2022 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 serve companies of all sizes from large national groups to small groups through an expansive product portfolio including: HMO, PPO, EPO, ASO, self-funded, Medicare Advantage HMO, Medicaid, and MMP plans with prescription drug coverage, experience rated and fully insured products and HSA compatible high deductible health plans with online consumer tools. Leased provider network services are available through HAP's subsidiary, Preferred Health Plan. HAP's HMO products include a commercial HMO, Medicare Advantage HMO and Medicare complementary products. HAP is affiliated with numerous primary care physicians and specialists. HAP holds contracts with hospitals throughout southeast Michigan and maintains contracts with 700 ancillary providers (such as nursing homes, mental health facilities, optical shops, laboratories, DME providers, ambulance services, and pharmacy chains). The Henry Ford Medical Group (HFMG) is HAP's largest single provider group, caring for approximately 33 percent of the total membership.

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

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

Mission

The HAP Empowered Quality Assessment and Performance Improvement program (QAPI) aims to assure that safe, effective, patient centered, timely, efficient, and equitable clinical care and services are provided to Medicaid members. HAP Empowered 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, and of services across the delivery system by improving the health status of the 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 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 (CQMC) 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 and 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 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 collaborating 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: CBHM engages a population health perspective which focuses on whole person care to improve the member clinical heath outcome and engagement by addressing the members strengths and challenges that are present in the everyday life. In addition to this perspective, we also employ a continuum of care approach for HAP members as they move across multiple caregivers, procedures, care facilities, and treatments. In 2021, the department recorded significant increase in activities related to our members behavioral health needs. The CBHM team is comprised of Clerical staff and Clinical staff who provide their support, empathy, coaching and clinical skills in various workflows including Call Center, Care Management, HEDIS Measures, Quality & Utilization Improvement Committee Activities, Provider & Member Appeals, and Annual Member & provider Satisfaction Surveys.

- 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 or 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 and 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 Empowered members through consumer, provider, and physician education, 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. 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.
- 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 Empowered completes a network analysis and a provider satisfaction survey annually. HAP Empowered 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.
- Multiple chronic illnesses
- Chronic illnesses that result in high utilization
- The level of case management and care coordination necessary is typically intensive and/or the amount of resources required for member to regain optimal health or improved functionality is typically extensive
- 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.

Programs to support case management initiatives include, but are not limited to:

- Digital Strategy to enhance health coaching in the management of diabetes, heart failure, respiratory disease, and behavioral health.
- Progeny (Medically complex newborn and Maternity Management)
- Aspire (Comfort & Palliative Care)
- Mom's Meals
- Livongo (Diabetes Management)
- CarePort (Realtime admission and discharge notifications)
- Smoking Cessation Program
- WedMD

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 Board meets 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 participates 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:

Peer Review Committee (PRC)

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

Membership:

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

Chairperson: Vice President, Clinical Operations & Strategy/designated Medical Director

Meeting Frequency: Meets at least four (4) times per year and up to twelve times per year if necessary

Credentialing Committee

Objective: The 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 Hospital Acquired Condition (HAC) or Serious Reportable Adverse Event (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
    - Vendor Relationship Manager and Project Coordinators for Delegated Medical Management Entities, NCQA, and CMS
    - Guests (when their special expertise would prove beneficial to the decision-making process)

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

Chairperson: Senior Medical Director and Director Coordinated Behavioral Health Management
Meeting Frequency: Meets at least 6 times per year

Ambulatory Pharmacy and Therapeutics (P&T) Committee

Objective: Optimizing the quality of drug therapy for HAP 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

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

The HAP Executive Quality and Compliance Committee is established to foster a culture of compliance by providing leadership, oversight and guidance for the development, implementation and monitoring of HAP's compliance and ethics programs and HAP's compliance policies and procedures. HAP is committed to conducting its business with honesty and integrity consistent with the highest standards of good business and professional ethics following all applicable laws, regulations, professional organization requirements and HAP policies and procedures.

Additional Responsibilities:

- Serves to prevent violations of applicable laws, regulations, federal/state contract obligations, and professional organization requirements as well as supports and protects the rights of HAP members and other stakeholders.
- Proactively audits and monitors to identify violations of laws, regulations and applicable professional organization requirements and provides appropriate response, mitigation, and remediation to any such misconduct as soon as it is suspected or discovered.
- Encourages individuals to promptly report any conduct, ethics, or compliance concerns that they reasonably believe violates HAP's Code of Conduct, applicable laws and regulations, professional organization requirements, or HAP policy or procedure.
- Appropriately disciplines individual(s) who fail to follow the standards of the Code of Conduct or other legal requirements, who engage in unethical practices, or any individual who fails to

take reasonable steps to identify, prevent, discontinue and report such failure(s) to follow the Code of Conduct or other legal requirements, or engagement in unethical practices.
- Develops, implements, monitors, and evaluates the sufficiency of appropriate corrective actions to ensure non-compliance or unethical practices will not be repeated.
- Creates a culture of compliance and ethics by, among other activities, establishing compliance and ethics training and awareness programs and supporting operational and functional areas in developing compliance processes, policies, and procedures.

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

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

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

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

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

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

Membership:
The core committee membership will consist of appointed representatives from internal HAP functional departments. Committee members must be free from any relationship that may interfere or appear to interfere with the exercise of their independent judgment in fulfilling their committee responsibilities. Any dispute regarding conflict of interest regarding a member should be referred to the committee chairperson.
Hearings require participation of at least two committee voting members. However, the preferred minimum number of voters is three. Additional subject matter experts may also participate in hearings as non-voting members.

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

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

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

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

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

Chairperson: Vice President Clinical Operations and Strategy
Meeting Frequency: Weekly

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

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

E. Quality Management (QM), Case Management (CM), Population Health Management (PHM), Coordinated Behavioral Health Management (CBHM) and Medical Configuration & Reporting are responsible for developing, supporting, and/or implementing the HAP 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.

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

F. Internal Collaboration
To support quality management across the delivery system, the QM staff collaborate with individuals and departments involved in research, patient safety, clinical assessment and quality improvement throughout Henry Ford Health. 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 Configuration and Reporting provides data analytic support to identify and address medical management opportunities including overuse and misuse of services. HAP Empowered also utilizes provider profiles, routine utilization statistics, program evaluations and other reports to support decision-making.

Establishing and managing relationships with non-profit organizations that support community health and well-being is an integral part of the mission and vision of HAP's community outreach department.

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

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

Credentialing ensures that affiliated practitioners and providers meet HAP credentialing standards through initial and recredentialing activities in alignment with regulatory and accreditation standards. Credentialing maintains accurate provider and practitioner data, and databases. Credentialing

collaborates in local and national credentialing initiatives such as statewide credentialing applications to standardize processes.

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

HAP Empowered 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, Region 6 and 10 perinatal collaborative, 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 (ProgenyHealth) for babies who begin their lives in neonatal intensive care unit (NICU) or Special Care Nursery (SCN). ~~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.

Confidentiality

The confidentiality of member, provider and practitioner, and HAP business information is of utmost concern in conducting activities of the Quality Program. HAP maintains all relevant information in

accordance with established HIPAA, regulatory, and accreditation standards. This includes storage, access, disposal and disclosure of the 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 Provider Network 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

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

Annually, HAP 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:

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

- The needs of individuals with serious and persistent mental illness

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

Following this analysis, findings are used to:

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

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 develops and implements a multi-year plan, policies/procedures and interventions to address beneficiary's health outcomes. In 2020-2022, 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.

In 2022 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 referral tracking
- Expanding the stratification of data by race/ethnicity, region, age, gender, etc.

Transitions of Care

HAP Empowered assists with a member's transition to other care when members are receiving approved services and benefit coverage will end while the member still needs the medically necessary care.
This includes members at the time of enrollment who:

- Have serious health care needs or complex medical conditions.
- Are receiving ongoing services such as dialysis, home health, chemotherapy and/or radiation
- therapy.
- If Children's Special Health Care Services transition requirements conflict with these transition of care requirements, CSHCS transition MDHHS contract requirements will apply first.

In addition, the HAP Empowered transition of care program for prescription drugs ensures continued access to services during a transition from FFS or another managed care entity when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

The Transition to Other Care Policy is available on HAP's website for public access. Instructions for members on how to access continued services upon transition are also included in the member handbook.

Addressing Health Disparities

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.

Healthy Michigan Plan Health Risk Assessment

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 develops a trusting relationship with the member, enabling them to serve as a liaison/link/intermediary between health and social services and the community to facilitate access to services

The CHW program was initiated to close 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 also encourages 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 Management Program

HAP Empowered's Maternity Management program powered by ProgenyHealth ensures members have a health pregnancy by:

- Connecting members with an OB or OB/GYN
- Providing reminders for prenatal and postpartum visits, and assisting with scheduling if needed
- Conducting maternity-specific assessments in order to ensure members are receiving the care they need
- Educating on benefits available while pregnant, including dental services
- Connecting members to nurses or behavioral health services if needed
- Referring members to a Maternal Infant Health Program (MIHP). MIHPs offer in-home visits by qualified nurses or social workers to provide education and support
- Checking in with members after delivery to make sure everyone is doing well
- Ongoing education, and support through the Ovia Health™ mobile application

Maternal Infant Health Program (MIHP)

The Maternal Infant Health Program (MIHP) is a home-visiting program for Medicaid-eligible women and infants to promote healthy pregnancies, positive birth outcomes, identify risk, deliver interventions, measure outcomes, and promote healthy infant growth and development. Health plans are required to have a signed care coordination agreement and contract with each MIHP Provider in their service areas. The purpose of the care coordination agreement and contract is to define the responsibilities and relationship between the MIHP Provider and HAP Empowered.

HAP Empowered continues to refer all pregnant members and infants to MIHP. MIHP services include prenatal teaching, childbirth education classes, nutritional support and education, newborn baby

assessments, referrals to community resources and help in finding baby cribs, car seats, and clothing, help with transportation to pregnancy related appointments, and support to stop smoking.

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 Projects

HAP Empowered conducts performance improvement projects (PIP) that focus on clinical and non-clinical areas.

Improving The Timeliness of Prenatal Care

HAP Empowered participates in the MDHHS PIP focused on Improving the Timeliness of Prenatal Care and continues to identify opportunities for improvement and collaborate on plan interventions.

HAP Empowered has 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 main activities include:

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

In 2022, a new PIP cycle with the same topic of Addressing Disparities in Timeliness of Prenatal Care will be implemented. MDHHS reviewed several factors when deciding the topic including HEDIS specification changes, MHP mergers and the COVID-19 pandemic. HAP Empowered will implement the new PIP protocol. In addition to statistically significant improvement, the new protocols allow for clinically significant and programmatically significant improvement

Adult Access to Preventive/Ambulatory Health Services (AAP) and Improving Comprehensive Diabetes Care-Eye Exam

The AAP and Diabetes Performance Improvement Projects serve as the foundation of HAP Empowered's commitment to continuously improve the quality of the treatment and services it provides. HAP is committed to the ongoing improvement of services that are provided in a safe, effective, patient-centered, timely recovery-oriented fashion. HAP is committed to the ongoing improvement of the quality of care its consumers receive, as evidenced by the outcomes of that care.

Quality Improvement Activities

Refine the gaps in care outreach program, provider incentives, and member incentives. Consider an approach to member incentives that includes a behavioral economics component. Include reminders in member newsletters, focused member mailings, and provide gaps in care reports to providers. Schedule clinic days on Saturdays, complete a geographic zip code analysis to identify hot spots for targeted interventions. Continue workgroup meetings to review, discuss and revise improvement efforts.

Re-engagement Strategy and Implementation Plan to address COVID-19 Impact

In response to the disengagement with healthcare due to COVID-19, HAP Empowered has implemented a performance improvement project focused on increasing access to care for members.

HAP Empowered has a multi-pronged approach to improve member access to care, prevention and screening, child and adolescent well visit measure domains.

The goal is to meet at a minimum the NCQA Quality Compass 50th percentile with a stretch goal of 75th percentile. Focus on improving the following HEDIS measures:

- Adult Access to Care (AAP)
- Timeliness of Prenatal Care (PPC)
- Postpartum Care (PPC)
- Cervical Cancer Screening (CCS)
- Breast Cancer Screening (BCS)
- Chlamydia Screening in Women (CHL)
- Weight Assessment/ Counseling for Children/Adolescents (WCC)- BMI Percentile
- Weight Assessment/ Counseling for Children/Adolescents (WCC)- Counseling for Nutrition
- Weight Assessment/ Counseling for Children/Adolescents (WCC) – Counseling for Physical Activity
- Childhood Immunization Status – Combo 3 and 10 (CIS)
- Adolescent Immunization – (IMA)
- Lead Screening (LSC)
- Child and Adolescent Well Care Visits (WCV)
- Well Child Visits in first 30 months (W30)

Pediatric Sickle Cell Quality Collaborative

MDHHS established a pediatric sickle cell quality improvement project to improve care by preventing serious infections, stroke, and pain crises among children with sickle cell anemia. The quality collaborative combines the collective knowledge and lived experiences of parents and individuals with sickle cell disease, in partnership with the University of Michigan, the state of Michigan, and Medicaid Health Plans in Region 10 to implement a pilot Pediatric Sickle Cell Improvement Program in Southeast Michigan.

This program aims to achieve improvement in preventive care delivery for this high-risk and vulnerable population through the development of an innovative quality collaborative that will have

Medicaid Health Plans working together as one team to improve the care of all children with sickle cell in the region, not just those enrolled in their individual plans. This initiative will develop a robust platform for interaction to share ideas and provide support as the health plans work together to improve the performance rates of antibiotic prophylaxis, transcranial Doppler screening, and hydroxyurea use.

The following quality measures will be utilized as performance measures and have been endorsed by the National Quality Forum.

- Daily Antibiotics Dispensed: Increase the percentage of children ages 3 months to 5 years who are dispensed appropriate antibiotic prophylaxis for at least 300 of 365 days per year.
- Annual Transcranial Doppler Ultrasonography (TCD) Screening: Increase the percentage of children ages 2 through 15 years old who receive at least one TCD screening per year.
- Daily Hydroxyurea Dispensed: Increase the percentage of children ages 1 to 18 years who are dispensed hydroxyurea for at least 300 of 365 days per year.

We Treat Hepatitis C Initiative

During 2021, MDHHS announced a public health campaign called *We Treat Hep C*, aimed at eliminating Hepatitis C Virus (HCV) in Michigan. The initiative involves increasing the number of people who are tested for HCV, increasing the number of providers who treat HCV, and expanding access to HCV curative treatments.

Below are the care coordination activities focused on HCV that will continue to be enhanced during 2022.

- A workgroup meets monthly to review the internal workplan, implement interventions from the *We Treat Hep C* Care Coordination Memo and discuss any barriers as needed. The workgroup is comprised of stakeholders from Care Coordination, Quality Management, Pharmacy, and Provider Network Management teams.
- Member Outreach
    - HCV letter template and fact sheet sent to all members ages 18 and older with quarterly mailings scheduled for new members
    - Utilizing CHWs, Community Based Organizations and homeless shelters to conduct outreach to beneficiaries that are transient/difficult to reach, including those who are homeless, disabled or those living with substance use disorders
    - Developing a report of members with an HCV diagnosis and without a record of treatment to conduct ongoing outreach
    - Follow-up with members who have a positive HCV test as well as their providers to initiate treatment with Mavyret
    - Utilizing the Daily Carve-Out Utilization File (5165), regarding members who are receiving Mavyret or another DAA to conduct outreach to members receiving treatment and provide education on medication adherence
- Provider Outreach
    - A Hepatitis C provider resource page was added to the HAP Empowered website
        - Education materials to network providers on the CDC's new universal testing guidelines

        - Promoting the resources listed on Michigan.gov/WeTreatHepC.
    - Work with providers to incorporate orders for HCV tests in routine primary care for all members
    - Ensure that CDC HCV testing algorithms are followed (running an HCV virus detection test or PCR for any persons who tests positive for HCV antibody)
    - Conduct targeted outreach and support to network providers in areas where HCV is prevalent as well as to network providers who treat opioid use disorder
    - Promote medication adherence to network providers and pharmacies to ensure that Mavyret is dispensed in an 8-week supply (or 12-week supply when appropriate)
    - Encourage providers to enroll patients receiving treatment in the Mavyret Nurse Ambassador program.
- Pharmacy Outreach
    - Provide ongoing education to network pharmacies s including the removal of prior authorization requirement for Mavyret

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 collaborate 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 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 Empowered and the PIHP
- Participate in the MHP-PIHP Workgroup. Activities include:

    - Enhancements to CC360 to streamline member search and risk stratification
    - Working to add homeless indicator and homeless vulnerability score to CC360
    - Worked to develop at least two standard of care protocols for care coordination as identified collaboratively with MDHHS
- Completed data validation for the following performance measures with the shared metrics with the PIHPs: Plan All-Cause Readmissions (PCR) and Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)
- 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 Empowered and the PIHPs for the ongoing coordination and integration of services

2022 Quality Initiatives

- Enhance HEDIS Performance Monitoring/Reporting and provider and member outreach
    - Adults' Access to Preventive and Ambulatory Health Services (AAP)
    - Children and Adolescents' Access to Primary Care Practitioners (CAP)
    - Women's Health Measures
    - Diabetes Care
- Maintain HEDIS, CAHPS and NCQA plan rankings
- Continue efforts toward maintaining regulatory, State, and CMS compliance
- Continue to develop and enhance performance improvement projects
- Continue to enhance and collaborate with Provider Network team on the Provider Best Practice Program
- Continue to identify health disparities and implement interventions to reduce racial/ethnic disparities in care
- Monitor and track performance monitoring standards for the following measures:
    - Healthy Michigan Plan (HMP) Measures
    - MDHHS Dental Measures
    - CMS Core Set Measures / HEDIS / Managed Care Quality Measures
- Continue collaboration on the following quality improvement projects:
    - Low Birth Weight
    - Pediatric Sickle Cell
    - Hepatitis C
    - Population Health Management focusing on Social Determinants of Health and Behavioral Health

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	.5
Medical Director of Behavioral Medicine	.425
Director, Quality Management	1
Manager, Quality Management	1
Senior Project Coordinator	3
Clinical Quality Coordinator	1
RN Quality Management	1
Quality Coordinator	1
Quality Analyst	1
QM Accreditation Coordinator	1
Appeal Grievance Leads	2
Manager of HEDIS & Reporting	2
HEDIS Coordinator	3
HEDIS Medical Records Analyst	1