Health Alliance Plan (HAP) is a nonprofit health plan based in Detroit, Michigan. HAP is a subsidiary of Henry Ford Health System (HFHS), one of the nation’s major comprehensive health systems. Founded in 1915, Henry Ford Health System (HFHS) is a non-profit, vertically integrated, mixed-model managed-care organization, and serves the primary and specialty health care needs of residents in southeastern Michigan, including Detroit and its surrounding metropolitan area. HAP has more than four decades of leadership in providing customers with access to quality health care coverage. HAP and its subsidiaries serve more than 675,000 members and serves companies of all sizes from large national groups to small groups through an expansive product portfolio including: HMO, PPO, EPO, ASO, self-funded, Medicare Advantage HMO and PPO plans with prescription drug coverage, experience rated and fully insured products and HSA compatible high deductible health plans with online consumer tools. Leased provider network services are available through HAP’s subsidiary, Preferred Health Plan. HAP’s HMO product is comprised of a commercial HMO, Medicare Advantage HMO and Medicare complementary products. We are affiliated with numerous primary care physicians and specialists. HAP holds contracts with hospitals throughout southeast Michigan and maintains contracts with 700 ancillary providers (such as nursing homes, mental health facilities, optical shops, laboratories, DME providers, ambulance services, and pharmacy chains). The Henry Ford Medical Group (HFMG) is HAP’s largest single provider group, caring for approximately 33 percent of the total membership.

HAP’s origins date back to the 1960s. Community Health Association (CHA), the first incarnation of what is now HAP, was founded by UAW President Walter Reuther and began operating as Michigan’s first nonprofit, prepaid group practice. CHA was renamed Metro Health Plan in 1972. As the call for managed health care grew, business, labor and health care leaders forged MHP into Health Alliance Plan. HAP was licensed as an HMO in 1979. HAP became the managed care component of what is now known as the Henry Ford Health System in 1986, providing our members with access to the HFHS provider network and its world-class teaching hospital. (PHP became a wholly owned subsidiary of HAP as part of this affiliation.) In 1988 HAP acquired Independence Health Plan, bringing with it approximately 74,000 members. In 1996, HAP assumed operational management of AHLIC. In March 2001, HAP purchased the HMO and POS product lines of SelectCare, Inc.

Alliance Health and Life Insurance Company (AHLIC) became operational in 1996 as an insurance company licensed by the State of Michigan. AHLIC offers EPA, POS and PPO products that are fully insured and experience rated. AHLIC’s license is state-wide and its products are primarily sold to employer groups with 50 to 250 eligible employees. Presently, most groups are located in the southeast Michigan market. HAP administers all functions for the AHL PPO product, including but not limited to claims, member services and medical management.

Midwest Health Plan
Midwest Health Plan (MHP) is a separate, wholly owned subsidiary of HAP that serves approximately 8,108 Medicaid/Medicare enrollees. MHP is headquartered in Southfield, Michigan, and was originally founded in Dearborn, Michigan in 1998. HAP Midwest Health Plan is invested in giving quality, low cost care to Michigan residents. Medicaid coverage is provided through HAP Midwest Health Plan and the Healthy Michigan Plan.
ASR Health Benefits
ASR Health Benefits is a full-service Third-Party Administrator in Grand Rapids, Michigan. The HAP-ASR affiliation with majority interest ownership offers competitive options for employers and health and welfare funds seeking to self-fund their health benefit costs, through Administrative Services Only (ASO) plans with a statewide network solution.

HAP Flint (formerly known as HealthPlus of Michigan)
HAP continues to seek opportunities to acquire membership and statewide expansion. One of the expansions was the merger of membership from HealthPlus of Michigan. On November 2, 2015, a definitive agreement between HealthPlus of Michigan (HPM) and Health Alliance Plan (HAP) was reached to merge the two companies. HealthPlus of Michigan (HPM) is headquartered in Flint, Michigan; the company was originally founded in 1979 as a not-for-profit organization. HealthPlus of Michigan (HPM) serves 61,839 fully insured and 13,880 Self-funded, Individual, Group, and Medicare enrollees. Both organizations developed and contributed to the development of a work stream grid that outlined critical activities, deliverables, and milestones associated with the transition. Several multidisciplinary committees were implemented to facilitate the transition of membership from HPM to HAP in accordance with health plan, accreditation, and regulatory policies and procedures. The Integration Steering Committee was comprised of HAP and HPM senior leadership members. The Steering Committee is responsible for setting direction for the HAP/HPM integration strategy, growth priorities and timing, sign-off on major decisions, and managing key program stakeholders. We are still addressing some final details with the State regarding the set up and funding of the trusts for running out the HealthPlus PPO and Partners business. Consequently, we will not be completing the merger transaction until early 2016. In the meantime, NCQA approved the consolidation of accreditation efforts. Both organizations have emerged as one entity and incorporated “best practices” in Quality, Population Health Management, Pharmacy, Credentialing, Contracting, and other programs throughout the health plan. Points of emphasis throughout the transition were as follows:

- Seamless Membership Transition & Positive Customer Experience
- Stakeholder Engagement & Change Enablement
- Process & System Changes
- Sustainability & Growth
- Talent Retention & Training

Mission
The Health Alliance Plan (HAP) Quality Program aims to assure that safe, effective, patient centered, timely, efficient, and equitable clinical care and services are provided to Commercial, HMO, PPO, ASO, Alliance Health and Life (AHL), and Senior Plus members/enrollees. The entire document applies to both Medicare and non-Medicare enrollees. HAP seeks to demonstrate value and improve quality through the elimination of over, under, and misuse of services. The Quality program focuses on coordinating activities for continuous quality improvement of clinical care and safety (including general medical and behavioral health care) and of services across HAP’s delivery system by:

- improving the health status of our members
- identifying and reducing healthcare disparities
- identifying organizational opportunities for improvement
- 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:
  o evidence-based clinical quality
  o patient safety
  o practitioner availability and accessibility
  o member and practitioner satisfaction
  o 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’s Commercial, PPO, and Senior Plus members.

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

B. Subcommittees
Initially the CQMC had subcommittees addressing Credentialing and Peer Review activities. A significant revision in committee structure took place in 2001 with several new subcommittees or committee reporting relationships established. New subcommittees included the following: Customer Experience Committee (CEM), and Hospital Quality/Patient Safety Committee. Reporting relationships were formalized with the Medical Management Oversight Committee, the Pharmacy Oversight Committee, and the Corporate Compliance Committee.

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

Scope
HAP has a proud, long-standing commitment to quality improvement initiatives that encompass the full spectrum of care and services provided by HAP. The Quality Program is dedicated to fulfilling that commitment by working with the physician and provider community to establish evidence-based clinical guidelines and service standards. The guidelines and measures are used to develop tools to provide feedback to patients and physicians to encourage improvement. The Quality Program applies to members enrolled through Commercial, PPO, ASO, and Medicare products in HAP and its subsidiaries. The Clinical Quality Management Committee (CQMC) approves the program’s annual goals and objectives from which health plan staff develops the Annual Quality Program Work Plan.
Specific clinical quality initiatives within the Quality Program and Annual Work Plan are categorized by quality of clinical care and service, safety of clinical care and member experience. The following groups are responsible for quality management but participation varies based on the intensity and scope of the efforts in that area. These priorities may be subject to change during the year based on new information and/or changing regulatory, accreditation, and/or purchaser needs:

- **Coordinated Behavioral Health Management (CBHM)**, HAP’s behavioral health department, provides systematic coordination of all aspects of behavioral health care for our members by our highly trained member call center and our seasoned Master level clinicians. CBHM has a robust member engagement program designed to assist our members in obtaining the best quality of care and quality of life. Member engagement touch-points include: receiving call about medication adherence, education and coaching about their emotional well being, coordination of care and transitional guidance through all levels of their behavioral health care. CBHM Case managers collaborate with behavioral health practitioners to coordinate care and encourage compliance with clinical practice guidelines. They also investigate, and resolve quality of care complaints in accordance with the Quality Program, with problem cases being referred to HGAP’s Peer Review Committee.

- **Medication Therapy Management Program**: HAP’s Medication Therapy Management (MTM) Program enrolls Medicare beneficiaries who are high risk for medication errors as identified by consuming multiple medications. The MTM Program is patient-centric, thereby including any and all disease states. The goal of our MTM Program is to ensure medication regimens provide optimal therapeutic outcomes through integration of the patient’s personal health care goals with evidence-based medicine in collaboration with the patient’s physician(s). Our MTM Program indirectly reduces medication errors by ensuring our program’s objectives address the three most common causes for preventable Adverse Drug Events: Failure to monitor medication therapy adequately, prescribing stage errors (e.g. wrong drug/wrong therapeutic choice, wrong dose, etc.) and patient non-adherence to medication therapy. Patients found eligible for the program and who do not decline enrollment are given a telephonic appointment with a specially trained clinical pharmacist at the patient’s preferred date and time. A Pharmacist reviews medications and retrievable medical data prior to calling patient. The Clinical Pharmacist will formulate a medication treatment plan that will encourage adherence to drug regimen and assure the highest quality of care is being provided with the most cost-effective approach by incorporating the patient’s personal healthcare goals with evidence base medicine. The pharmacist will discuss the patient case with the patient’s physician telephonically or in-person. In collaboration with patient’s physicians, pharmacist will develop and implement the new regimen. Pharmacist will counsel patient on new medication regimen and ePrescribe/call in any medication changes to the patient’s preferred pharmacy. Each time the patient receives a Comprehensive Medication Review, the beneficiary and physicians will be mailed a cover letter, medication action plan and updated personal medication list that meets CMS’s requirements. All patients enrolled into our MTM program receive at least one follow-up call to assure the previously rendered MTM services meet medication-related outcomes: a) Improved effectiveness, b) Improved safety, c) Improved adherence, and/or d) Lower drug costs. Patient’s not attaining set medication-related goals have additional medication changes made in collaboration with the patient and patient’s physician. In addition, each patient that does not decline the MTM services receives a quarterly letter providing education on drug adherence; the letter is personalized to provide specific education on diabetes, blood pressure and/or cholesterol drugs. To further improve drug adherence, each quarter the patient’s physician also receives a letter listing all the medications his/her patient has filled using a HAP prescription card, along with the dates of fill and associated amounts filled on those dates.

- **Quality Improvement**: Quality improvement is a systematic approach to measurement, analysis and intervention that defines a distinct area of opportunity, seeks to identify the causes of suboptimal performance/outcomes and targets interventions to address the identified causes. Quality improvement
programs include community collaborations (weight management), practitioner accessibility and member education related to prevention, provider profiling, targeted member reminders, physician and member incentives, and guideline implementation activities.

- **Population Health Management, Health Promotion & Preventive Care:** Health promotion programs include guideline implementation activities and general or targeted practitioner and/or patient education (i.e., office posters, member outreach initiatives, health events, and educational mailings).

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

- **Hospital Quality/Patient Safety:** Focus on hospital quality initiatives that seek to improve, support, and promote quality of care, outcomes and safe patient care for HAP members through consumer, provider, and physician education/information, collaboration, quality contracting, and recognition. The initiatives may incorporate hospital performance metrics, analysis, and research findings to align with corporate strategies. A Committee collaborates with applicable internal customers to provide data, research findings, and support in meeting strategic objectives. This Committee assists in providing hospital performance reports mined from publicly posted performance data, e.g., The Leapfrog Group and Hospital Compare. Additionally, the Committee facilitates the monitoring, analysis and reporting of certain preventable medical errors that occur during hospitalizations as regulated by Centers for Medicaid and Medicare Services (CMS). The preventable medical errors include, but are not limited to, catheter associated urinary tract infections, vascular catheter-associated infections, falls and trauma, and manifestations of poor glycemic control that are not present upon admission. Through contributing HAP departments these conditions are identified through claims and payment data that may identify issues that contribute to poor patient safety. The Committee continues to lead a multidisciplinary workgroup to ensure HAP preparedness for emergent health situations that are congruent with Henry Ford Health System. This includes serving as a liaison between Henry Ford Health System Resuscitation Advisory Council to report and align HAP workplace safety measures. Moreover, educational newsletters to improve patient and employee safety are developed quarterly for various internal and external customer segments.

- **The Healthcare and Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. This information is reported annually to the National Committee for Quality Assurance (NCQA) and is used to compare health plans on a local and national scale. HAP continually reviews these results to focus its efforts on improving care to its members. Contributing to these efforts is a series of initiatives driven by three basic strategies designed to promote and support performance improvement. These strategies are:**
  1. Outreach initiatives to improve member engagement and self-management of chronic conditions
  2. Provider group collaboration and outreach initiatives to improve practice-site delivery of health care to members
  3. Data quality initiatives to improve the timeliness, accuracy and completeness of data used to measure performance and to provide prospective alerts to members and physicians regarding preventive and chronic care needs.

**Objectives**
The objectives of the HAP Quality Program are:
A. To assure and continually improve the value (member and practitioner satisfaction), quality, safety, availability, accessibility, appropriateness, and effectiveness of behavioral 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 HAP practitioner and provider qualifications and competence through credentialing and recredentialing 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 cultural and linguistic needs of our membership.

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

The HAP complex case management (CCM) program provides coordination of care and services to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

The goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member’s condition; determination of available benefits and resources; and development and implementation of a case management plan with personalized goals, monitoring and follow-up.

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

- The degree and complexity of their illness or condition is typically severe.
- The level of case management and care coordination necessary is typically intensive and/or
The amount of resources required for member to regain optimal health or improved functionality is typically extensive.

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

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

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

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

The purpose of Restore CareTrack® Population Health Management Program is to provide population health management services in the form of health education and support to members with chronic conditions. The objective of the program is to improve member health and help members adhere to their physician’s treatment plan. This is accomplished through the provision of interventions based on acuity levels. Lower risk individuals, for example, may receive educational materials and gap-in-care reminders, while higher risk members may work with a nurse health coach who uses motivational interviewing to assess members’ health status and help improve member self-management. These programs are made available to members in all HAP lines of business with the exception of HAP Preferred (unless purchased by the employer group), Midwest Health Plan, ASR Health Benefits, and Medicare Complementary products. Members have the right to participate or decline participation in the program.

Structure

A. HAP Board of Directors (Governing Body)

The HAP Board of Directors is responsible for the quality of health services delivered to HAP members. The Clinical Quality Management Committee (CQMC) reports directly to the Board. The Board meets four times annually. The Alliance Health and Life (AHL) Board is empowered to act on behalf of the corporation to perform all acts that are permitted to be performed by corporations under Michigan Law. The Board is solely responsible for the quality program and structure of AHL. Currently, the Board is made up of the same individuals who serve on the HAP Board of Directors Executive Committee.

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

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

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

C. HAP Clinical Quality Management Committee (CQMC) and Other Committees
The Vice President Quality Management and Credentialing chairs the Clinical Quality Management Committee. The CQMC includes practitioners from the HAP delivery system, research or administrative representatives of practitioner groups, HAP’s Senior Medical Directors, and HAP senior staff. The CQMC evaluates and approves the Quality Program and Work Plan, annual evaluation, and monitors progress toward meeting program goals and objectives. The CQMC oversees patient safety, clinical, administrative, and service quality improvement throughout the plan; recommends policy decisions; and is accountable to the Board through its Quality Committee. Executive Summaries of CQMC outcomes are presented during the Board meetings. The CQMC is comprised of HFHS physicians, HAP network physicians, HAP Board members, HAP Senior Medical Directors, and representatives from Quality, Case Management, Population Health Management, Coordinated Behavioral Health Management, and the Medicare division. The committee meets a minimum of five times per year.

D. Reporting Relationships and Resources
Significant staff resources are dedicated to quality management activities. Approximately 26 full-time equivalents reside in the quality management and credentialing departments (Appendix A). Additionally, the Health Alliance Plan Health and Network Management Division organizational chart demonstrates reporting relationships (Appendix C) and the significant staff resources dedicated to quality management activities.

A number of organizational committees or subcommittees are charged with functions linked to support the Quality Program. These committees and subcommittees provide reports to the CQMC as applicable, at least once a year and upon request.

CQMC Subcommittees:
Peer Review Committee (PRC)
Objective: Identify, review, monitor and aid in the improvement of the technical and professional performance of affiliated practitioners and providers, in accordance with HAP policies and accreditation standards.

Membership
- Vice President Quality Management and Credentialing
- Senior and Associate Medical Directors
- Registered Nurses (Quality Management Department)
- Affiliated physician

Chairperson: Vice President Quality Management and Credentialing
Meeting Frequency: Meets at least (4) four times per year

Credentialing Committee
Objective: The Credentials Committee reviews the credentials of providers applying for initial appointment or reappointment and makes recommendations for affiliation with HAP.

Membership
- Vice President Quality Management and Credentialing
- Associate Vice President Performance Improvement and Management
- Senior Medical Directors
- Registered Nurses (from the Quality Management Department)
- Credentialing Department
- Quality Management
- Provider Contracting
- Community physicians

Chairperson: Vice President Quality Management and Credentialing
Meeting Frequency: Meets at least 22 times per year

Credentialing Oversight Committee
Objective: Reviews and revises credentialing policies and assures that the credentialing program complies with regulatory and accrediting requirements

Membership
- Vice President Quality Management and Credentialing
- Associate Vice President Performance Improvement and Management
- Senior Medical Directors
- Registered Nurses (from the Quality Management Department)
- Credentialing Department
- Quality Management
- Provider Contracting
- Community physicians

Chairperson: Vice President Quality Management and Credentialing
Meeting Frequency: Meets at least 6 times per year

Customer Experience Management (CEM)
Objective: Monitor availability of and member satisfaction with administrative and clinical services to identify opportunities for improvement and partner with internal and external stakeholders to improve performance in those areas

Membership
- Market Intelligence
• Quality Management
• Coordinated Behavioral Health Management
• Clinical Care Management
• Customer Service
• Operations (Claims)
• Provider Plan Management
• Other Departments

Chairperson: Vice President, Customer Experience
Meeting Frequency: Meets at least 6 times per year

**Hospital Quality/Patient Safety Committee (HQ/PSC)**

Objectives: Monitors, evaluates, educates and reports patient safety performance data, identifies centers of excellence and supports patient safety improvement efforts across the delivery system

Additional Responsibilities: Participates in national and local patient safety initiatives such as, the Greater Detroit Area Health Council and Michigan Health and Hospital Association (MHA) initiatives to foster safety and quality care improvements

Membership
- Senior Medical Directors
- Finance
- Quality Management
- Performance Improvement
- Reporting and Analysis
- Provider Development

Chairperson: Vice President Quality Management and RN Quality Management Associate
Meeting Frequency: Meets at least 4 times per year

**Health Care Management Compliance Oversight Committee (HCM MOC)**

Objective: The Health Care Management Compliance Oversight Committee (HCM MOC) oversees the performance of utilization management activities for medical, behavioral health and pharmacy services by HAP and its delegated utilization management entities. The committee also oversees the performance of case and population health management program interventions and outcomes. The HCM MOC meets monthly to review and assess audit materials, activity report data, utilization management, case management and population health management program documents, clinical criteria, and other relevant information on HAP and its delegated entities. This allows HAP to compare the level of delegated entity performance with HAP’s expectations and to implement, when necessary, corrective action plans to ensure compliance with CMS Regulations and National Committee on Quality Assurance (NCQA) standards.

Audits are reported from all UM areas at a minimum of 3 times per year. All clinical criteria and program documents in use at HAP and its delegates are reviewed and approved annually at MMOC. Senior Medical Director and the Director of Utilization Management Compliance and Shared Services or designee co-chair the HCM MOC. Membership is included but not limited to Project Coordinator for Delegated Entities, the Project Coordinator for CBHM, and a management representative from the following departments: Referral Management, Admission and Transfers, Pharmacy Care Management, Case and Population Health Management and Senior Medical Directors. The HCM MOC Co-Chairs report to HAP’s Clinical Quality Management Committee, which in turn conveys information to the HAP Board of Directors.

Additional Responsibilities:
• Reviews and assesses audit materials, activity report data, utilization management, case management and population health management program documents, clinical criteria with input from network practitioners and other relevant information on HNM and the delegated entities
• Gauges performance levels with HAP’s expectations and implements, when necessary, corrective action plans to ensure compliance with the National Committee on Quality Assurance (NCQA) standards

Membership
• Senior Medical Directors
• Quality Management
• Utilization Management
• Coordinated Behavioral Health Management
• Case Management
• Population Health Management

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 patients while controlling drug costs through the approval and availability of efficacious, safe and cost-effective medications
Additional Responsibilities:
• Approves the HAP Oncology P&T Sub-Committee formulary decisions
• Approve P&T related policies and procedures
• Works cooperatively with other system committees to identify opportunities to enhance ambulatory drug therapy and integrate formulary and drug use evaluation with condition management and wellness programs

Membership
• Physician representatives from HAP contracted networks
• HAP Medical Directors
• Geriatric Physician
• Geriatric Pharmacist

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

HAP Oncology Pharmacy and Therapeutics (P&T) Sub-Committee
Objective: Optimizing the quality of oncology-related drug therapy for HAP patients while controlling drug costs through the approval and availability of efficacious, safe and cost-effective medications
Additional Responsibilities:
• Provides support for development of cost/value drug treatment algorithms
• Works cooperatively with other system committees to identify opportunities to enhance ambulatory drug therapy and integrate formulary and drug use evaluation with condition management and wellness programs

Membership
• Oncologist and Hematologist representatives from HAP contracted networks

Chairperson: HFHS Oncologist or Hematologist with strong relationships with HFHS and non-HFHS oncologists and hematologists
Meeting Frequency: Quarterly
HAP’s Corporate Compliance Committee

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

Additional Responsibilities:

- Serves to prevent violations of applicable laws, regulations, federal/state contract obligations, and professional organization requirements as well as supports and protects the rights of HAP members and other stakeholders.
- Proactively audits and monitors to identify violations of laws, regulations and applicable professional organization requirements and provides appropriate response, mitigation and remediation to any such misconduct as soon as it is suspected or discovered.
- Oversees compliance of HAP with regulations including NCQA privacy guidelines and the HIPAA federal privacy and security regulations on a company and subsidiary wide basis.

Membership

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

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

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

Chairperson: HAP’s Chief Compliance Officer

Meeting Frequency: Meets Monthly

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

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

- The Corporate Leadership Council (CLC) meets once a month. The meetings are designed to share updates on ongoing and emerging initiatives and issues. There is an expectation that information shared at CLC meetings will be cascaded to other leaders and to HAP staff with the outcome that front line staff would receive key information regarding HAP at the appropriate time and level. Membership is comprised of plan-wide representation from HAP’s senior leadership team.

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

E. Quality Management (QM), Case Management (CM), Population Health Management (PHM), Coordinated Behavioral Health Management (CBHM), and Medical & Business Informatics (MBI)

Quality Management, Case Management, Population Health Management, and Coordinated Behavioral Health Management are responsible for developing, supporting, and/or implementing the HAP 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 accreditation standards

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

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

F. Internal Collaboration

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

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

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

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

Worksite Health Promotion addresses purchaser requests while supporting HAP’s clinical quality improvement priorities.

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

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

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

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

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

H. Delegation
As of October 2016, Health Alliance Plan delegates complex case management to a vendor (Progeny) for neonatal intensive care unit babies. HAP delegates specific appropriate credentialing-related, pharmacy benefits management, behavioral health, and utilization management components of the quality program through formal agreements with affiliated institutions or groups. The responsibility for oversight and evaluation of delegated credentialing, pharmacy, and UM functions, to assure that policies, procedures, and performance metrics are comparable to non-delegated functions is managed by the CQMC subcommittees. Quality Management, Credentialing, Pharmacy, and the Medical Management Oversight Committee also assure that HAP maintains compliance with state and federal regulations and accrediting standards. Establishment of new delegated agreements involves participation of staff from the QM, Credentialing, Health and Network Management, Governance, and Legal and Regulatory Affairs departments.

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

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

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

Culturally and Linguistically Diverse Membership
These goals are achieved through collaborative efforts and initiatives with Henry Ford Health System who has made significant strides in obtaining race, ethnicity, and language data directly from members. HAP’s healthcare equity campaign is designed to improve the health status of our members through meeting regulatory requirements for capturing and reporting race and language data. Having this data would allow the ability to increase awareness of disparities in health care and develop population health management programs designed to identify and minimize the impact of disparities. Additional programs include literacy and language interpretation services.

Improving Services to HAP Medicare Members
Each year HAP sets goals for Medicare to improve our services to members. We submit annual Healthcare Effectiveness Data and Information Set (HEDIS) measures for quality reporting. HAP uses HEDIS results to track quality performance from year to year and to identify opportunities for improvement. Additionally, HAP annually measures member satisfaction using the Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey results for the Medicare 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 Medicare members. HAP also participates in the annual Health Outcomes Survey (HOS), which is used to evaluate the physical and mental health status and outcomes of our Medicare members, and to identify opportunities for improvement in programs and services, public reporting, and member health. HEDIS, CAHPS, and HOS initiatives are discussed at the Medicare Star Ratings work group, which is focused on improving health outcomes and satisfaction for the Medicare enrollees. The work group meets regularly to track initiatives, discuss program progress, and identify opportunities to improve access to providers and services, quality of care, and member experience. Additional programs designed to improve the health and well-being of the lives we touch include HAP’s Case and Population Health Management programs and provider quality improvement education.

**Centers for Medicare and Medicaid (CMS) Quality Improvement Program (QIP) and Chronic Care Improvement Program (CCIP)**

HAP’s Medicare Quality Program encompasses strategies to design programs that are population based, provide for identification of high risk members with chronic conditions for enrollment into nurse health coaching and case management, measure performance outcomes (clinical, satisfaction, and costs), support systematic and periodic follow-up on the effectiveness of interventions. Additionally, the quality improvement projects address clinical and non-clinical activities and are based on measurable, evidenced-based, achievable interventions that are analyzed annually. The outcomes are reported to the Clinical Quality Management Committee (CQMC) and Board of Directors. CMS has requested that all Medicare Advantage Organizations (MAOs) develop and implement a CCIP focusing on decreasing cardiovascular disease and a QIP that addresses plan all cause readmission for each of their plans. As of 2018 CMS is requesting that health plans submit attestations in lieu of the actual program documents. However, health plans must be prepared to submit the programs at the discretion of CMS.

**Centers for Medicare and Medicaid (CMS) Quality Rating System (QRS) Measures for Qualified Health Plans (QHPs)**

The Centers for Medicare & Medicaid Services (CMS) has contracted with IMPAQ International, LLC, to develop quality measures for Qualified Health Plans (QHPs) operating in the Health Insurance Marketplace (or Exchanges). The contract name is Development and Implementation of Quality Rating System (QRS) Measures for Qualified Health Plans (QHPs). The overarching purpose of the project is to develop a set of measures that can be used to evaluate QHPs operating on the Exchanges and provide Medicare beneficiaries with timely and comparative information on QHPs for their choice of insurer. As part of its measure development process, CMS asks measure developers to convene groups of stakeholders and experts who contribute direction and thoughtful input to the measure developer during measure development and maintenance.

**Project Objectives**

The primary objectives of this project include:

- Assess the landscape of current measures, measure development priorities, and priority gaps for QHPs.
- Identify priority measure concepts for new measure development.
- Recommend any existing measures that can be adapted to plan-level analysis for this project.
- Develop new measures or adapt existing measures for QHPs.
• Test new or adapted measures at the QHP level of analysis.
• Submit new measures to a consensus-based entity for endorsement (e.g., National Quality Forum) if necessary.
• Provide maintenance and reevaluation technical support to ensure that the measures in the QRS have the most up-to-date and evidence-based specifications.

Appendix A
Quality Resources

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<thead>
<tr>
<th>Position</th>
<th>Percentage FTE allocated to MCO QI</th>
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<tbody>
<tr>
<td>Chief Medical Officer</td>
<td>.45</td>
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<tr>
<td>Vice President Quality Management and Credentialing</td>
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<tr>
<td>Medical Director for Utilization</td>
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<td>Medical Director of Behavioral Medicine</td>
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<tr>
<td>Associate Vice President Quality and Credentialing</td>
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<tr>
<td>Senior Project Coordinator</td>
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<td>QM Data Analyst</td>
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Appendix B
Committee Approval

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