedback from members and providers, plan level and provider level HEDIS® results, care management and utilization management activities and network analysis, HAP conducts an internal review to evaluate the effectiveness of the QAPI. Measures of performance before and after interventions are reviewed and compared to benchmarks. Action plans are developed for selected HEDIS® reported measures. These action plans identify the tasks associated with correcting any deficiencies and improving care and outcomes.

Improving Services to HAP Medicare Members

The HAP Quality Improvement Program supports the application of the principles of Continuous Quality Improvement (CQI) to all aspects of HAP's service delivery system. HAP engages in performance measurement and quality improvement projects designed to achieve significant improvements in clinical care and non-clinical care.

Each year HAP sets goals to improve our services to members. We submit annual 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. 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 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 for 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) and MMP's 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.

HAP has a QIP/CCIP workgroup consisting of representatives from the Quality Management, Performance Improvement/ HEDIS®, Outreach, and Care Management departments. This workgroup meets bimonthly to discuss ongoing barriers, interventions, and strategies to improve member outcomes The interventions are tracked for effectiveness and reported during the next remeasurement period cycle. The workgroup's main activities include:

- Reviewing HEDIS® performance data
- Identifying key drivers and areas in need of improvement utilizing the initial fishbone diagram
- Identifying interventions to implement
- Developing action and work plans
- Monitoring intervention performance and outcomes
- Revise or discontinue interventions when necessary

HAP's CCIP promotes effective management of chronic disease and improves care and health outcomes for enrollees with chronic conditions. Effective management of chronic disease is expected to slow disease progression, prevent complications and development of comorbidities, reduce preventable emergency room (ER) encounters and inpatient stays and improve quality of life.

The goals of the CCIP are to:

- Support the CMS Quality Strategy
- Include interventions that are above and beyond inherent care coordination role and overall management of enrollees
- Engage members as partners in their care
- Increase disease management and preventive services utilization
- Improve health outcomes
- Be universally applicable to MAOs
- Facilitate development of targeted goals, specific interventions, and quantifiable, measurable outcomes
- Guard against potential health disparities and produce best practices

Planning and carrying out the interventions for these projects are tracked in the "Plan, Do, Study, Act" PDSA cycle. A CCIP is generally conducted over a three-year cycle.

Social Determinants of Health (SDOH)

SDOH are the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Population Health Management initiatives are designed to improve SDOH screening and referrals, decrease food insecurity, reduce homelessness, and embed SDOH and health equity across the population. Focus areas include food insecurity, housing, utility assistance, employment/education/training, stress, depression and anxiety.

Population Health and Health Equity

The Population Health Management (PHM) Strategy is a comprehensive and integrated approach that addresses member needs across the continuum of care for high-quality, cost-effective health care delivery. The strategy is a framework that defines how health services are offered and delivered to meet the needs of our members across all areas of population health.

Annually, HAP reviews member population data through a combination of reports on characteristics, including demographics of HAP membership. This analysis of data includes a review of:

- Characteristics and needs, including social determinants of health
- Relevant subpopulations and subpopulation needs
- The needs of children and adolescents
- The needs of individuals with disabilities
- The needs of individuals with serious and persistent mental illness

A regional and statewide population review is also performed to determine health disparities and other potential population issues that may need to be addressed for the HAP membership.

Following this analysis, findings are used to:

- Identify changes to business rules which will better identify individuals for PHM programs, including but not limited to, the number of events (hospitalizations and ER visits) used to flag potential PHM program candidates; the cost threshold levels; which diagnosis or procedure codes are used to target members; and the risk score ranges or other new methods to consider when identifying potential PHM candidates
- Review and identify changes to PHM processes to best address member needs. The business drivers for these changes include but are not limited to, compliance with mandatory regulations, reduction of redundant member outreach; continuous improvements including clinical effectiveness, outcomes and quality, and increased coordination across programs
- Review PHM resources and modify them, if necessary, to address member needs

Patient Safety

HAP fosters a supportive environment to help providers improve the safety of their practice. HAP also informs members of what they can do to help ensure they receive safe clinical care. These are accomplished through:

- Oversight of regulatory guidelines from the Center for Medicare and Medicaid Services (CMS) and to apply updates to HAP processes for compliance with monitoring health care acquired conditions.
- Maintaining an ongoing process to monitor and investigate hospital-acquired conditions (HACs) and provider preventable conditions (PPCs).
- Collaborating with HAP's Director of Support Services for Building Operations to promote awareness of corporate safety responses to emergencies including pandemics, fire and weather disasters, and workplace violence.
- Maintaining a liaison relationship with HFHS for alignment of patient and member safety goals through participation on the HFHS Resuscitation Advisory Council (RAC) and communicating pertinent discussions to the Quality & Safety Committee.
- Participating in the ongoing community Michigan Health and Hospital Association, Quality Improvement Directors' meetings, and other forums to address and support quality and safety improvement initiatives locally and statewide.
- Participation in the Michigan Quality Improvement Consortium (MQIC) to promulgate evidence-based medicine, preventive services, health promotion, disease management programs, and clinical practice guidelines to practitioners

Clinical Practice Guidelines

HAP adopts and supports clinical practice or care guidelines for the treatment of a variety of medical and behavioral conditions. Care Guidelines help caregivers provide the right care at the right time using the most current evidence to result in the best outcomes. HAP's clinical and medical policy team continue to evaluate scientific data, published evidence, and directives from trustworthy health care organizations to promote and establish clinical guidelines. HAP partners with the Michigan Quality Improvement Consortium (MQIC) to research, develop and approve the guidelines. HAP is a key member of this group which is focused on the health of Michiganders. This group is led by doctors and other clinicians from different health plans. They look at current scientific information to write guidelines. This is done to help primary care doctors in Michigan give most up to date care to their patients. MQIC reviews and updates published guidelines every two years. These guidelines are available on the HAP web site. Upon request, HAP will disseminate a listing to MDHHS and a description of all clinical guidelines adopted, endorsed and utilized on behalf of HAP.

Communication of Clinical Practice Guidelines

- Clinical Practice Guidelines are available statewide to MI physicians
- HAP maintains posting of all guidelines on HAP website(s) (updated MQIC guidelines, new and modified on *www.hap.org* with link to *www.mqic.org*)
- Notifies physicians of the HAP posting via Provider News Bulletin and Provider Manual
- Notifies applicable internal customers of guideline updates and new approved guidelines
- Solicits and shares, guideline activity feedback between HAP and MQIC
- Member communications (member and provider website, member newsletter, member handbook as applicable, etc.)

Transitions of Care

HAP addresses continuity of care to ensure uninterrupted service medically necessary medically necessary services which disrupt medically necessary services. An enrollee's primary care physician, specialist, clinics, & dentists are covered by continuity of care requirements. A transition supply of prescriptions is supplied when applicable.

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 allows for 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.

Quality Program Evaluation and Work Plan

An annual work plan is developed to document the Quality Improvement Program objectives, planned projects, responsible person and targeted time frames for completion. The work plan is initiated by the Quality Management department and is forwarded to the Clinical Quality Committee for review and recommendations. Annual approval by the Board of Directors is obtained.

The work plan provides a mechanism for tracking quality activities over time. The Work Plan is not a static document; it is updated quarterly to reflect ongoing progress on QI activities

Program Annual Review

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

Appendix A

Quality Resources	
Position	**Percentage FTE allocated to MCO QI**
Chief Medical Officer	.45
Vice President Clinical Operations & Strategy	.7
Medical Director for Utilization	.5
Medical Director of Behavioral Medicine	.425
Director, Quality Management	1
Manager, Quality Management	1
Senior Project Coordinator	3
Clinical Quality Coordinator	1
RN Quality Management	1
Quality Coordinator	1
Quality Analyst	1
QM Accreditation Coordinator	1
Appeal Grievance Leads	2
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
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
Clinical Quality Management Committee	February 9, 2021