



2020 Quality Program Medicaid Populations

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

HAP Midwest Health Plan rebranded as HAP Empowered. Both may be referenced in this document. The transition is occurring in phases. HAP Midwest is a separate, wholly owned subsidiary of HAP that serves approximately 4,171 Medicaid enrollees. HAP Empowered Health Plan is invested in giving quality, low cost care to Michigan residents. Medicaid coverage is provided through HAP Empowered Health Plan and the Healthy Michigan Plan. HAP has a HAP Empowered Dual Special Needs Plan in Genesee county. HAP's 2020 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)

Trusted Health Plan Acquisition

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

Mission

The HAP Empowered Quality Program (QAPI) aims to assure that safe, effective, patient centered, timely, efficient, and equitable clinical care and services are provided to Medicaid members/enrollees. HAP MHP

seeks to demonstrate value and improve quality through the elimination of over, under, and misuse of services.

The HAP Empowered QAPI focuses on coordinating activities for continuous quality improvement of clinical care and safety (including general medical and behavioral health care) and of services across the delivery system by:

- improving the health status of our members
- identifying and reducing healthcare disparities
- identifying organizational opportunities for performance improvement
- identifying under underutilization and overutilization of services
- 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 including dental care
 - member and practitioner satisfaction
 - supporting the continued development of proactive practitioner practices

This comprehensive QAPI is a program that institutionalizes HAP Empowered's commitment to environments that improve clinical quality, maximize safe clinical practices, and enhance service to members throughout the organization. It is designed to objectively and systematically monitor and evaluate the appropriateness of clinical and non-clinical member care and services. The evaluation 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 in the quality and safety of clinical care and the quality of services, an analysis of whether there have been demonstrated 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, including progress toward influencing safe clinical practices throughout the network.

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 Midwest's Medicaid members.

History

A. Program

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

B. Subcommittees

Initially the CQMC had subcommittees addressing Credentialing and Peer Review activities. A significant revision in committee structure took place in 2001 with several new subcommittees or committee reporting relationships established. New subcommittees 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.

C. NCQA

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

Scope

HAP MHP has a proud, long-standing commitment to quality improvement initiatives that encompass the full spectrum of care and services provided by HAP MHP. 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 QAPI applies to members enrolled through Medicaid 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:

Behavioral Health Care

- Behavioral health care coverage is a benefit for which the health plan is responsible for outpatient treatment. All inpatient psychiatric hospitalizations and partial hospitalization services require authorization from the local Community Mental Health Board (CMHB) in the county where the member resides. Case Management Services, Intensive Out-Patient therapy (IOP), Active Community Treatment (ACT) and other services are all provided by the CMHB's. HAP MHP collaborates with the Prepaid Inpatient Health Plans (PIHPs, regional administrative entities for BH services) to establish joint care planning processes for the sharing of information and coordination of care for shared members. As a result, HAP MHP collaborates with PIHP organizations to improve the communication and coordination of care between behavioral health and physical medicine. Members have open access to Community Mental Health (CMH) providers. Upon member or practitioner request, HAP MHP issues a referral for behavioral services to facilitate prompt payment.
- Quality Improvement: Quality improvement is a systematic approach to measurement, analysis and intervention that defines a distinct area of opportunity, seeks to identify the causes of suboptimal performance/outcomes and targets interventions to address the identified causes. Quality improvement programs include community collaborations, population health, health equity, performance improvement projects, practitioner accessibility and member education related to prevention, targeted member reminders, physician and member incentives, and guideline implementation activities.
- Population Health Management, Health Promotion & Preventive Care: Health promotion programs include guideline implementation activities and general or targeted practitioner and/or patient education (i.e., office posters, member outreach initiatives, health events, and educational mailings).
- Evidence-based Medicine: Practice Guideline implementation programs include clinical practice and preventive service guidelines, regular monitoring for practitioner performance and member education (i.e., information available on the web and in newsletters).
- Hospital Quality/Patient Safety: Focus on hospital quality initiatives that seek to improve, support, and promote quality of care, outcomes and safe patient care for HAP members through consumer, provider, and physician education/information, collaboration, quality contracting, and recognition. The initiatives may incorporate hospital performance metrics, analysis, and research findings to align with corporate strategies. A Committee collaborates with applicable internal customers to provide data, research findings, and support in meeting strategic objectives. This Committee assists in providing hospital performance reports mined from publicly posted performance data, e.g., The Leapfrog Group and Hospital Compare. 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 include, but are not limited to, catheter associated urinary tract infections, vascular catheter-

associated infections, falls and trauma, and manifestations of poor glycemic control that are not present upon admission. Through contributing HAP departments these conditions are identified through claims and payment data that may identify issues that contribute to poor patient safety. The Committee continues to lead a multidisciplinary workgroup to ensure HAP preparedness for emergent health situations that are congruent with Henry Ford Health System. This includes serving as a liaison between Henry Ford Health System Resuscitation Advisory Council to report and align HAP workplace safety measures. Moreover, educational newsletters to improve patient and employee safety are developed quarterly for various internal and external customer segments.

- 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 MHP continually reviews these results 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 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 MHP 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 Performance Improvement 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. Health/educational fairs are held in collaboration with the community outreach department. The

Performance Improvement 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 newsletters, 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 newsletters are available on the HAP MHP website. These activities are reported to the CMQC.

Objectives

The objectives of the HAP Empowered Medicaid QAPI are:

- A. To assure and continually improve the value (member and practitioner satisfaction), quality, safety, availability, accessibility, appropriateness, and effectiveness of behavioral, oral care (dental), 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 practitioner and provider qualifications and competence through credentialing and re-credentialing 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 social determinants of health and cultural and linguistic needs of our membership.

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

The HAP Empowered Medicaid 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.
- 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.
- Assessing the needs of children in foster care
- Assessing the needs of individuals with disabilities

CSHCS Care Coordination

The HAP Empowered Medicaid CSHCS CM program is designed to assist members to reach their optimum level of wellness, self-management, and functional capability at the appropriate level of care while maintaining cost-effectiveness, quality, and continuity of care.

The goal of Case management is to provide seamless care to this population to remove barriers to care and services as the families' transition to the Managed Care Health Arena.

CSHCS Case Managers work with members to link them with covered medical and improve access to dental health services and provide direction to assist in obtaining eligible non-medical resources.

Once the member is identified as possibly being a candidate for case management, the member is to be contacted by phone and must agree to case management services. When the member has no phone available, letters may be sent to the address of record requesting a return call. The local health department is also utilized to assist in contact of the member and coordination of care for case management.

Services are bridged to ensure coordination of care, deletion of care fragmentation and ensure there is no duplication of services.

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

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

The types of members who are managed in this program have the following general characteristics:

- The member or the discharge type carries increased risk for readmission.
- The event, illness or condition requires that the member be supported with step-down, rehabilitative or at-home services.
- The level of case management and care coordination necessary is typically short term and focused on addressing a set of specific issues.
- The amount of resources required for member to regain optimal health or improved functionality is expected to be lessening and the member is likely to become independent in their care.

The Utilization Management (UM) Program includes monitoring the access, availability and quality of health care and dental services provided to the HAP Empowered Medicaid membership. This is accomplished by monitoring utilization practices through prior authorization, concurrent review and retrospective review of services as mandated by the contract with the State of Michigan. Utilization data, review of care rendered in alternative settings and the use of available sources for medical decision making is also reviewed. The scope of the Utilization Management Program includes:

- The evaluation of data available through the utilization process to improve the quality of services provided to members
- Providing authorization and oversight of care rendered across the entire health care continuum

- medical necessity determinations for Children’s Special Health Care Services (CSHCS) members, Medical Directors may consult with the Office of Medical Affairs Medical When making Consultants to determine appropriate subspecialists, hospitals, and ancillary providers available to render services. Medical Directors may also follow this process when determining appropriate durable medical equipment for CSHCS members.
- Information sources used to make determinations of medical appropriateness.
- The evaluation of multiple resources to determine members who would benefit from case management services.
- HAP MHP does not compensate practitioners, physicians or other individuals for conducting utilization review for denial of coverage. UM decisions are based on appropriateness of care and services.

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 HAP Midwest Health Plan Board of Directors is responsible for the quality of health services delivered to HAP MHP members. The Clinical Quality Management Committee (CQMC) reports directly to the Boards. The Boards meet four times annually.

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

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

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

Management project team. The CBHM Medical Director provides ongoing consultative support for all behavioral health quality activities, Population Health Management, preventive health programs, and utilization management.

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

The Vice President Quality Management and Credentialing chairs the Clinical Quality Management Committee. The CQMC includes practitioners from the HAP & HAP MHP 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/ HAP MHP Board members, HAP Senior Medical Directors, and representatives from Quality, Case Management, 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 26 full-time equivalents reside in the quality management and credentialing departments (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 Quality, Stars, Credentialing, and Reporting
- Senior and Associate Medical Directors
- Registered Nurses (Quality Management Department)
- Quality Management
- HAP-Affiliated physician(s)

Chairperson: Vice President Quality, Stars, Credentialing, and Reporting

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 Quality, Stars, Credentialing, and Reporting Associate Vice President Performance Improvement and Management
- Senior Medical Directors
- Credentialing Department
- Quality Management
- Provider Contracting
- Community physicians

Chairperson: Vice President Quality, Stars, Credentialing, and Reporting

Meeting Frequency: Meets at least 22 times per year

Customer Experience Management (CEM)

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 Quality, Stars, Credentialing, and Reporting

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

HAP's Corporate Compliance Committee

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 MHP 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
- Oversees compliance of HAP MHP with regulations including NCQA privacy guidelines and the HIPAA federal privacy and security regulations on a company and subsidiary wide basis

Membership

- President and Chief Executive Officer
- Chief Compliance Officer
- Chief Financial Officer
- Chief Information Officer
- Chief Marketing Officer
- Chief Medical Officer
- Chief Operating Officer
- Deputy General Counsel
- Vice President, Human Resources

Regular attendees, but non-voting membership, shall include:

- Chief Compliance Officer, Henry Ford Health System
- Compliance Director, Business Compliance
- Compliance Director, Government Programs

Chairperson: HAP's Chief Compliance Officer

Meeting Frequency: Meets Monthly

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

- The Henry Ford Health System, HAP's parent company, provides ongoing support for HAP MHP's Quality Program. The Henry Ford Health System Quality Forum consists of senior administrative, nursing, and physician leaders from the Henry Ford Medical Group, Henry Ford Hospital, Health Alliance Plan, Henry Ford Macomb Hospital, Henry Ford Macomb Hospital-Warren Campus, Henry Ford Wyandotte Hospital, Henry Ford Cottage Hospital, Henry Ford Behavioral Health Services, and Community Care Services. Additional representatives include the Henry Ford Health System Chief Quality Officer, the Henry Ford Health System Vice-President of Planning and Performance Improvement, and other quality professionals supporting the Forum's improvement teams. The Quality Forum is responsible for identifying improvement opportunities, integrating improvement efforts across departments and business units, and tracking progress on System goals. Chaired by the

Henry Ford Health System President and CEO, the Quality Forum reports its progress to the Henry Ford Health System Board of Trustees Quality Committee. The Forum meets monthly.

- The 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 MHP staff with the outcome that front line staff would receive key information regarding HAP and HAP MHP 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 MHP developments and provide input on quality programs. Membership consists of community physicians and administrators, HAP Senior Medical Directors, and representatives from Case Management, Population Health Management, Provider Contracting, and Provider Relations.
- E. Quality Management (QM), Case Management (CM), Population Health Management (PHM), Coordinated Behavioral Health Management (CBHM) and Medical & Business Informatics (MBI) are responsible for developing, supporting, and/or implementing the HAP MHP Medicaid Quality Program and work plans. Responsibilities include but are not limited to:
- Staffing the CQMC and many of its subcommittees
 - Performing quality assessment, measurement, evaluation, and improvement activities
 - Supporting other HAP departments in clinical, service, and operational/administrative quality improvement activities
 - Providing consultation and expertise regarding quality improvement, process improvement, and measurement techniques
 - Providing guidance on and information to support identification of priority areas for improvement
 - Partnering with Credentialing staff to provide oversight of delegated credentialing functions and performance monitoring activities

Directing accreditation activities and providing support to other areas to meet Automated systems are used to assist with the quality improvement processes. QM, CM, PHM, and CBHM rely upon data sources including: member complaint reports, survey results, medical records, CareRadius, utilization statistical reports, HEDIS results using MedMeasures, benefit manual, Cactus, and Facets. We have transitioned the Health Management core platform from Clinical Care Management System (CCMS) to CareRadius/CareAffiliate from EXL. There were three primary drivers of our need to replace our former Health Management systems, including the Clinical Care Management System (CCMS), and ancillary systems Internet Referral Authorization and (IRA) and Online Admission Application (OAA). Rationale for the transition includes:

- The prior 12-year old Health Management core platform was incapable of supporting many the functions needed to achieve our strategic priorities.
- Prior core platform had limited lifetime (2-3 years) for continued maintenance and support – McKesson (prior vendor) was moving to new product ‘Vital’ with limited ongoing support for previous product CCMS.
- Ancillary systems were cumbersome and expensive to maintain and upgrade.
- Enhance the ability to significantly increase the breadth and value of our utilization management functions.
- Ability to streamline pre-and post-member call functions (case mgt., etc.) to allow our nurses to spend more time with more members.
- More efficient administrative functions, such as letter generation.
- Ability to dynamically prioritize members/providers on which to target Health and Network Management activities.

Pegasystems (Pega):

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

F. Internal Collaboration

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

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

Medical and Business Informatics (MBI) provides data analytic support to identify and address medical management opportunities including overuse and misuse of services. MBI produces provider profiles, routine utilization statistics, program evaluations and other reports to support decision-making.

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

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

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

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

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

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

G. External Collaboration

Health Alliance Plan strongly believes in a collaborative approach to quality improvement and health promotion in the community. Through collaboration we can learn from each other and apply best practices and develop a common message and set of priorities for physicians and the community. HAP MHP staff actively participates in several external groups to support common efforts to improve the health of our members and community. These include Weight Watchers®, Greater Flint Health Coalition, Save Lives Save Dollars initiative, Michigan Quality Improvement Consortium, Michigan Association of Health Plans and their Foundation, Michigan Department of Health and Human Services, American Cancer Society Colorectal Awareness Network (CRAN), Alliance of Community Health Plans, Alliance for Immunizations in Michigan and topic-specific groups such as the Detroit Asthma Coalition, the Kidney Foundation, the Michigan Cancer Consortium, and the American Diabetes Association.

H. Delegation

As of October 2016, Health Alliance Plan delegates complex case management to a vendor (Progeny) for neonatal intensive care unit babies. HAP delegates specific appropriate credentialing-related, pharmacy

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

Confidentiality

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

Work Plan

The QI Work Plan includes all HAP Empowered Medicaid planned activities for the year. It is developed annually. The Work Plan is not a static document; it is updated quarterly to reflect ongoing progress on QI activities throughout the year.

Program Evaluation Review

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

Standards for Medical Record Documentation

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

Improving Services to HAP Midwest Medicaid Members

Each year HAP Empowered Medicaid sets goals to improve our services to members. We submit annual Healthcare Effectiveness Data and Information Set (HEDIS) measures for quality reporting. HAP MHP uses HEDIS results to track quality performance from year to year and to identify opportunities for improvement. Additionally, HAP MHP annually measures member satisfaction using the Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey results for the Medicaid population. The survey evaluates key satisfaction drivers including health plan performance and the members' experience with providers and access to care. The results are collected and analyzed annually and used to improve satisfaction among Medicaid members. HAP MHP also participates in the annual Health Outcomes Survey (HOS), which is used to evaluate the physical and mental health status and outcomes of our

Medicaid/Medicare members, and to identify opportunities for improvement in programs and services, public reporting, and member health. Additional programs designed to improve the health and well-being of the lives we touch include HAP MHP Case and Population Health Management programs and provider quality improvement education.

Population Health and Health Equity

HAP Empowered Medicaid will utilize various measures to identify community health disparities to meet the needs and improve health equity within our population. HAP MHP utilizes information such as demographics, claims data, pharmacy data, laboratory results, UM data, health risk assessment results, and eligibility and measure status to monitor and stratify for health disparities. This information is used by medical providers in healthcare management and decision making.

HAP Empowered Medicaid participates in the multi-year state-wide P4P Low Birth Weight initiative to align efforts to reduce disparities in maternity care and infant mortality. A baseline analysis was conducted in 2018 based on literature review and data collection. In 2019, interventions that target low birth weight from the baseline analysis will be developed.

Population Health Management

An individual's health is shaped profoundly by life circumstances that fall outside the traditional purview of the health care system. Housing, nutrition, education, transportation and other dynamics are referred to as "social determinants of health" (SDoH). SDoH are cited as factors that collectively have the most significant influence on health outcomes. To address the social determinants of health impacting Michigan Medicaid beneficiaries, HAP Empowered Medicaid will develop and implement a multi-year plan, policies/procedures and interventions to address beneficiary's health outcomes. Beginning in 2018, HAP MHP focused on housing stability and developed of a baseline analysis.

Addressing Health Disparities

HAP Empowered Medicaid reviews and identifies members with social determinants of health from data analysis information including race/ethnicity. HAP can identify and reduce barriers to healthcare access and root cause analysis application. HAP MHP utilizes race and ethnicity data contained in Medicaid enrollment files with the highest-risk populations. This allows us to identify cultural disparities and develop targeted interventions linked to race, ethnicity, and gender. Our plan also identifies subpopulations that have disparities due to barriers such as housing, food, transportation etc. One example includes identifying areas of highest geographic disparities from ED utilization reports for a specific zip code and utilizing Community Health Workers (CHW) for communicating and encouraging medical and dental screening and follow up care management. Our plan also collaborates with community- based groups such as faith- based organizations and neighborhood associations.

Community Collaboration Project

To improve population health HAP MHP participates in community led initiatives. HAP Midwest Health Plan (HAP MHP), in partnership with HAP and Henry Ford Health System (HFHS), conducted a community project in Genesee County throughout 2016 and into early 2017. This was a comprehensive and broad-based community project in Flint around the water crisis. It included resources from HAP, HAP MHP and HFHS as well as those organizations' employees. We worked with the American Red Cross, United Way of Genesee County and the Community Foundation of Greater Flint, with the goal of meeting both short- and long-term community needs.

In 2018, HAP and HAP MHP worked with Hamilton Community Health Network (HCHN) in their on-going effort to bring patient centered health care to underserved communities throughout Genesee, Lapeer and Saginaw counties. HAP will align with and support HCHN's "Cooking Matters" initiative, which seeks to teach healthy food selection and preparation to residents living in and around the city of Flint. Program participants will receive education on healthy snacks, food safety at home, smart shopping, and practical tools to expand cooking skills. They will also be encouraged to develop healthy "dining out" strategies and receive a free recipe book.

HAP and HAP MHP also participated in several planned activities during National Health Center Week in August and work closely throughout the year with Hamilton's local community partners (such as Genesee county Community Action, Carriage Town Ministries and others). Community collaboration activities are being planned for 2019.

Healthy Michigan Plan Health Risk Assessment

HAP Midwest Health Plan implements and operates healthy behavior incentives and assessments in accordance with the MDHHS Contract and the CMS approved Operational Protocol for Healthy Behaviors. Medical & dental needs are assessed on the HRA. HAP Midwest Health Plan educates members on the HRA completion process and conducts outreach to encourage HMP members to schedule an appointment within 60 days, complete the HRA with their provider, and assist with transportation information. HAP Midwest provides outreach and follow up based on member's responses to the healthy behavior section of the HRA.

Community Health Worker Program

HAP MHP maintains its obligation to the communities it serves by completely integrating its outreach initiatives into strategic planning, goal setting, budgeting and performance metrics of the managed care population. The plan provides targeted goals to identify and support opportunities to improve health disparity populations by providing a non-clinical professional advocating for members in a community-based healthcare setting. HAP MHP partners with community health agencies to implement the Community Health Worker (CHW) program.

The CHW program functions to institute and maintain a constant infrastructure designed to increase health information, engage and assist members in managing healthcare and dental care needs and utilizing resources to advocate on behalf of the member. The CHW can develop a trusting relationship that enables the CHW to serve as a liaison/link/intermediary between health/social services and the

community to facilitate and improve access to health & dental services and improve the quality and cultural competence of service delivery.

Oral Health/Dental Program

HAP is committed to promoting Oral Health for all Medicaid Members. Programs offered include a pregnancy dental program, baby dental hygiene program, foster care children program, healthy kids' program and diabetic dental program.

Healthy Baby Program

HAP Healthy Start for Baby is a benefit designed for pregnant women in Region 6 and Genesee County. The goals of the program are to encounter healthy deliveries & decrease preterm deliveries. Pregnant women are case managed throughout their pregnancy, assessed post-partum, and case managed for continued care. Resources provided include community, social work for housing and food insecurities, educational, transportation, incentives for prenatal care, free prenatal vitamins, dental benefits and Text4Baby App.

ED Utilization

Emergency Department (ED) utilization provides a snapshot about quality and access issues faced by Medicaid members and their surrounding community. HAP MHP interventions focus on the reduction and/or elimination of ED visits related to behavioral/mental health. In 2018, a baseline analysis was conducted followed by the development of an intervention proposal and timeline. 2019 consisted evaluating the interventions as well as ongoing assessments at 6- month intervals

This activity did not make the impact on meeting members' needs that had been anticipated. HAP Empowered is currently investigating other ways to impact this population. The Short-Term Engagement program has been added for members who have unmet needs, but who do not meet the criteria for the Complex Case Management (CCM) program. The Social Worker also has a report to track members who have been assisted with SDoH needs. HAP Empowered is in the process of updating the post-ED survey to be more aligned with the ED visit and follow up needs that members may have.

PCMH (Patient-Centered Medical Home)

HAP MHP is committed to promoting PCMH programs to integrate the transformation of primary care practices into PCMH to improve the delivery care system and to increase the membership of these primary care practices HAP MHP will continue to coordinate with practice-based and Michigan Primary Care Transformation (MiPCT) care managers for members. HAP MHP will report to MDHHS the number of members receiving services from PCMH practices.

Performance Improvement Project

HAP Empowered participates in the MDHHS PIP. The study indicator for the project is improving the Timeliness of Prenatal Care in the Black/African American Population. HAP MHP will be measuring if

targeted interventions increase the percentage of Black/African American women who receive a prenatal care visit in the first trimester, on the enrollment date, or within 42 days of enrollment into the MHP. HAP Empowered analyzes HEDIS results to measure the effectiveness of interventions and to identify additional opportunities for improvement. The Baseline measurement period is the 2018 HEDIS rate. For remeasurement period 1, the overall total HEDIS 2019 prenatal care rate is 60.6%; this is a slight increase of 4.9% compared to the HEDIS 2018 rate of 55.7%. HAP Empowered further compared the study indicator of the Black/African American rate for HEDIS 2018 to HEDIS 2019. HEDIS 2018 results are 13 out of 27 Black/African American members received prenatal care compared to 12 out of 25 in HEDIS 2019. Using the Fishers two tailed exact test the p value was 1.000. This indicates that even though the rate decreased from 48.2% to 48%, this is not statistically significant. Lastly, HAP Empowered did not meet the goal of the 50th percentile for HEDIS 2019 prenatal care measure. HAP Empowered continues to identify opportunities for improvement and collaborate on plan HAP Empowered implemented a prenatal care 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 prenatal care. The interventions will be tracked for effectiveness and reported during the next remeasurement period cycle. The workgroup completed the following activities throughout 2018-2019:

- 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

Integration of Behavioral Health and Physical Health Services

To ensure collaboration and integration between health plans and Pre-paid Inpatient Health Plans (PIHPs), HAP MHP in conjunction with the PIHPs is creating policies and procedures to engage in integration and collaboration of these services. It is the policy of HAP Midwest Health Plan, as a Medicaid Health Plan responsible for services to individuals enrolled in Medicaid, to coordinate care provided to individuals with the PIHP also managing services for those individuals. It is further the policy of HAP MHP to work cooperatively with other PIHPs to jointly identify priority need populations for purposes of care coordination. Ongoing activities are noted below:

- At least monthly, identify which members are assigned to an MHP and have sought services through the PIHP
- Quarterly, demonstrate that joint care plans exist for members with appropriate severity risk that have been identified as receiving services from both HAP MHP and the PIHP
- Quarterly, participate, via the MHP-PIHP Workgroup, in reviewing and validating MDHHS reports that include but not limited to the number of care coordination plans, the reasons for closing care coordination plans, and the average length of time for active care coordination plans
- Work jointly to develop at least two standard of care protocols for care coordination as identified collaboratively with MDHHS

- Receive information from electronic sources
- Participate in MiHIN (Michigan Health Information Network)
- Establish and implement joint care plan management standards and processes to ensure appropriate communication exists and enough efforts are being made to support success in integration. The joint care plans will foster an environment of collaboration between HAP MHP and the PIHPS for the ongoing coordination and integration of services

Appendix A

Quality Resources

| Position | FTE |
|--|------|
| Chief Medical Officer | .45 |
| Vice President Quality Management, Stars and Credentialing | .7 |
| Medical Director for Utilization | .3 |
| Medical Director of Behavioral Medicine | .425 |
| AVP Performance Improvement & Management | 1 |
| Director Quality Management | 1 |
| Manager, Quality Management | 1 |
| Senior Project Coordinator | 2 |
| Clinical Quality Coordinator | 1 |
| RN Quality Management | 2 |
| QM Data Analyst | 1 |
| Quality Coordinator | 1 |
| Quality Analyst | 1 |
| Manager, Credentialing | 1 |
| Credentialing Lead | 1 |

| | |
|----------------------------------|---|
| Credentialing Analyst II | 8 |
| Credentialing Coordinator | 3 |
| Credentialing Business Associate | 2 |