2021 Quality Program
Medicaid Populations

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 Midwest Health Plan rebranded as HAP Empowered. HAP Empowered is a separate, wholly owned subsidiary of HAP that serves approximately 20,310 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 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)

<u>Trusted Health Plan Acquisition</u>

HAP acquired Trusted HP – Michigan, a Medicaid plan headquartered in Detroit in 2020. This acquisition l expanded 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 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 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
    - Monitoring includes provider performance reports including provider and member specific details on underutilization and overutilization of services including but not limited to provider profiles consisting of HEDIS and gaps in care reports, utilization, and financial data.
- implementing interventions to improve the safety, quality, availability and accessibility of, and member satisfaction with, care and services
- promoting members' health, through health promotion, disease prevention, and condition management through targeted interventions and health fairs
- through partnerships with physicians and office staff
- assisting in the development of informed members engaged in healthy behaviors and active self-management
- measuring, assessing, and/or coordinating the following:
    - evidence-based clinical quality
    - patient safety
    - practitioner availability and accessibility including dental care
    - member and practitioner satisfaction
    - supporting the continued development of proactive practitioner practices

Quality Management (QM) works collaboratively with other departments and stakeholders to support and help achieve administrative, clinical, and service quality improvements, to assure appropriate utilization and to enhance continuity of care for HAP Empowered 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 Empowered has a proud, long-standing commitment to quality improvement initiatives that encompass the full spectrum of care and services provided by HAP. The Quality Program is dedicated to fulfilling that commitment by working with the physician and provider community to establish evidence-based clinical guidelines and service standards. The guidelines and measures are used to develop tools to provide feedback to patients and physicians to encourage improvement. The 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:

<u>Behavioral Health Care</u>

- 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 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 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 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 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 contracted PCP providers. In addition, member newsletters are mailed to members throughout the year. The QAPI supports and addresses findings of compliance reviews (annual, onsite, and ad hoc) by MDHHS, external quality reviews, and statewide focus studies. Additional support processes include utilization management activities. These activities are recorded and reported on a continual basis. These monitoring activities include the monitoring of lengths of stays, number and types of services, and types of births and deliveries, under and over-utilization, and pharmacy issues. The utilization management program, evaluation, and other related activities are reported to the CQMC.

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

- HAP completes a network analysis and a provider satisfaction survey annually. HAP also oversees the provider 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 Empowered 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 system.

CSHCS Case Managers work with members to provide additional services beyond what is available through the Medicaid plan. These potential services include assistance with navigating community support services, access to specialty care, such as dental services, development of a plan of care that includes family and community 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 carries increased risk for readmission.
- The event, illness or condition requires that the member be supported with post-acute , 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 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 Empowered 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 Empowered Board of Directors is responsible for the quality of health services delivered to HAP Empowered 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 Empowered 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.

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

The Vice President Clinical Operations and Strategy chairs the Clinical Quality Management Committee. The CQMC includes practitioners from the HAP & HAP Empowered 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 Empowered 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 20 full-time equivalents reside in the quality management department (Appendix A). Several organizational committees or subcommittees are charged with functions linked to support the Quality Program. These committees and subcommittees provide reports to the CQMC as applicable, at least once a year and upon request.

CQMC Subcommittees:

<u>Peer Review Committee (PRC)</u>

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

Membership:

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

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

<u>Credentialing Committee</u>

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 Provider Network Management

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

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

Member Experience (ME)

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

Membership

- Physician representatives from HAP & HAP contracted networks
- HAP Medical Directors
- Geriatric Physician
- Geriatric Pharmacist

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

HAP's Corporate Compliance Committee

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.

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

Additional forums utilized to exchange ideas and obtain input for the HAP Empowered 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 Empowered' 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 staff with the outcome that front- line staff would receive key information regarding HAP and HAP at the appropriate time and level. Membership is comprised of plan-wide representation from HAP's senior leadership team.

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

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, 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 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 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 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.

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

G. External Collaboration

Health Alliance Plan strongly believes in a collaborative approach to quality improvement and health promotion in the community. Through collaboration we can learn from each other and apply best practices and develop a common message and set of priorities for physicians and the community. HAP staff actively participates in several external groups to support common efforts to improve the health of our members and community. These include 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 Empowered 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.

<u>Confidentiality</u>

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

<u>Work Plan</u>

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.

<u>Program Evaluation Review</u>

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

<u>Standards for Medical Record Documentation</u>

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 Empowered 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 uses HEDIS results to track quality performance from year to year and to identify opportunities for improvement. Additionally, HAP annually measures member satisfaction using the Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey results for the 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. Additional programs designed to improve the health and well-being of the lives we touch include HAP Case and Population Health Management programs and provider quality improvement education.

Population Health and Health Equity

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

Annually, HAP Empowered reviews member population data through a combination of reports on characteristics, including demographics, of HAP Empowered membership. This analysis of data includes a review of relevant subpopulations including the needs of children and adolescents, the needs of individuals with disabilities, and the needs of individuals with serious and persistent mental illness.

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

Findings of these analyses are used to:

- Identify changes to current assessment practices to more effectively identify individuals for services. Metrics evaluated can include events like hospitalizations and ER visits used to flag potential case management candidates; cost threshold levels; diagnosis or procedure codes used to target members; and risk score ranges or other methods considered when identifying members who may benefit from services and programs offered through HAP Empowered.

- Review and identify changes to case management processes to better address member needs. The business drivers for these changes can include compliance with mandatory regulations; reduction of redundant member outreach; continuous improvements including clinical effectiveness, outcomes and quality; and increased coordination across programs.

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 develops and implements a multi-year plan, policies/procedures and interventions to address beneficiary’s health outcomes. In 2020, the emergence of Covid 19 brought a fresh focus on members’ SDoH needs, and increased the demand for medical, social, and behavioral needs as well.

Emergency Department (ED) utilization provides a snapshot about quality and access issues faced by Medicaid members and their surrounding community. Going forward, ED use will be addressed as part of the overall Population Health strategy as opposed to be a separate project.

In 2021, the population health focus will be on

- Rapid and accurate identification of members with SDoH needs including but not limited to food insecurity, stress, housing, depression, utility assistance, anxiety, behavioral health and employment/education/training.
- Strengthening assessment and referral service relationships to standardize communication and include a feedback loop with the agencies receiving the referrals.

<u>Addressing Health Disparities</u>

HAP Empowered’s Quality Assessment and Performance Improvement (QAPI) program leads the effort to address health disparities and other obstacles that can impact health. Members are stratified by age, geography, race, gender, and ethnicity. This is followed by implementation of actions to decrease or eliminate barriers to care.

HAP Empowered accesses historical data from a variety of sources to include Care Connect 360, CMS historical data, pharmacy data, HEDIS, HRAs, and encounter, claims and lab data. Information is updated on a continual basis as data enters the data warehouse. Building clinical profiles from administrative data improves and targets case management efforts for high-risk populations.

HAP utilizes race and ethnicity data contained in Medicaid enrollment files to track and monitor health disparities. This allows the plan to identify health disparities and develop targeted interventions linked to race, ethnicity, and gender. HAP Empowered also identifies subpopulations that have needs such as housing, food, or transportations. HAP Empowered also collaborates with community- based groups such as faith- based organizations; community action agencies; and neighborhood associations to improve health equity of the members.

<u>Healthy Michigan Plan Health Risk Assessment</u>

HAP Empowered 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 Empowered 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 Empowered care management team provides outreach and follow up based on member’s responses to the healthy behavior section of the HRA.

Community Health Worker Program

HAP Empowered 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 Empowered has an internal team 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.

HAP Empowered initiates the CHW program to close the gaps between medical and social services, providing members with information and resources necessary to promote best health practices, self-management, and health maintenance. The program will also encourage wellness and injury prevention programs.

Oral Health

HAP Empowered is committed to promoting and improving Oral Health for its members through ongoing analysis, evidence based interventions and continuous quality improvement activities to achieve outcomes. HAP Empowered administers dental coverage for pregnant women and Healthy Michigan Plan members through Delta Dental. The state of Michigan's Medicaid program covers dental care for children. Quality Management (QM) works collaboratively with other departments and stakeholders to support and help achieve administrative, clinical, oral health and service quality improvements, to assure appropriate utilization and to enhance continuity of care for HAP Empowered members.

Maternity Program

The HAP Empowered Maternity Program is offered to help members achieve a healthy pregnancy. The program provides outreach to maximize and support the wellness of the pregnant member. Through screening the team will identify high risk behaviors, any member concerns about health care, and their social and economic conditions. Any member identified as moderate or high risk will be referred to the CM. Any member with an identified social or economic issue will be referred to Social Work. All care will be coordinated with the member and treating OB/GYN Care Provider to create a comprehensive plan of care to address identified issues.

PCMH (Patient-Centered Medical Home)

HAP Empowered is committed to promoting PCMH programs to integrate the transformation of primary care practices into PCMH to improve the delivery care system.

Performance Improvement Project

HAP Empowered participates in the MDHHS PIP. The study indictor for the project is improving the Timeliness of Prenatal Care in the Black/African American Population. HAP Empowered measures 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 plan. 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. The overall total HEDIS 2020 prenatal care rate is 90.1%; this is an increase of 34.4% compared to the HEDIS 2018 rate of 55.7%. HAP Empowered further compared the study indicator of the Black/African American baseline rate for HEDIS 2018 to HEDIS 2020. HEDIS 2018 results are 13 out of 27 (48.2%) Black/African American members received prenatal care compared to 29 out of 31 (93.5%) in HEDIS 2020. Using the Fishers two tailed exact test the p value equals 0.0002. The association is extremely statistically significant.

Lastly, HAP Empowered met the goal of the 50th percentile for HEDIS 2020 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 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

Lead Monitoring Activities

The HAP Empowered Medicaid Elevated Blood Level Outreach Program provides education, support and care coordination to pediatric members who have a reported blood lead level greater than 5 micrograms per deciliter.

The goal of the Elevated Blood Lead Level Outreach Program is to ensure members are receiving the appropriate medical care and follow-up to decrease blood lead levels and improve the member's overall health and well-being. Community Health Outreach Workers work with the members/families to remove barriers to care and provide education on sources of lead and preventive measures for exposure to lead. When appropriate, a referral is made to the RN Case Manager to address clinical issues, concerns and questions. Members/families are provided resources and contact information for the local health department for additional programs and support focused on decreasing lead levels and lead exposure. In addition, an assessment of social determinants of health is completed. Based on the identified needs or concerns, the Community Health Outreach Worker will assist the member with

community-based resources, referrals and ongoing support to help the member/family overcome any barriers.

Integration of Behavioral Health and Physical Health Services

To ensure collaboration and integration between health plans and Pre-paid Inpatient Health Plans (PIHPs), HAP Empowered in conjunction with the PIHPs creates policies and procedures to engage in integration and collaboration of these services. It is the policy of HAP Empowered, 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 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 a Medicaid health plan 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 Empowered 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 and the PIHPS for the ongoing coordination and integration of services

Transitions of Care

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

HAP Empowered's Case Management will implement the transition of care policy and provide oversight and manage all transition processes. Services for transitioned members will be enhanced and support for continuation of services will be provided.

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