2021 Quality Program
MMP/MI Health Link

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 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 Empowered Health Plan is a separate, wholly owned subsidiary of HAP. HAP's 2021 Family of Health Care Plans includes the following HAP Empowered products:
- HAP Empowered Medicaid
- 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.

HAP Empowered MI Health Link reports and complies with all quality measures required under the MI Health Link MMP Demonstration Project in conjunction with the Coordination Agreements with the State of Michigan and the contract. HAP Empowered MI Health Link reports all measures related to behavioral health, care coordination, and care transitions, as well as Long Term Services and Supports (LTSS), as required by the contract. HAP Empowered MI Health Link also reports the following:
- Medication Therapy Management Programs (MTMP)
- Model of Care (MOC)
- Chronic Care Improvement Program (CCIP)
- Continuous Quality Improvement Program (CQIP)

CQMC: 2/9/2021, 4/13/2021

- Quality Improvement Project (QIP)
- Continuous reporting of CMS Part C and Part D requirements via Health Plan Management System (HPMS)
- Core and MI specific measures
- Quality Withhold Measures
- Health Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems survey (CAHPS)
- Health Outcomes Survey (HOS)

The purpose of the HAP Empowered MI Health Link Continuous Quality Improvement Program (CQIP) is to enhance the quality and safety of health care services provided to the MMP 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 Empowered MI Health Link 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.

MI Health Link serves dual eligible populations in Wayne and Macomb counties as part of the State of Michigan MMP demonstration. The members must have both Medicaid and Medicare. These members typically have at least one chronic medical or behavioral health condition. HAP Midwest Health Plan undertakes a variety of projects to improve the quality of care to all members.

Identification
HAP Empowered MI Health Link identifies and monitors the most vulnerable members of the MMP population in the following ways:
Registered Nurse (RN) or a Social Work (SW) Care Coordinator visits each member in the home to conduct a Health Risk Assessment (HRA). This assessment allows the Care Coordinator to evaluate the member's medical conditions, medications, providers, pain level, ability to conduct activities of daily living, and understanding of their medical conditions. The information is then entered the Integrated Care Bridge. This system generates a proposed plan of care that is discussed and agreed upon with the member. The system also generates reminder prompts to the Care Coordinator for follow up activities based on the assessment and care plan. If a member does not wish a home visit, the Care Coordinator can set up a time to conduct the HRA by telephone.
All member calls into Customer Service are tracked in the Enrollment Tracking System. If a member who calls Customer Service indicates that they may need additional assistance with managing medical conditions or activities of daily living (ADLs), that member is referred to the Case Management department

for further assessment and follow up.

The Medical Director conducts periodic reviews of utilization data and reviews for any outliers, trends, or patterns, or for members that have had multiple hospitalizations or use of ER services. These members are also referred to the Case Management department.

The Pharmacy Director conducts periodic reviews of prescription data to identify opportunities to improve medication management. Specific medications or conditions may be reviewed for safety, quality, or adherence opportunities. Ad hoc review for specific members with multiple medications may also occur.

All members in the Case Management program are followed by a Care Coordinator who follows up with the member based on the plan of care and the member's needs. An annual re- assessment is conducted by the Care Coordinator with the member and any caregivers the member wants to include. During this re-assessment, the Care Coordinator, member, and other involved caregivers review and update the member's goals, plan of care, medical history, and providers.

Monitoring

The plan of care is shared with the Primary Care Provider (PCP) through phone, face to face interactions, fax, and mail. When changes occur in the plan of care, the PCP and member are notified. Ongoing monitoring of all of HAP Empowered's MMP members is conducted through Case Management with results of monitoring and reporting activities such as HEDIS and CAHPS, Medication Therapy Management Programs, Utilization Management data review, Model of Care program, and other activities discussed in the CQIP.

Many of the MMP members have been identified as having behavioral health diagnoses and are receiving services through the community mental health system. HAP Empowered's MI Health Link has partnered with Detroit Wayne Mental Health Authority (DWMHA) and Macomb County Community Mental Health (MCCMH) to establish guidelines for the exchange of information to promote optimum health for members with co-occurring behavioral and physical health disorders. Monthly meetings between behavioral health providers and HAP have resulted in verifying contact information, identifying gaps in care, and creating a venue to discuss current concerns involving mutual members.

HAP and DWMHA worked jointly to develop an assessment tool. This tool became the basis for the Level I Health Risk Assessment (HRA). The HRA is administered by the HAP Empowered MI Health Link Care Coordinators and contracted provider agencies delegated to perform this assessment. HAP Empowered MI Health Link and DWMHA use the HAP Integrated Care Bridge to house all the assessments shared by the two organizations. HAP Empowered MI Health Link also uses the same process and protocols to exchange assessment information with MCCMH.

HAP Empowered MI Health Link also has a contract with the agencies that work with the developmentally disabled population providing community living support and respite care for caregivers. The HAP MHP care coordinator communicates with these organizations as needed to assist the member and caregivers to obtain needed services.

Data collection, integration, analysis and ensuring accuracy and completeness

The Information Technology (IT) Department maintains hardware and software programs that can collect, analyzing and integrating data to assist in the CQIP activities, and ensure that data is complete and reliable. Systems are backed up for safety on a regular basis. The IT Department is central to efforts to manage patient care and to improve health care quality and outcomes. The data warehouse is the main source for all reporting. This warehouse can collect and integrate data from all components of the network to develop a comprehensive picture of member needs, utilization, and performance improvement programs as well as other quality management activities. The warehouse maintains all data at the member level and health information for CMS and Michigan Department of Health and Human Services (MDHHS) review.

Claims, encounters, eligibility, Michigan Care Improvement Registry (MCIR), participating hospitals, credentialing and all electronic data is stored in this warehouse. From there, data is fed to the Case Management System and other internal reporting programs.

The following software systems enable HAP Empowered Mi Health Link to implement components of the QIP:

Integrated Care Bridge is used to house information on the member's health risk assessment and care plan, as well as hospitalizations, referrals, pharmacy, and lab data. The software generates an individualized plan of care for each member. Prompts are then generated when follow up is due on members. These prompts are displayed in each care coordinator's assignment log. An annual report on the case management activities is generated and reported to the Clinical Quality Management Committee. Quality improvement projects are developed out of this report.

The information from the data warehouse is also 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. The results of the HEDIS reports are discussed at the Clinical Quality Management Committee annually. The committee then reviews the information and makes recommendations on actions to improve care.

The data warehouse is also used to populate the information on member demographic and eligibility history, provider contracting, and claims history into the case management system.
The Customer Service Representatives utilize the enrollment system to review information and log all calls received. All calls are given reason codes and reports can be generated based on the codes. Complaints are recorded into this system and reports are generated to determine the number and types of complaints. Member experience reports including analysis of complaints is presented at the Clinical Quality Management Committee, which recommends appropriate interventions.

The data warehouse and the ancillary systems are backed up nightly. In the case of a prolonged power failure or other disaster, the backups would be used to rebuild the systems.
Hardware systems include desk top computers, laptop computers, copy machines, and routine office supplies. Software systems include HEDIS data collection and reporting software, a care management system, Integrated Care Bridge for care coordination and the enrollment system. Microsoft Office, Excel, Power Point, and other standard computer programs are also used.

Annual review and actions
All components of the CQIP are data driven. Utilizing the reports from the systems outlined above, feedback from members and providers, plan level and provider level HEDIS results, case management and utilization management activities and network analysis, HAP Empowered MI Health Link conducts an internal review to evaluate the effectiveness of the CQIP. 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 are done in conjunction with the annual strategic planning.

Fraud and Abuse

HAP Empowered MI Health Link is committed to the prevention, detection, and correction of any fraud, waste, abuse, or criminal conduct. The mission of the Compliance Department is to promote an organizational culture that encourages ethical conduct and compliance with the law. Any HAP MHP associate or business partner (Member, Employee, Provider, First Tier and Downstream Related Entity and

their governing   bodies) must share this commitment to lawful and ethical conduct.

All potentially fraudulent or abusive practices regarding a provider, member or employee that are identified by HAP are reported to the Program Investigation Section at MDHHS, Office of Investigator General (OIG), and all other appropriate regulatory agencies. HAP MHP cooperates with any investigation into the identified fraudulent or abusive action, and provides information, as requested. When appropriate, HAP MHP will also inform the National Practitioner Data Bank- Healthcare Integrity and Protection Data Bank (NPDB-HIPDB).

Compliance concerns about any provider, member, employee, or contractor of HAP MHP can be called to the 24 hours, toll free Compliance Hotline at 1-877-746-2501. The report can be filed anonymously, and concerns may also be put in writing and mailed to the following address:

HAP Empowered MI Health Link
Attention: Compliance Officer PO Box 2578
Detroit, MI 48202

CAPS

Corrective action plans (CAPs) are developed based on findings resulting from medical and service reviews, member, and provider feedback, or HEDIS results. Committee members or the Medical Director can recommend the development of a corrective action plan. A CAP may consist of focused education to an individual provider, service site administrative manager, or all medical or management staff. HAP Empowered MI Health Link addresses any aspects of health care or administrative practices that impact the delivery of health services to its members.

Depending upon the issue, interdisciplinary teams of professionals may be assembled to begin a quality improvement process to resolve identified deficiencies. This process relies on the team to fully understand the issue, identify the magnitude of the problem, develop strategies for improvement, pilot the recommendations, and monitor the outcomes to fully realize achievable benefits. If the issue requiring correction involves a provider, the Medical Director meets with the appropriate   provider as necessary to discuss the nature of the problem and the recommended solution.

The Medical Director can offer technical assistance in support of the provider's effort to resolve the problem. The Medical Director also stipulates the frequency with which the provider formally assesses the improvement process. The Medical Director or the QI Director is responsible for monitoring the effectiveness of the CAP and for determining whether plan revisions are warranted. If upon review the provider did not follow the CAP, the Medical Director will meet with the provider and discuss future steps, possibly including termination from the network, if the provider fails to comply with the CAP. The Medical Director reports this activity to the QI Committee.

HIPAA and Privacy

HAP Empowered MI Health Link staff work with data related to the development, review, and implementation of all aspects of the CQIP. HAP incorporates a systematic data collection and performance monitoring approach into all activities and complies with accrediting and regulatory requirements. The data collection follows the parameters set forth in the Health Insurance and Portability and Accountability Act (HIPAA) Privacy and Security Regulations, state mental health and substance abuse regulations, and NCQA regulations to ensure that the data collected meets the minimum standards for disclosure of Protected Health Information (PHI), Individually Identifiable Health Information (IIHI), and Personally Identifiable Financial Information (PIFI). PHI may be accessed by HAP staff according to minimum   necessary standards for the purposes of treatment, payment, and health care operations without obtaining member or member representative consent or authorization.

The privacy of member information is maintained by providing secure work sites, ensuring that computers and data submissions are password protected, and locking desks or cabinets that are used to store member PHI. PHI is monitored by the HAP Compliance Program to ensure that only employees with a need to know have access to the information and that the staff has access to the minimum of information needed to complete the task. Any violations of the HIPAA requirements for improper release of member PHI will be managed by HAP's human resources department in accordance with HAP's Compliance Program. The actions taken can include a verbal warning, education, suspension, management oversight for a period or termination. This protection applies to all members, both living and deceased.

Protection of member PHI includes all activities performed by HAP. Unless a signed HIPAA consent form is on file with HAP MHP, all member data will be de-identified prior to release to any entity where there is not a business need to have access to it.

Exceptions to the HIPAA regulations are detailed in the HAP Corporate Compliance Policy which states that uses and disclosures of PHI for which member consent, authorization, or opportunity to agree or object is not required include the following:

Purposes of public health activities, including preventing or controlling disease, public health investigations or interrogations, reports to the Food and Drug Administration (FDA) for adverse events or post-marketing surveillance.
Concerning victims of abuse, neglect, or domestic violence, as required by law.
Health oversight activities authorized by law, regulatory programs, or requirements, within the scope and authority of the regulations.
For judicial and administrative purposes (including response to subpoena, discovery request, warrant, or other lawful process) to the legal body issuing the subpoena, or court order.
Purposes of law enforcement or specialized government functions, including national security and intelligence activities.

Employees are required to complete annual HIPAA training and take post training tests to determine their level of knowledge of HIPAA and fraud and abuse. Documentation of the training is monitored through the Henry Ford Health System University online training system. Reports can be generated as needed for oversight of the training requirement. Oversight bodies such as CMS and MDHHS may review documents related to the compliance program and policies and procedures at any time.

Internal Quality Improvement Activities
HAP Empowered MI Health Link maintains a Quality Improvement (QI) Program structure for the MI Health Link members that is separate from any of its existing Medicaid, Medicare, or commercial lines of business. The HAP Empowered MI Health Link Quality Improvement Program supports the application of the principles of Continuous Quality Improvement (CQI) to all aspects of HAP Empowered MI Health Link'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.

Clinical Guidelines
HAP Empowered MI Health Link utilizes the Michigan Quality Improvement Consortium (MQIC) guidelines as a basis for provider education and care management/outreach programs. These guidelines utilize current literature and nationally recognized standards, as well as input from providers. These guidelines are reviewed at least every 2 years or more frequently if current literature indicates that they need to change. These guidelines are sent to every provider in Michigan each year. HAP also publishes these guidelines in the Provider Newsletter and they are available on the HAP Empowered web site: https://www.hap.org/providers/provider-resources/empowered-providers Upon request, HAP Empowered MI Health Link will disseminate a listing to MDHHS and a description of all clinical guidelines adopted, endorsed and utilized on behalf of HAP.

Network Analysis
HAP Empowered MI Health Link conducts an annual review of the provider network to ensure that the network meets the cultural needs of the members, that appointment times meet required standards, and that the number and types of providers meet the requirements of the members.
Adequate number of Primary Care Providers: HAP Empowered contracts with primary care providers (PCPs) whose specialties include geriatric medicine, internal medicine, family practice, and general medicine. HAP ensures that members have adequate access to PCPs by conducting access mapping to confirm that there are contracted providers within 30 minutes or 30 miles from the member's home.

The PCPs work closely with the HAP MHP and the members to coordinate their needed care and services.

- Adequate number and types of specialists: HAP MHP contracts with specialists to care for members. Specialties can include cardiology, gastroenterology, hematology/oncology, infectious disease, endocrinology, nephrology, neurology, oncology, ophthalmology, pain management, urology, physical medicine and rehabilitation, podiatry, psychiatry, pulmonology, rheumatology, all surgical specialties, and wound care.
- Cultural diversity: The HAP provider network includes physicians who speak other languages to meet the needs of members. HAP has access to a telephone language service to communicate with members who speak other languages. The provider directory lists the languages spoken by the providers, as well as general office information. HAP also works to accommodate members with disabilities and follows the Americans with Disabilities Act of 1990 (ADA).
- Clinical expertise used to meet the needs of members with complex health and social needs: HAP works to ensure the network includes providers who have the clinical expertise and training to successfully meet the needs of members who may be frail, suffering from multiple chronic illnesses, or near the end of life.
- Out of network providers: It is understood that in some instance's members will need specialty care not available from a network provider. When there is a need for a specialist that is not currently in network, HAP MHP arranges for services to be provided by a non-network provider and negotiates a single case agreement.

Member Satisfaction and Grievances

All member calls are documented in Pega system. Calls are separated by member inquiries, complaints, and grievances. Member complaints are separated into the following categories:

- Quality of Care
- Access
- Customer Service
- Marketing
- Benefit Plan
- Appeals

The number and types of grievances and complaints are reported in the annual member satisfaction report and are presented to the Clinical Quality Management Committee. All grievances and complaints are acknowledged, investigated, and resolved within 30 days of receipt of the grievance. Quality of care complaints are forwarded to the Quality Improvement Department.

Efforts continue and process' are in place to prevent, detect, and remediate critical incidents. Quality Management provider's oversight of the critical incident process. Enhancements and opportunities for improvement include ongoing education and reporting requirements for internal staff, providers, and subcontractors regarding critical incidents. Case Management has a standardized process is in place to trend critical incidents.

Complaints and Grievances from the CMS Health Plan Management System (HPMS) Complaint Tracking Module web site and from MDHHS are also downloaded, reviewed, and reported for the analyses. Analysis of all member complaints and grievances received at HAP, HPMS, MDHHS, and other internal or external departments are reported annually in the Annual Member Satisfaction Report.

Provider Satisfaction

An annual provider satisfaction survey is conducted to determine the level of satisfaction providers have with HAP, including behavioral health providers. This survey assesses the provider's satisfaction with getting reports from specialists, hospitals, and other providers. It also assesses their satisfaction with the case management programs, the referral process, billing/payment, prior authorization process, care coordination and ICT/IICSP development, overall satisfaction with the plan and the Provider and Customer Service departments. The results of this survey are presented at the CQMC and shared with MDHHS and CMS as needed.

Continuity and Coordination of Care
HAP Empowered MI Health Link members select a PCP upon enrollment. If a member does not select a PCP, one is auto assigned during the enrollment process based on the member's zip code. The PCP is responsible for ensuring the coordination of services for both the Medicare and Medicaid benefits. Since members may receive health care services from other providers such as specialists, hospitals, local health departments, behavioral health care providers, and other providers inside and outside of the HAP network of providers, the following areas are monitored to help ensure continuity and coordination of care:

- Continuity of care between hospitals and PCPs regarding follow-up after discharge
- Communication of treatment information between hospitals and PCPs
- Physician feedback through the annual PCP satisfaction survey on consistency in receiving information from consultants
- Coordination of care when members receive prescriptions from multiple physicians
- Continuity and coordination of care across all care and service settings, including transitions in care

Patient Safety

HAP Empowered MI Health Link 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:

- Member education about getting the best care possible
- Member education about falls and fall prevention
- Providing PCPs with current immunization schedules, clinical practice guidelines, and preventive health guidelines
- Providing PCPs with forms to document care and services
- Updating web site to include links to safety related information
- Publishing information about safety initiatives in the member and provider newsletters
- Notifying affected members and providers about FDA drug recalls related to safety
- Conducting retrospective drug utilization review for specific quality and safety

Utilization
HAP Empowered MI Health Link works to provide appropriate care and services for its members. HAP monitors the utilization of:

- Inpatient admissions for appropriate level of care and length of stay
- Selected ambulatory procedures
- Pharmacy utilization
- Under and over-utilization of selected services
- Emergency Department usage

Enhancements for 2021 include provider performance reports for all lines of business including provider and member specific details on underutilization and overutilization of services including but not limited to provider profiles consisting of HEDIS and gaps in care reports, utilization, and financial data.

Credentialing and Re-credentialing
HAP Empowered ensures that members have access to providers that have met credentialing and re-credentialing standards. HAP complies with NCQA standards and performs the following activities:
- Utilizes credentialing database
- Verifies credentials through primary source verification by an approved organization
- Collects application data through a national vendor
- Provides oversight of the following delegated credentialing entities:

   1. Genesys PHO
   2. William Beaumont Hospital System
   3. Henry Ford Health System
   4. University of Michigan Health System
   5. University Physicians Group (Wayne State University)
   6. United Physicians, Inc.

Quality Improvement Projects
HAP Empowered MI Health Link's Quality Improvement (QI) program is monitored throughout the calendar year to ensure its members are receiving the highest quality of care. HAP conducts internal monitoring, assesses its QI program through annual program evaluations and makes recommendations concerning the level of care members receive as well. HAP continually evaluates its internal structures and processes and makes changes based on the results of these evaluations. The results that are also monitored include surveys, audits, and feedback from HAP's network of providers, office staff and members.

Quality Improvement Program
Health Services Advisory Group (HSAG) is the External Quality Review (EQR) organization chosen by MDHHS to oversee this initiative. In 2020, the focus for the MMP QIP was the "Follow Up After Behavioral Health Hospitalization (FUH)" HEDIS measure. This QIP initiative continues to be focused on the 30-day measure. The baseline year for this initiative was 2018; remeasurement year 1 is 2019; and remeasurement year 2 was 2020. Because of Covid 19 and its possible impact on this measure, MDHHS added a remeasurement year 3, 2021 to this project. Interventions continue to be developed and refined in conjunction with the Quality Withhold workgroup. HAP Empowered has also formed a workgroup to find ways to improve low-performing HEDIS measures. This workgroup is comprised of Health Care Management, Customer Service, HEDIS, Quality, and Provider Network Services.

The workgroup completed the following activities in 2020:
- Reviewing HEDIS performance data
- Identifying key drivers and areas in need of improvement utilizing the initial fishbone diagram
- Identifying evidence-based interventions/change concepts to implement
- Developing action and work plans
- Monitoring intervention performance and outcomes
- Revise or discontinue interventions when necessary

In 2020, the HAP Empowered MMP team employed the following strategies related to the QIP:
- Development of a process and tracking method for following up with members with behavioral health admission
- Monthly and quarterly meetings with PIHPs for process improvement
- Monthly encounter workgroup meetings to discuss & resolve barriers
- Analysis of data received from PIHPs and admission/discharge tracking log

Summary:
The HEDIS 2020 FUH population was 68 members. From that total, 26 members, or 38.2%, had a follow up visit with a mental health provider within 30 days of discharge. This did not meet the benchmark of the Quality Withhold measure, which was 56%. The goal for Remeasurement Year 3 will be to meet or exceed this benchmark. To determine statistical significance, HAP Empowered utilized the Fisher's exact test, with a two tailed P value. The P value was found to be 0.0700, which was determined not to be statistically significant.

Chronic Care Improvement Program (CCIP)
The 2021 CCIP focus continues to be diabetes. The goal is to demonstrate an increase in the number of MMP members who complete required preventive testing, as well as demonstrate an increase in MMP members who have a HbA1c <8.

HAP Empowered implementation of the Livongo program for their diabetic members continues. This program assists eligible HAP members in better managing their diabetes with a connected meter, unlimited strips, and health coaching. HAP Empowered also continued to utilize a program in which medical professionals with the Matrix health care group went to diabetic members' homes to assist members in completing preventive health screens

Baseline data for HbA1c—HEDIS 2019:
- HbA1c measured: 78.28%
- HbA1c Poor control (>9%): 80.17%
- HbA1c Control (<8%): 15.84%
- Medical Attention for Nephropathy: 91.61%
- Retinal Eye Examination: 52.47%

Goal: Meet or exceed above rates for HEDIS 2021.

Results and Findings: As of November 2020, the results were as follows:
- HbA1c measured: 76.59 %
- HbA1c Poor control (>9%): 75.24%
- HbA1c Control (<8%): 21.73%
- Medical Attention for Nephropathy: 91.54%
- Retinal Eye Examination: 44.41%

In summary, HAP Empowered continues to enroll MMP members into the Livongo program. HAP Empowered will also continue to utilize the Matrix home health program to help diabetic members to obtain preventive screenings.

MDHHS Performance Incentive Program
CMS and MDHHS withhold a percentage of the plan Capitation Payment, except for Part D Component amounts. The withheld amounts will be repaid subject to HAP performance consistent with established quality thresholds.

Methodology
MMPs receive a "pass" or "fail" score for each withhold measure. MMPs have two ways in which to pass a core measure:

- If the MMP meets the established benchmark for the measure, or
- If the MMP meets the established goal for closing the gap between its performance in the calendar year prior to the performance period and the established benchmark by a stipulated percentage

Quality withhold payments are determined based on the percentage of all withhold measures, including CMS core and state-specific measures, each MMP passes. All measures are weighted equally, with no distinction made between measures that earned a "pass" by meeting the benchmark and measures that earned a "pass" by meeting the gap closure target. If one or more measures cannot be calculated for the MMP because of timing constraints or enrollment requirements (e.g., the reporting period does not fall during the applicable demonstration year, an MMP does not have enough enrollment to report the measure as detailed in the technical notes), it will be removed from the total number of withhold measures on which an MMP will be evaluated. In circumstances where the removal of measures results in fewer than three measures that are eligible for inclusion, alternative measures will be added to the quality withhold analysis.

MMPs will be evaluated using the following bands:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

Benchmarks
Benchmarks for individual measures are determined through an analysis of national or state-specific data depending upon the data available for each measure. In general, benchmarks for CMS core measures are established using national data such that all MMPs across demonstrations are held to a consistent level of performance. For state-specific measures, benchmarks are developed by states using state-specific data, as well as national data when available/appropriate.

HAP is evaluated to determine whether it has met quality withhold requirements at the end of each Demonstration Year. The MDHHS quality withhold measures for Demonstration Year 6 (2021) are included in the table below.

Quality Withhold Measures for Demonstration Year 2021

Encounters	Encounter data submitted accurately and completely in compliance with contract.	CMS/State defined process measure
Plan all-cause readmissions	The ratio of the plan's observed readmission rate to the plan's expected readmission rate. The readmission rate is based on the percent of plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason	NCQA/HEDIS
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season	CAHPS
Follow up after hospitalization for mental illness	Percentage of discharges for Enrollees 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS
Controlling blood pressure	Percent of Enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year	NCQA/HEDIS

Medication Review-All Populations	Percent of Enrollees whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	State defined

Part D medication adherence for diabetes medications	Percent of Enrollees with a prescription for diabetes medication who fill their prescription often enough to cover eighty percent (80%) or more of the time they are supposed to be taking the medication.	CMS
Care Transition Record Transmitted to Health Care Professional	Percent of members discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care on the day of discharge or the following day	State defined
Annual Dental Visit	Percent of members who had one or more dental visits with a dental practitioner during the reporting period	State Defined
Antidepressant Medication Management – Effective Acute Phase Treatment	Percent of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	HEDIS
Colorectal Cancer Screening	Percent of members 50–75 years of age who had appropriate screening for colorectal cancer	HEDIS

Medication Reconciliation Post-Discharge	Percent of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days)	HEDIS
Minimizing Institutional Length of Stay	The ratio of the MMP's observed performance rate to the MMP's expected performance rate. The performance rate is based on the proportion of admissions to an institutional facility that result in successful discharge to the community within 100 days of admission.	State/Core Reporting

Care Management Plan--Model of Care (MOC)

MOC Quality Performance Improvement Plan
HAP Empowered maintains a well-defined Quality Improvement (QI) Program structure for the MI Health Link members that is separate from any of its existing Medicaid, Medicare, or commercial lines of business. The Quality Improvement Program supports the application of the principles of Continuous Quality Improvement (CQI) to all aspects of HAP's service delivery system.

Measurable Goals and Health Outcomes for the MOC
The HAP Empowered QI Program includes measurable goals related to health outcomes. Goals are specific for improving access and affordability for the health care needs for the HAP MMP members. Goals are monitored to evaluate the improvement of care coordination and delivery of services for members through the alignment of the Health Risk Assessment (HRA), Individual Integrated Care and Supports Plan (IICSP), and Integrated Care Team (ICT). Care transitions are evaluated to show enhancement across all health care settings and providers for members.

Measuring Patient Experience of Care
HAP Empowered conducts member experience surveys as directed by MDHHS or CMS. The survey activities are as follows:
- an annual CAHPS survey and supplemental questions as determined by MDHHS using an approved CAHPS vendor
- a consumer experience survey for members utilizing LTSS during the prior calendar year

HAP uses a broad sample of members to conduct an annual member experience survey. Results are analyzed to identify issues that can be integrated into the performance improvement plan. Member complaints and inquiries are also reviewed for improvement opportunities.

HEDIS: Collection and reporting
The Healthcare Effectiveness Data and Information Set (HEDIS) measures are collected, reported, and analyzed to determine the quality of care delivered by HAP P. The HEDIS results are reported annually to NCQA and CMS. The, oversight and auditing by an NCQA accredited third party vendor follows the

HEDIS Technical Specifications. HAP utilizes NCQA certified HEDIS software to prepare and submit HEDIS annually. The data warehouse contains all claims and encounter data, pharmacy data, eligibility and demographic information on all current and past members, provider contracting information, and laboratory data, and feeds into the HEDIS software. Qualified nurse reviewers audit the medical records for the HEDIS measures that allow hybrid review. Training on data abstraction is conducted annually and inter-rater reliability is conducted before and throughout the medical record data abstraction to ensure accuracy of the medical record review. The medical record abstraction process and results of inter-rater reliability are audited by an NCQA accredited vendor. The HEDIS measures that will be reported in 2021 include:

	Effectiveness of Care Measures
BCS	Breast Cancer Screening[6]
COL	Colorectal Cancer Screening[6]
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of ChronicObstructive Pulmonary Disease (COPD)[6]
PCE	Pharmacotherapy Management of COPD Exacerbation[1]
CBP	Controlling High Blood Pressure[6]
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack[1,6]
SPC	Statin Therapy for Patients with Cardiovascular Disease[1,6]
CDC	Comprehensive Diabetes Care[6]
KED	Kidney Health Evaluation for Patients with Diabetes[6]
SPD	Statin Therapy for Patients with Diabetes[1,6]
ART	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis[4,6]
OMW	Osteoporosis Management in Women Who Had a Fracture[6]
AMM	Antidepressant Medication Management[6]
FUH	Follow-Up After Hospitalization for Mental Illness[6]
FUM	Follow-Up After Emergency Department Visit for Mental Illness[6]
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse orDependence
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia[6]
TRC	Transitions of Care[1,5,6]

	Effectiveness of Care Measures
FMC	Follow-up After Emergency Department Visit for People with Multiple High-RiskChronic Conditions[6]
PSA	Non-Recommended PSA-Based Screening in Older Men
DDE	Potentially Harmful Drug-Disease Interactions in Older Adults
DAE	Use of High-Risk Medications in Older Adults
HDO	Use of Opioids at High Dosage

UOP	Use of Opioids from Multiple Providers
HOS	Medicare Health Outcomes Survey
FRM	Falls Risk Management (collected in HOS)
MUI	Management of Urinary Incontinence in Older Adults (collected in HOS)
PAO	Physical Activity in Older Adults (collected in HOS)
FVO	Flu Vaccinations for Adults Ages 65 and Older (collected in CAHPS)
MSC	Medical Assistance with Smoking and Tobacco Use Cessation (collected in CAHPS)
PNU	Pneumococcal Vaccination Status for Older Adults (collected in CAHPS)
	Access/Availability of Care measures
AAP	Adults' Access to Preventive/Ambulatory Health Services
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
	Utilization and Risk-Adjusted Utilization measures
FSP	Frequency of Selected Procedures[1]
IAD	Identification of Alcohol and Other Drug Services[1]
ABX	Antibiotic Utilization
PCR	Plan All-Cause Readmissions[1,6]
HFS	Hospitalization Following Discharge from a Skilled Nursing Facility[1,2,6]
AHU	Acute Hospital Utilization[1,6]
EDU	Emergency Department Utilization[1,6]
HPC	Hospitalization for Potentially Preventable Complications[1,6]
	Health Plan Descriptive Information
LDM	Language Diversity of Membership
ENP	Enrollment by Product Line
	Measures Collected Using Electronic Clinical Data Systems
BCS-E	Breast Cancer Screening[6]
COL-E	Colorectal Cancer Screening[6]
DSF	Depression Screening and Follow-Up for Adolescents and Adults[6]
DMS	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults[6]
DRR	Depression Remission or Response for Adolescents and Adults
ASF	Unhealthy Alcohol Use Screening and Follow-Up
AIS	Adult Immunization Status (incorporates the former Pneumococcal Vaccination Coveragefor Older Adults (PVC) measure)

Once the HEDIS audit is completed, the results are reviewed at the CQMC. The results are compared to NCQA benchmarks as well as internal goals. The CQMC is comprised of internal staff and participating physicians. The CQMC reviews the results and recommends methods and projects to improve the outcomes. These results are also shared with the network PCPs. Potential barriers to receiving recommended services are also analyzed.

HAP Empowered conducts an internal review to evaluate the effectiveness of the Quality Improvement Program. Action plans will be developed to identify the tasks associated with correcting any deficiencies and improving care as needed. The annual evaluation of the QI Program will incorporate the findings and actions taken to improve care.

Health Outcomes Survey (HOS)

The purpose of this survey is to measure the targeted population in managed care settings. It assesses over time the ability of HAP Empowered to maintain or improve the physical and mental health of its members. The survey is conducted through a series of a baseline cohort and follow-up cohorts thereafter in a random sample. The objective of the Medicare HOS is to gather data to help target quality improvement activities and resources, monitoring health plan performance, rewarding top-performing health plans and helping Medicare members make informed health care choices. HAP must participate in the Medicare Health Outcomes Survey. HAP has contracted with an approved survey vendor that follows all technical specifications as dictated and regulated. Once the results are received, HAP reviews them and makes recommendations for interventions and actions to improve outcomes that do not meet goals. A report is prepared that includes the survey data results and is discussed at the CQMC as needed. The committee then makes recommendations for implementing actions based on the results.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

HAP Empowered contracts with an NCQA approved survey vendor that follows the CAHPS technical specifications. Standard NCQA protocols for administering CAHPS include a mixed-mode mail and telephone protocol and a mail-only protocol. HAP utilizes the mail and telephone protocol.
The protocol includes the following:

- A list of all members is sent to the survey vendor
- Vendor creates all mail materials for final approval for HAP
- Vendor reviews the sample for accuracy
- Surveys are mailed to members, and a toll-free telephone number is made available for questions regarding the survey
- Reminder postcards are sent after each of the mailings
- After second mailing, up to 6 telephone calls are made to each non-responder
- Vendor sends member level to NCQA, who creates summary files and returns them to the vendor and HAP
- HAP reviews results and sends signed attestation to NCQA
- Vendor produces and sends NCQA Accredited Plan reports, including data tabulations, to HAP MHP
- HAP examines the Key Driver Analysis to determine the high priority areas for improvement and primary recommendations
- HAP Quality Department works with affected departments to create action plans for improvement
- Barriers and opportunities are identified, and action plans are developed and presented to CQMC
- The results of the survey are analyzed, evaluated, and reported to the CQMC

Collection, analysis, and reporting Requirements

HAP Empowered submits reports to Michigan Department of Health and Human Services (MDHHS), Data Validation, HEDIS auditors, and the Centers for Medicare and Medicaid Services (CMS). HAP collects, and reports quality measures and fulfills all other reporting requirements. The following is a current listing of the MMP reporting requirements:

- HEDIS measures
- CAHPS survey results
- HOS survey results
- Part C Reporting Elements: benefit utilization, appeals, complaints, grievances, procedure frequency, network adequacy, serious reportable events
- Quality Withhold Measures
- Part D Reporting Elements: Coverage determinations and exceptions, enrollment, appeals, fraud, waste, and abuse, LTC utilization, Pharmacy and Therapeutics committee, discounts, and other price concessions
- Core and MI Specific Measures
- Medication Therapy Management Program
- CCIP and QIP projects due annually
- Contact changes for HPMS and Acumen on an ongoing basis
- Bid (PBP and PBT)
- Annual audited financial statements
- Plan to plan reconciliation
- Prescription drug events
- Direct and indirect remuneration (DIR) monthly submissions
- Critical incidents and reports of abuse
- Grievances and appeals related to ADA rights and reasonable accommodations

Reporting Process

Throughout the year, CMS informs contractors of required reports through emails from HPMS. It is the responsibility of the Compliance Department to ensure the most up to date memos, requirements, technical specifications, or templates are distributed to the appropriate staff. HAP MHP utilizes an Online Monitoring Tool (OMT) that is an oversight and performance management program created to track compliance items and actions. It enables business areas to have all Medicare-related regulations, corrective action steps and measurement in a single software and location. OMT is a web-based, hosted solution software system. Access is controlled by individual HAP MHP administrators. HAP currently utilizes the "notices" module of OMT which allows for memo analysis and assignment. This allows HAP to document compliance with HPMS memos and review actions taken in response. Tasks and reminders associated with HPMS memos are documented and can be reassigned if staffing changes occur.

Communication on Quality Improvement Program with Stakeholders

HAP Empowered's CQIP is administered by a multidisciplinary Clinical Quality Management Committee (CQMC) which includes administrative staff, physicians, and other clinical and quality personnel. The individual components of the CQIP are the responsibility of the HAP Quality Improvement (QI) personnel. An annual evaluation of the effectiveness of the QIP is conducted by internal QI staff and the members of the CQMC. The CQMC meets every other month and reviews reports and results of studies. Examples may include PCP satisfaction surveys, HEDIS results, MTMP, program documents and evaluations and network analysis. The CQMC then makes recommendations for any necessary changes. The activities of the Committee are reported to the Board of Directors. HAP Empowered obtains feedback from the Advisory Council. In addition to the committee and board members, HAP facilitates the participation of providers and the interdisciplinary care team in the Quality Improvement Program in the following ways:

- Provider educational articles
- PCP access to a web-based portal that identifies gaps in care for their members
- PCPs receive an annual satisfaction survey regarding satisfaction with the QI program, Health Outreach programs, Case Management and Utilization Review processes.
- The Quality Improvement Program, Work Plan and Annual Evaluation of the QIP are on HAP

Empowered website.

HAP MMP facilitates the participation of the members and caregivers in the QI program through:
- Representation on the Advisory Council
- Member Satisfaction Survey
- The Quality Improvement Program, Work Plan and Annual Evaluation of the QIP are on HAP
- MHP's website.

Communication of Improvements:
HAP Empowered works to improve quality of care daily. An annual review of all the activities   described in the CQIP is conducted and presented to the CQMC and then to the Board of Directors. The annual evaluation is also summarized in the provider newsletters and the CQIP and annual evaluation are posted to the HAP MHP website.

Authority

HAP Empowered CQIP is commissioned by the Board of Directors and reports to the governing body. The Chief Medical Officer or designee delegates the responsibility and authority for establishing, maintaining, and supporting the CQIP. The Board of Directors, at each of its regular meetings, receives and addresses reports regarding the status of the ongoing CQIP, member complaints and grievances, credentialing information, policies and procedures, results of audits and surveys, and utilization management reports.

The Chief Medical Officer, through the Clinical Quality Management Committee (CQMC), is accountable for:
- Overseeing the CQIP and assuring that all program functions are coordinated and integrated,
- Assuring that the CQIP is defined and understood by all those involved in the process,
- Developing and assuring proper documentation of the CQIP activities

The Behavioral Health Care Practitioner representative, through the CQMC, is responsible for advising the CQMC on behavioral health care activities such as:
- Guideline review and approval,
- Peer review activities,
- Consultant for utilization issues, and
- Assistance with the activities required for continuity of care between PCPs and behavioral health providers

Resources
- The Manager of Quality Management is committed full time to developing and implementing the CQIP. Additional support staff include:
- Chief Medical Officer
- Vice President (VP) Clinical Operations & Strategy
- Corporate Compliance Officer
- Director of Quality Management
- Quality Coordinator
- Clinical Quality Coordinator
- Quality Analyst
- Director of Population Health
- Case Management and Utilization Management staff
- VP of Operations
- Claims Director
- Customer Service Manager
- Customer Service Representatives

- Medical Director
- Chief Information Officer
- Information Technology staff

Support Processes
Many processes are involved in the development and implementation of the goals set forth in the CQIP. Member services support occurs through the monitoring of customer calls and member transfers. All member inquiries, complaints, and appeals are tracked and investigated.

Credentialing processes also support the CQIP by performance of credentialing and re-credentialing activities, overseeing the performance of the delegated credentialing entities and record file reviews. Credentialing activities are reported to the CQMC.

Additional support processes include utilization management activities. Many utilization management (UM) activities are evaluated on a continuous basis. Continuous monitors include inpatient admission rate, readmission rate, emergency department utilization, and pharmacy utilization. The UM program monitors top diagnoses, under and over-utilization, HEDIS reports, and various ad hoc reports. The UM program, evaluation, and other related activities are reported to the CQMC.

The Information Technology Department supports hardware and software capable of collecting, analyzing, and integrating data to assist in the CQMC activities, and ensuring data is complete and reliable. The data warehouse is the main source for all reporting. The data warehouse stores all electronic data and is backed up regularly.

Structure
HAP Board of Directors (Governing Body)
The HAP Board of Directors is responsible for the quality of health services delivered to HAP members. The HAP Empowered 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 Boards. The Boards meet four times annually.

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 and Strategy is designated to work closely with the Director and Manager of 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, 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.

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 4 times per year and one virtual meeting.

Reporting Relationships and Resources
Significant staff resources are dedicated to quality management activities. Approximately 26 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.

CQMC 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 and Strategy
- • Senior and Associate Medical Directors
- • Registered Nurses (Quality Management Department)
- • Quality Management
- • HAP-Affiliated physician(s)

Chairperson: Vice President Clinical Operations and Strategy and designated Medical Director
Meeting Frequency: Meets at least four (4) times per year

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 Clinical Operations and Strategy
- Senior Medical Directors
- Credentialing Department
- Quality Management
- Provider Contracting
- Community physicians

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

Member Experience
Objective: Monitor availability of and member satisfaction with 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: Vice President, Customer Experience
Meeting Frequency: Meets at least 6 times per year

Hospital Quality/Patient Safety Committee (HQ/PSC)
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 Medical Director(s)
- Finance/Claims
- Quality Management
- Information Technology

Chairperson: Vice President, Clinical Operations and Strategy and designated Medical Director
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 minimum of one Medical Director from Health Care Management
A minimum of one 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
- 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 MHP members 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 & HAP MHP contracted networks
- • HAP Medical Directors
- • Geriatric Physician
- • Geriatric Pharmacist

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

<u>HAP's Corporate Compliance Committee</u>
Objective: The HAP Corporate Compliance Committee is established by the Chief Executive Officer 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 tests 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.

Membership
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 Corporate 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, Corporate 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

The MI Health Link (MMP) Advisory Council
The Advisory Council is established by the Compliance Officer to foster a culture of patient centeredness by providing leadership, oversight and guidance for the development, implementation and monitoring of HAP MMP program, policies, and procedures.

The members of the Advisory Council include:
- Compliance Officer (Liaison to the Board)
- Health services staff
- Members (mandatory 1/3 of composition of council)
- Stakeholder from the Area Agency on Aging
- Stakeholder from the mental health community
- Others as deemed appropriate for the MI Health Link program

The duties and functions are:
- Review and monitor the effectiveness of HAP MMP Program, including reviewing the results of care coordination activities and results of quality monitoring and audits
- Review and provide input into HAP MMP policies and procedures, member communications, and training materials that are designed to be responsive to the various requirements in the MMP program
- Ensure HAP MHP has policies and practices to address the operation of HAP MMP
- Using information presented at the council meetings to give input, suggestions for improvement and feedback on ways to improve the program
- Review and understand the reports and results presented as well as oversee implementation and validation of corrective actions, if necessary
- Receive and review feedback from the Board

HAP Advisory Council, through its Chairperson (Compliance Officer), makes quarterly reports of the activities conducted and any recommendations to the Clinical Quality Management Committee and the Board of Directors.

Evaluation
HAP Empowered completes an annual evaluation of the CQIP. Results are submitted to the QI Committee and Board of Directors. Results become the basis for the next year's work plan. The CQIP and annual evaluation are made available to members and providers upon request and are also found on the website.

Approval
The annual revisions to the CQIP description and the QI Work Plan are approved by the Clinical Quality Management Committee and Board of Directors.

Confidentiality of Committee Information
HAP is responsible for implementing mechanisms to protect the confidentiality of all information obtained or generated during committee meetings. This includes results of record reviews and other information HAP obtains from facilities and providers on the services received by covered members.

Appendix A

Quality Resources

Quality Resources	
Position	**Percentage FTE allocated to MCO QI**
Chief Medical Officer	.45
Vice President Clinical Operations & Strategy	.7
Medical Director for Utilization	.3
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
Sr. Director Performance Improvement & Management	1
Manager of HEDIS & Reporting	2
HEDIS Coordinator	3
HEDIS Medical Records Analyst	1