2022 Quality Program
MI Health Link Medicare-Medicaid Plan (MMP)

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 Medicare/Medicaid Plan (MMP: MI Health Link) plans with prescription drug coverage, experience rated and fully insured products and health savings account (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. 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 Health Plan is a separate, wholly owned subsidiary of HAP. HAP's 2022 Family of Health Care Plans includes the following HAP Empowered products:

- HAP Empowered Medicaid
- HAP Empowered Healthy Michigan Plan
- HAP Empowered MI Health Link
- HAP Empowered Duals (HMO SNP)

MI Health Link, also known as the Medicare Medicaid Plan (MMP), is a health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid, and live in specified counties in Michigan. MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care, all in a single program designed to meet individual member needs. HAP Empowered began the first year of the MMP demonstration project in 2015 and continues to serve the needs of the dual eligible population in Wayne and Macomb counties with continued participation in the project. Individuals eligible for MI Health Link can voluntarily enroll or are passively enrolled by MDHHS. Currently, approximately 85% of membership enrollment is passive.

The program brings together services for members into one plan, one card and one care coordinator. Members receive single plan coverage for:

- Medical care
- Behavioral health care
- Home and community-based services
- Nursing home care
- Medications
- Dental, Vision and Hearing

The program also offers Care Coordinators and Care Teams to help members manage all their providers and services, ensuring they work together to provide the care the member needs.

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

The QAPI is approved by the HAP Board of Directors and is updated as necessary and reviewed annually at a minimum. The review includes a description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services, the trending of measures to assess performance, an analysis of whether there have been improvements in the quality of clinical care and the quality of service to members, and an evaluation of the overall effectiveness of the QI Program. Practicing providers participate in the Clinical Quality Management Committee as well as the associated subcommittees. Members and providers who wish to learn more about the QI program can request information on a description of the QI program and a report on progress towards meeting QI goals. This information is also found on the website at hap.org/emp/hap-empowered/mi-health-link/member

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 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 MI Health Link members.

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 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 member 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. 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. member outreach initiatives, health events, and educational calls/mailings).

- Evidence-based Medicine: Practice Guideline Implementation programs include clinical practice and preventive service guidelines, regular monitoring for practitioner performance and member education (i.e., information available on the web and in newsletters).

- 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 and analysis 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.

- 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 Empowered 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.

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

Objectives

The objectives of the HAP Empowered MI Health Link 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.

Structure/Authority

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

HAP Empowered maintains a well-defined Quality Improvement (QI) Program structure for the MI Health Link members that is separate from any of its existing Medicaid, Medicare, or commercial lines of business. The Quality Improvement Program supports the application of the principles of Continuous Quality Improvement (CQI) to all aspects of HAP's service delivery system. The HAP Empowered QI Program includes measurable goals related to health outcomes. Goals are specific for improving access and affordability for the health care needs for the members. Goals are monitored to evaluate the improvement of care coordination and delivery of services for members through the alignment of the Health Risk Assessment (HRA), Individual Integrated Care and Supports Plan (IICSP), and Integrated Care Team (ICT). Care transitions are evaluated to show enhancement across all health care settings and providers for members.

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 and Benefit 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 twenty 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. The Manager of Quality Management is committed full time to developing and implementing the QAPI. Additional support staff include:

- Chief Medical Officer
- Vice President (VP) Clinical Operations & Strategy
- Corporate Compliance Officer
- Director of Quality Management
- Quality Coordinator
- Clinical Quality Coordinator
- Quality Analyst
- Director of Population Health
- Case Management and Utilization Management staff
- Claims Director
- Customer Service Manager
- Customer Service Representatives
- Medical Directors
- Chief Information Officer
- Information Technology staff

E. 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 Credentialing Committee reviews and evaluate the qualifications of each applicant for initial credentialing and reappointment and makes recommendation for affiliation with HAP.

Membership:

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

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

Member Experience (ME)

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

Membership

- Market Intelligence
- Member Experience
- Quality Management
- Coordinated Behavioral Health Management
- Healthcare Management
- Customer Service
- Claims

- Provider Network
- 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, 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

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 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 Corporate Quality Committee, HAP Corporate Leadership Council, and the Network Medical Directors' Committee.

- Henry Ford Health, HAP's parent company, provides ongoing support for HAP Empowered's Quality Program. The Henry Ford Health 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 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 President and CEO, the Quality Forum reports its progress to the Henry Ford Health 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.

F. 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 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.

G. 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 Network helps 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.

- 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.

H. 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.

Data collection, integration, analysis and ensuring accuracy and completeness

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

- **Facets**: Claims processing system
- **Pega**: Customer Service Call Center Software
- **Care Connect 360**: MDHHS website
- **EPIC**: Henry Ford Health Electronic Health Record (EHR)
    - Data is accessed by team members from the following teams via secure read only access:
        - Case Management
        - Utilization Management
        - Quality Management
        - Program Development
- **MiHIN (**Michigan Health Information Network): An ADT feed that HAP receives from the State of Michigan of HAP members who have had an admission or discharge from any hospital in Michigan. This feed also:
    - Sends immediate notification of all member utilization to HAP
    - Contains admissions and discharges from the following facilities:
        - Inpatient Hospitals
        - Skilled Nursing Facilities (SNFS)
        - Emergency Room Departments
- **Careport**: Software that interprets and cleanses MiHIN data directly from facility data. Provides an online tool that tracks member history through the continuum of care.
- **Laboratory Results**: Laboratory results are available for HAP via CarePort's HAP's ADT feed. This information is available in the patient summary and is shared with Case Management, as well as PCPs for post hospitalized members. The labs are included in the member summary/transitions of care record.
- **ACG Tool**: Tool developed by Johns Hopkins Healthcare combining the expertise of Johns Hopkins Hospital and Johns Hopkins University that is utilized to stratify HAP's population. The ACG tool transforms data from CareRadius (HAP's care management platform), Medical/Behavioral Claims, Pharmacy Claims, Laboratory results, Health Appraisal Results and Health services programs within the organization into analytics and reporting for use across the Population Health Management areas of focus.

- **Member Pharmacy Fills**: These are uploaded to CareRadius from the pharmacy claims processor (ExpressScripts [ESI]). This pharmacy information is then reviewed by case management, pharmacy, medical directors and utilization management staff. The pharmacy information is used to educate members on their medication changes and increase medication adherence. A comprehensive medication review is completed for members who are on high-risk medications, are prescribed 15 or more medications, and/or if medication reviews requested by members.

- **Health Risk Assessments**: Health Risk Assessments are completed for MMP, DSNP, and Medicaid Healthy Michigan Plan Members upon enrollment.

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

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

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

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

Annual review and actions

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

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

Each year HAP Empowered sets goals to improve our services to members. We submit annual HEDIS® measures for quality reporting. HAP uses HEDIS® results to track quality performance from year to year and to identify opportunities for improvement. Additionally, HAP annually measures member satisfaction using the Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey results for the MMP 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 members.

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. In 2022, HAP Empowered will obtain NCQA LTSS and MED Module Accreditation.

Care Coordination
HAP Empowered's MI Health Link program provides the full spectrum of integrated care following the Care Delivery Model of Three-Way Contract, including coordinating care along the continuum of health and wellbeing. These principles are utilized to maintain or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum. They include an overarching emphasis on health promotion and disease prevention and incorporate community-based health and wellness strategies with a strong focus on the Social Determinants of Health, creating Health Equity and supporting efforts to build more resilient communities.

Every member enrolled in MI Health Link is assigned a Care Coordinator and is eligible for an initial face-to-face or telephonic Health Risk Assessment. The program is a person-centered model, and every member has an Integrated Individualized Care Service Plan (IICSP). Behavioral health services are available to MI Health Link members who have a diagnosed mental illness, intellectual or developmental disability, and/or substance use disorder. Members can access these services by contacting their dedicated care coordinator, Pre-Paid Inpatient Health Plan (PIHP), or local Community Mental Health Service Provider (CMHSP). The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care and align financial incentives.

The MI Health Link program incorporates Long Term Support Services (LTSS), which include a variety of supports and services that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Members must qualify for LTSS through various screening and assessments. Only a subset of members enrolled in MI Health Link qualify for LTSS services.

The purpose of MI Health Link LTSS program is to help members function optimally in their preferred setting. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

LTSS Performance Improvement Project

MDHHS requires ICOs to implement a Performance Improvement Initiative to reduce administrative burden for LTSS providers, such as streamlined preauthorization processes or improvement in the accuracy and timeliness of Provider payments. HAP Empowered collaborates on this project with LTSS providers to gather feedback and implement impactful interventions. HAP Empowered submits updates quarterly to MDHHS using a template and also discuss during Contract Management Team (CMT) meetings.

Project Timeline:

- March 2022 –Brainstorming the Approach
- June 2022 –Finalizing the Approach
- September 2022 –Implementing the Initiative
- December 2022 –Assessing Progress
- March 2023 –Evaluating the Impact

Based on provider survey responses collected and through regular account status meetings with the Area Agencies on Aging (AAAs), the following areas of improvement were identified:

- Improve lead time on reporting and compliance requests to allow for adequate turnaround time back to HAP Empowered
- Enhance training on the HAP Empowered Care Management platform (CareRadius) that is utilized by AAA staff to document personal care assessments
- The need to improve collaboration efforts with HAP Empowered

HAP Empowered is committed to continue:

- Meeting regularly with the AAAs and encouraging honest feedback from both the AAAs and HAP Empowered key stakeholders
    - Acting on realistic feedback where solutions are attainable
    - Providing resources from HAP Empowered as applicable, to reduce barriers
- Optimizing how the HAP Empowered Care Coordination team collaborates with the AAAs
- Continuing to revisit the AAA training curriculum and the frequency of trainings
- Continuing to work with key HAP Empowered and AAA stakeholders to improve our relationship
- Continuing to gather feedback from AAA and Nursing Facilities related to opportunities for improvement

Integration of Physical and Behavioral Health Services

Many of the MMP members have been identified as having behavioral health diagnoses and are receiving services through the community mental health system. HAP Empowered's MI Health Link has

partnered with the following Pre Paid Inpatient Health Plans (PIHPs), Detroit Wayne Integrated Health Network (DWIHN) and Macomb County Community Mental Health (MCCMH) to establish guidelines for the exchange of information to promote optimum health for members with co-occurring behavioral and physical health disorders. Monthly meetings between the PIHPs and HAP Empowered are held for administrative oversight, contract compliance, discussion on quality improvement goals and progress towards meeting benchmarks, etc. Clinical meetings are also held to verify member contact information, identify gaps in care and discuss current care plans involving mutual members.

The HRA is administered by the HAP Empowered MI Health Link Care Coordinators. HAP Empowered MI Health Link, DWIHN and MCCMH use the HAP Integrated Care Bridge to house all the assessments shared between the organizations.

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

Clinical Practice Guidelines

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

Communication of Clinical Practice Guidelines

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

Network Analysis

HAP Empowered MI Health Link conducts an annual review of the provider network to ensure that the network meets the cultural needs of the members, that appointment times meet required standards,

and that the number and types of providers meet the requirements of the members. Adequate number of Primary Care Providers: HAP Empowered contracts with primary care providers (PCPs) whose specialties include geriatric medicine, internal medicine, family practice, and general medicine. HAP ensures that members have adequate access to PCPs by conducting access mapping to confirm that there are contracted providers within 30 minutes or 30 miles from the member's home. The PCPs work closely with HAP and the members to coordinate their needed care and services.

Provider Satisfaction

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

Provider Survey Methodology

- A mixed mode methodology survey including online, mail and telephone follow-up is used
- Where available providers receive an email invitation to complete the survey. Those that don't respond or complete online receive a four-page survey accompanied by a one-page cover letter as well as a business reply envelope for returning the surveys
- A reminder call will be made to all non-respondents
- Surveys are conducted each year in the fall
- Survey results are analyzed and reported to the Member Experience (ME) committee annually
- HAP Empowered examines the Key Driver Analysis to determine the high priority areas for improvement and primary recommendations
- HAP ME Committee works with all departments to create action plans for improvement.
- If there are areas that need improvement, barriers and opportunities are identified and action plans are developed and presented to ME

Patient Safety

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

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

improvement initiatives locally and statewide.
- Participation in the Michigan Quality Improvement Consortium (MQIC) to promulgate evidence-based medicine, preventive services, health promotion, disease management programs, and clinical practice guidelines to practitioners

Utilization Management

The Utilization Management (UM) Program includes monitoring the access, availability and quality of health care services provided to the HAP Empowered 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
- 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.

Quality Improvement Projects

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

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

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

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

In 2022, the quality improvement project is focused on reducing racial and ethnic disparities in healthcare and health outcomes. HAP Empowered used measurement year (MY) 2021 HEDIS®

preliminary data in conjunction with the race and ethnicity data that is collected through enrollment to determine disparity. After reviewing the data and information, HAP Empowered found that there is a very large disparity between the Black/African American population and the White/Caucasian population for Controlling Blood Pressure (CBP). This measure had the largest disparity out of those that were found. For this reason, HAP Empowered will focus on the CBP measure for the Quality Improvement Project.

Chronic Care Improvement Program (CCIP)

HAP Empowered MI Health Link's Chronic Care Improvement Programs (CCIP) promote effective management of chronic disease and improve care and health outcomes for enrollees with chronic conditions. Effective management of chronic disease is expected to slow disease progression, prevent complications and development of comorbidities, reduce preventable emergency room (ER) encounters and inpatient stays and improve quality of life.

The goals of the CCIP are to:

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

Planning and carrying out the interventions for these projects are tracked in the "Plan, Do, Study, Act" PDSA cycle. A CCIP is generally conducted over a three-year cycle. A CCIP/QIP workgroup was formed to more closely align the CCIP with internal and external benchmarks and to determine ongoing interventions to improve measures. This workgroup meets monthly to assess opportunities for improvement.

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

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 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.

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
    - Include information about hepatitis C and the importance of getting tested in member communication and newsletters
    - Provide materials in beneficiaries' preferred language. Ensure communication efforts

meet national Culturally and Linguistically Appropriate Services (CLAS) standards
    - 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
    - Ensure that beneficiaries have access to providers, laboratories and pharmacies through transportation, telemedicine and mail order where appropriate
    - Incorporate hepatitis C testing in all care management/care coordination discussions
- 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
    - To promote medication adherence, work with providers to specify on the DAA prescription that the full treatment course should be dispensed at one time.
- Pharmacy Outreach
    - To promote medication adherence, work with providers and pharmacies to ensure that the full treatment course of the DAA is dispensed at one time. In most cases, the full treatment course is 8-12 weeks
    - Ensure that network pharmacies in areas where HCV is prevalent have adequate stock of DAAs

Critical Incidents

The HAP MI Health Link Care Management team identifies, investigates, resolves, and reports all critical incidents. A critical incident is defined as any of the following: exploitation; illegal activity in the member's home; medication errors that result in harm to the member; neglect; physical abuse; provider no shows that result in harm to the member; restraints; seclusion or restrictive interventions; theft; verbal abuse; suspicious or unexpected deaths; workers consuming alcohol or drugs on the job; risky behavior that results in harm to self or others (including suicidal ideation or tendencies); and emergency or disaster events.

The Quality Management Department in collaboration with Care Management, Health Care Management, Compliance, and the Special Investigations Unit (SIU) collects and analyzes critical incident data on a quarterly basis. A comprehensive report with thresholds is monitored for plan wide stakeholders to conduct analysis and identify provider, member and/or systemic trends. This is reviewed during quarterly meetings and findings are reported to the Clinical Quality Management Committee (CQMC). Reporting includes:

- Quarterly reporting with a YTD analysis inclusive of member, provider and systemic trends to CQMC and to the Compliance Committee

Critical Incidents are also included in the quality management workplan to enable oversight of the critical incidents reporting process. The workplan is updated quarterly and reviewed at the Clinical Quality Management Committee (CQMC).

Passive Algorithm

Passive Enrollment is a process through which an eligible individual is enrolled by MDHHS (or its vendor) into an ICO's plan, following a minimum 60 calendar day advance notification that includes the plan selection and the opportunity to select a different plan, make another Enrollment decision, or decline Enrollment into an ICO, or opt-out of future passive enrollment into the Demonstration.

The MI Health Link Passive Assignment Algorithm consist of 7 ICO health plans. The Passive Algorithm assigns each ICO a score based on their performance on 9 measures. ICOs can score up to 10 points on each individual measure, for a total of 30 possible points in each weight category. The following measures are included:

High Weight: 45% of total score

- Measure 1: Percentage of New Enrollees Who Received an In-person Assessment.
- Measure 2: Percentage of Waiver Enrollees Who Received More Than One Waiver Service
- Measure 3: Members with Care Plan Completed within 90 days of Enrollment

Medium Weight: 35% of total score

- Measure 4: First follow-up Visit within 30 Days of Hospital Discharge
- Measure 5: Members with Level I Assessment Completed Within 60 Days
- Measure 6: Emergency Room Behavioral Health Services Utilization

Standard Weight: 20% of total score

- Measure 7: Care Coordinator Ratio
- Measure 8: Satisfaction with Coordination of Care
- Measure 9: Encounter Timeliness

Performance Improvement Strategy

The Passive Algorithm and Quality Withhold workgroups meet monthly to continue collaboration efforts and target ongoing barriers, interventions, and strategies to improve measure outcomes.
Workgroup activities consist of the following:

- Reviewing performance data
- Identifying key drivers and areas of improvement
- Identifying interventions/change concepts to implement
- Developing action and work plans
- Monitoring intervention performance and outcomes
- Revise, enhance and/or discontinue interventions as deemed appropriate
- Tracking member enrollment trends for passive algorithm

MDHHS Performance Incentive Program

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

Methodology

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

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

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

MMPs will be evaluated using the following bands:

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

Benchmarks

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

HAP Empowered is evaluated to determine whether it has met quality withhold requirements at the end of each Demonstration Year. The MDHHS quality withhold measures for Demonstration Year 7 (2022) are included in the table below.

Quality Withhold Measures for Demonstration Year 2022

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

Part D medication adherence for diabetes medications	Percent of Enrollees with a prescription for diabetes medication who fill their prescription often enough to cover eighty percent (80%) or more of the time they are supposed to be taking the medication.	CMS
Care Transition Record Transmitted to Health Care Professional	Percent of members discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care on the day of discharge or the following day	State defined
Annual Dental Visit	Percent of members who had one or more dental visits with a dental practitioner during the reporting period	State Defined
Antidepressant Medication Management – Effective Acute Phase Treatment	Percent of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	HEDIS
Colorectal Cancer Screening	Percent of members 50–75 years of age who had appropriate screening for colorectal cancer	HEDIS
Medication Reconciliation Post-Discharge	Percent of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days)	HEDIS

Minimizing Institutional Length of Stay	The ratio of the MMP's observed performance rate to the MMP's expected performance rate. The performance rate is based on the proportion of admissions to an institutional facility that result in successful discharge to the community within 100 days of admission.	State/Core Reporting

HEDIS®: Collection and reporting

Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA®) to objectively measure, report, and compare quality across health plans. NCQA develops HEDIS® measures through a committee represented by purchasers, consumers, health plans, health care providers, and policy makers. As state and federal governments move toward a quality-driven healthcare industry, HEDIS® scores are becoming more important for both health plans and individual providers.

HAP MI Health Link uses the HEDIS® tool each year as one of the ways to help make sure that the members are getting the preventive screening and services needed with the intent of keeping our members healthy and/or assist in the identification of potential health problems early. The HEDIS® results are reported annually to NCQA and CMS. The oversight and auditing by an NCQA accredited third party vendor follows the HEDIS® Technical Specifications. HAP utilizes NCQA certified HEDIS® software to prepare and submit HEDIS® annually. HEDIS® results are reviewed at the CQMC annually.

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
On an annual basis, HAP Empowered contracts with an NCQA certified CAHPS® vendor to administer the satisfaction survey. For CAHPS® results to be considered in HEDIS® results, the CAHPS® 5.1H survey must be fielded by an NCQA certified survey vendor using an NCQA-approved protocol of administration in order to ensure that results are collected in a standardized way and can be compared across plans. Standard NCQA protocols for administering CAHPS® 5.1H include a mixed-mode mail and telephone protocol and a mail-only protocol. HAP Empowered utilizes the mail and telephone protocol. The protocol includes the following:
Pre-notification postcard mailed (optional)

- Questionnaire with cover letter and business reply envelope (BRE) mailed
- 1st reminder postcard mailed
- Replacement questionnaire with cover letter and BRE to all non-responders
- Telephone interviews conducted with non-responders (minimum of 3 and maximum of 5 attempts to contact member)

Member Survey Methodology
HAP Empowered utilizes a NCQA certified CAHPS® vendor. The survey methodology is below:

- All members, whether the primary subscriber or dependent, are sent to the survey vendor
- Vendor creates all mail materials for final approval for HAP Empowered
- Vendor reviews the sample for accuracy
- Surveys are mailed to members, and a toll-free telephone number is made available for questions regarding the survey
- Reminder postcards are sent after first mailing
- After second mailing, up to 5 telephone calls are made to non-responders
- Vendor sends member level data to NCQA, who creates summary files and returns them to the vendor and HAP Empowered
- HAP Empowered reviews results and sends signed attestation to NCQA
- Vendor produces and sends NCQA Accredited Plan reports, including data tabulations, to HAP Empowered
- The results of the survey are analyzed, evaluated and reported to ME
- HAP Empowered examines the Key Driver Analysis to determine the high priority areas for improvement and primary recommendations
- HAP Member Experience (ME) Committee works with affected departments to create action plans for improvement
- Barriers and opportunities are identified, and action plans are developed and presented to ME

Ongoing MI Health Link Reporting

HAP Empowered MI Health Link reports and complies with all quality measures required under the MI Health Link Demonstration Project in conjunction with the Coordination Agreements with the State of Michigan and the contract. HAP Empowered MI Health Link reports all measures related to behavioral health, care coordination, and care transitions, as well as Long Term Services and Supports (LTSS), as required by the contract. HAP Empowered MI Health Link also reports the following:

- Medication Therapy Management Programs (MTMP)
- Model of Care (MOC)
- Chronic Care Improvement Program (CCIP)
- Quality Assessment and Performance Improvement Program
- Quality Improvement Project (QIP)
- Continuous reporting of CMS Part C and Part D requirements via Health Plan Management System (HPMS)
- Core and MI specific measures
- Quality Withhold Measures
- Critical Incidents
- Health Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems survey (CAHPS)
- Health Outcomes Survey (HOS)

Communication on Quality Improvement Program with Stakeholders

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

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

HAP Empowered MI Health Link facilitates the participation of the members and caregivers in the QI program through:

- Representation on the Advisory Council
- Member Satisfaction Survey
- The Quality Improvement Program, Work Plan and Annual Evaluation of the QIP are on the website

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 MI Health Link 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 Quality program description and evaluations shall be reviewed and evaluated annually by the CQMC and the Board of Directors and revised or updated as necessary.

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

2022 Quality Initiatives

- Improve HEDIS® performance measures to meet/exceed state averages
- Continue coordination of Member Connections Committee
- Obtain LTSS Distinction and MED Module NCQA Accreditation
- Maintain NCQA Health Plan rankings
- Continue efforts toward maintaining regulatory & CMS compliance
- Continue coordination of Quality Withhold and Passive Algorithm Workgroups
- Participate in Health Equity initiatives to monitor and improve ethnic disparities
- Providing gaps in care information to providers to assist them in performing outreach to their members and implementing member gaps in care via the provider portal

Appendix A

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